

October 7, 2015

Ms. Kimberly Martone  
Director of Operations  
Office of Health Care Access  
410 Capitol Avenue  
MS #13HCA  
P.O. Box 340308  
Hartford, CT 06106



Re: Northeast Medical Group, Inc. and L&M Physician Association, Inc.  
Certificate of Need Application

Dear Ms. Martone:

Enclosed please find the original, four hard copies in 3-ring binders, and an electronic copy on CD of a Certificate of Need (CON) application for the merger of L&M Physician Association, Inc. with and into Northeast Medical Group, Inc. Also enclosed is a check with the filing fee of \$500.00.

Please do not hesitate to contact me with any questions or concerns.

Thank you for your time and support of this project.

Sincerely,



A handwritten signature in black ink, appearing to read "Nancy Rosenthal".

Nancy Rosenthal  
Senior Vice President – Health Systems Development

Enclosures

Northeast Medical Group, Inc.  
L&M Physician Association, Inc.

Certificate of Need

Merger of L&M Physician Association, Inc. and  
Northeast Medical Group

October 7, 2015

**Merger of L&M Physician Association, Inc. and Northeast Medical Group  
Certificate of Need Application**

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**State of Connecticut  
Department of Public Health  
Office of Health Care Access**

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**Certificate of Need Application  
Main Form  
*Required for all CON applications***

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**Contents:**

- Checklist
- List of Supplemental Forms
- General Information
- Affidavit
- Abbreviated Executive Summary
- Project Description
- Public Need and Access to Health Care
- Financial Information
- Utilization

## All Supplemental Forms

In addition to completing this Main Form and the appropriate financial worksheet, applicants must complete one of the following supplemental forms listed below. All CON forms can be found on the OHCA website at [OHCA Forms](#).

Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
(1)	<b>Establishment of a new health care facility (mental health and/or substance abuse) - see note below*</b>
(2)	<b>Transfer of ownership of a health care facility</b> (excludes transfer of ownership/sale of hospital – see “Other” below)
(3)	<b>Transfer of ownership of a group practice</b>
(4)	<b>Establishment of a freestanding emergency department</b>
(5) (7) (8) (15)	<b>Termination of a service:</b> termination of inpatient or outpatient services offered by a hospital termination of surgical services by an outpatient surgical facility termination of an emergency department by a short-term acute care general hospital termination of inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended
(6)	<b>Establishment of an outpatient surgical facility</b>
(9)	<b>Establishment of cardiac services</b>
(10) (11)	<b>Acquisition of equipment:</b> acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners acquisition of nonhospital based linear accelerators
(12)	<b>Increase in licensed bed capacity</b> of a health care facility
(13)	<b>Acquisition of equipment utilizing [new] technology</b> that has not previously been used in the state
(14)	<b>Increase of two or more operating rooms</b> within any three-year period by an outpatient surgical facility or short-term acute care general hospital
Other	<b>Transfer of Ownership / Sale of Hospital</b>

\*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other “health care facilities,” as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

# EXHIBIT I

Notice to Purchaser - In the event that this check is lost, misplaced or stolen, a sworn statement and 90-day waiting period will be required prior to replacement. This check should be negotiated within 90 days.

### Cashier's Check - Customer Copy

No. 1321105813

Void After 90 Days

30-1/1140

Date 09/29/15 10:16:37 AM

NTX

GREENWICH TRUST

0901 0001397 0030

Pay  **BANK OF AMERICA** **500.00**  
FIVE ZERO ZERO CTSCTS

\*\*\*\$500.00

To The Order Of **TREASURER STATE OF CONNECTICUT**

Not-Negotiable

Customer Copy

Retain for your Records

Remitter (Purchased By): **MATTHEW J MCKENNAN**

001641005594

Bank of America, N.A.  
SAN ANTONIO, TX



### Cashier's Check

No. 1321105813

Notice to Purchaser - In the event that this check is lost, misplaced or stolen, a sworn statement and 90-day waiting period will be required prior to replacement. This check should be negotiated within 90 days.

Void After 90 Days

30-1/1140

Date 09/29/15 10:16:37 AM

NTX

GREENWICH TRUST

0901 0001397 0030

Pay  **BANK OF AMERICA** **500.00**  
FIVE ZERO ZERO CTSCTS

\*\*\*\$500.00

To The Order Of **TREASURER STATE OF CONNECTICUT**

Remitter (Purchased By): **MATTHEW J MCKENNAN**

Bank of America, N.A.  
SAN ANTONIO, TX

  
\_\_\_\_\_  
AUTHORIZED SIGNATURE

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. ■ HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENTS. ■

# EXHIBIT II

APARTMENTS FOR RENT (UNFURNISHED)

WEST HAVEN - Studios \$600. 1BR \$695-895. 2BR \$1045. 3BR \$1500. Many incl. h/w, balconies + pkg. No Pets. 203-937-9363

West Haven, 1 BR, 1st fl AND 1 BR, 2nd fl, opposite green. Stove, refrigerator, coin laundry, on bus line. Utilities included. \$1,075/mo. References + security deposit. Call 203-936-6582

WEST HAVEN, Sunny 1 BR in immaculate bldg, w/dishwasher + laundry, W/W, appliances, pool, FREE HEAT/HW + DOCKING GAS. Generous closet space. \$800/mo. Other locations avail. 203-932-4707.

ROOMS FOR RENT

NEW HAVEN 1351 State St. 1 Room/Entr. Clean, Pkg., Ref. Lin. Cable. \$150/wk. Bus. \$500 dep. (203) 469-1996

HELP WANTED GENERAL

ELECTRICIANS CT Lic. E2 for Immed. hire @ well-established company. Salary commensurate with experience. We offer health insurance, 401K, 40-hour work week, overtime, rate jobs at times. Signing bonus and vehicle available depending on experience. Call to hear what we have to offer. 203-785-6429 or fax 203-798-8670.

JOB DEVELOPER/EMPLOYMENT SPECIALIST \$77 - 35hrs/wk + benefits. Rec'd Bachelor's degree in Marketing, Human Service discipline or related field; 2 yrs exp marketing, job development + placement; 2 yrs exp case management, career counseling + employment training, strong oral communication/interpersonal skills. Resp. for participant recruitment, training + employment placements. Employer/community outreach + collaboration. Submit cover letter + resume to info@womenfamilies.org or WFC-HR Office, 160 Colony St. Milford, CT 06451. AA/EOE

HELP WANTED FULL TIME

CIRCULATION MANAGER NEWSPAPER (New Haven Area)

Growing company based in LA with multiple sites nationwide is looking for a Circulation Manager to oversee 3 site warehouse staff, and to force for a new site launch in New Haven area...

Duties include: Distributing 255K weekly newspapers are timely and professionally

Recruit, contract, and administer Independent Contractor Delivery (IC) force

Understand warehouse operating procedures and staging

Ensure site staff are qualified, trained and QA product delivery

Possess excellent client and customer service skills

Experience with newspaper circulation and marketing/distribution industry must.

Salary: \$50-55k Please email resumes to ATTN: HR at cvandrey@clpsmarketing.com

LUCK IS only part of it! A classified ad is the rest!

HELP WANTED FULL TIME

DISTRIBUTION CENTER FACILITATOR (DCF) NEWSPAPER (New Haven Area)

Growing company based in LA with multiple sites nationwide is looking for a Distribution Center Facilitator for a new site launch in New Haven area...

Duties include: Assisting the Manager in ensuring all client product is distributed timely and professionally

Responsible for quality assurance on routes checking independent Contractor forces.

Understand warehouse operating procedures

Ensure that site adheres to ethical business practices to the extent it depends on you.

Must communicate well. Be flexible and cooperative.

Experience with newspaper circulation and marketing/distribution industry preferred.

Salary: \$13.50-\$15.00/hour, overtime paid at time + half

Part-time & full-time positions available

Must have own car and willing to use to QA distribution, mileage reimbursed at .51/mi driven.

Please email resumes to ATTN: HR at cvandrey@clpsmarketing.com

DISTRICT MANAGER NEWSPAPER (New Haven Area)

Growing company based in LA with multiple sites nationwide is looking for a District Manager for a new site launch in New Haven area...

Duties include: Distributing 100-125K weekly newspapers are timely and professionally

Recruit, contract, and administer Independent Contractor Delivery (IC) force

Understand warehouse operating procedures and staging

Ensure site staff are qualified, trained and QA product delivery

Possess excellent client and customer service skills

Experience with newspaper circulation and marketing/distribution industry must

Salary: \$35-38K Please email resumes to ATTN: HR at cvandrey@clpsmarketing.com

CARPENTERS LANDSCAPERS

Please your ad in Our Business and Services or our Services Directory. Our readers will call you! They trust our advertisers to do the job right! Call 203-850-8628

ACCOUNTING & FINANCE

Financial Analyst Global leading manufacturing company based in central CT with 15 worldwide locations is seeking highly motivated CPA interested in growth opportunity within the finance department reporting directly to the CFO. Position Requirements: Must be able to travel extensively and have the ability to work independently. Understanding of Financial Analysis in international settings. Understanding of multi-currency environments. Education Requirements: B.S. in Accounting required. Masters Degree in Accounting or Finance required. MUST BE A CPA. Compensation based on the skill and background of the candidate. Please forward your resume to: Fax: (860) 347-9805 or Email to: Jarvis.products.corp@snet.net

CAREER TRAINING

EMT COURSE STARTS 9-1 DAY - NIGHT PROGRAMS AVAILABLE. Call Meed 203.632.9247 to register or for more info.

LEGAL NOTICES

PUBLIC NOTICE

Pursuant to 12 CFR §303.65 of the regulations of the Federal Deposit Insurance Corporation (the "FDIC"), notice is hereby given that Liberty Bank, whose main office is located at 315 Main Street, Middletown, Connecticut 06457, has filed with the FDIC an application to engage in a merger transaction whereby Naugatuck Valley Savings and Loan (NVSLS) will merge with and into Liberty Bank with Liberty Bank being the surviving entity. It is contemplated that all offices of the above named institution will be operated with the exception of NVSL's Cheshire Branch located at 1699 Highland Avenue, which will be closed and consolidated with Liberty Bank's Cheshire branch located at 160 Highland Avenue, Cheshire, CT at the effective time of the transaction.

Any person wishing to comment on such application may file his or her comments in writing with the regional director of the FDIC at the appropriate FDIC office: John Vogel, Regional Director, FDIC, 15 Braintree Hill Office Park, Suite 200, Braintree, MA 02184-8701, not later than August 7, 2015. The non-confidential portions of the application are on file at the appropriate FDIC office and are available for public inspection during regular business hours. Photocopies of the non-confidential portion of the application file will be available upon request.

PUBLIC NOTICE

Northeast Medical Group, Inc. (NEMGI) and L&M Physicians Association, Inc. are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-636 (a)(3) for the merger of the two Medical Foundations with NEMGI being the surviving entity. This transfer of ownership of a group practice is part of the larger transaction involving Yale-New Haven Health Services Corporation ("YHNSC") and Lawrence + Memorial Corporation ("L+M"). There is no capital expenditure associated with this Application.

SHOP FROM your easy chair.

Shopping the classifieds is easy, relaxing and you don't have to worry about parking.

LEGAL NOTICES

Public Notice: Yale-New Haven Health Services Corporation ("YHNSC") and Lawrence + Memorial Corporation ("L+M") are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-636 (a)(2) and 19a-466. YHNSC and L+M will require CON approval for YHNSC to become the sole member of L+M, which will result in Lawrence + Memorial Hospital joining and becoming part of the Yale New Haven Health System. Lawrence + Memorial Hospital's current location at 365 Mootzauk Avenue, New London, CT will not change as a result of this transaction. There is no capital expenditure associated with this Application.

TAX COLLECTOR'S NOTICE CITY OF WEST HAVEN

Including: CITY OF WEST HAVEN FIRE DISTRICT ALLINGTON CENTER FIRE DISTRICT WEST SHORE FIRE DISTRICT

Pursuant to Sec. 12-145 of the Connecticut State Statutes, the undersigned Tax Collector of the City of West Haven gives notice that taxes for the October 1, 2014 grand list, for real estate, motor vehicle, personal property and sewer use fees are due and payable on July 1, 2015 and January 1, 2016. Last day to pay in time, official US Postmark accepted, is August 3, 2015 for the first installment and February 1, 2016 for the second installment. Late payments will be charged interest from the due date at a monthly rate of 1.5 percent or fraction thereof, 18 percent per annum as required by Connecticut Gen Stat 12-134, 145 and 146. The minimum interest charge is \$2.00 on each tax bill. Failure to receive a bill does not invalidate the tax nor interest and penalties incurred per Connecticut Gen Stat Sec. 12-130 and 12-146. Make checks payable to Collector of Taxes and mail with tax bill, to Collector of Taxes - City of West Haven, PO Box 150461, Hartford, CT 06115. Payments can also be made at the tax office, 355 Main St., first floor, West Haven, CT. Office hours are Mon-Fri from 9:00 a.m. to 4:00 p.m. During the collection cycle only, a drop box is available outside the tax office weekdays from 7:30 a.m. to 7:30 p.m. Point and Click LLC services all credit/debit card payments (convenience fee applies). To pay online log on to www.cityofwesthaven.com - see Quick Links - Tax Collector Dept info.

NOTICE TO CREDITORS

The Hon. John A. Keyes, Judge of the Court of Probate, Derby Probate District, by decree dated July 2, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Edward Cleary, Assistant Clerk. The fiduciary is: Catherine Pierce c/o Shelby L. Wilson, Esq., Bercham, Moses & Devlin, 75 Broad Street, Milford, CT 06460 58347

CLASSIFIED IS OPEN

8:00 AM - 5:00 PM MON-FRI Call 1.800.922.7066 or email: CLASSIFIEDS@NHREGISTER.COM

CANT FIND what you're looking for? Find it the fast & easy, effective way by using the Classifieds Call and place a low cost classified ad under "Wanted to Buy" in next weeks paper.

LEGAL NOTICES

The West Haven Inland Wetlands Agency made the following decision at a regular meeting on Tuesday, June 16, 2015 in the Harriet North Room, 2nd Floor, City Hall, 355 Main Street, West Haven, CT.

85 Cooper Road: Application to add a 12'x16 sunroom and a 16'x16 deck to the existing structure within the wetlands. Applicant: George Nasir/Owner: Philip Ruggiero HW #15-025 APPROVED WITH CONDITIONS

120-140 Fresh Meadow Road: Application to fill 0.25 acres of historic wetlands for a construction yard/ storage area. Applicant/owner: GC Realty LLC Principal: Giancarlo Colonna IW #15-026 APPROVED WITH CONDITIONS

136 Ivy Street: An application to install an above ground pool in the inland regulated area. Applicant/owner: Paul C. Dinicola IW #15-028 APPROVED

20 Simos Lane: Application to install an above ground pool with in the regulated Inland Wetland area. Applicant: Lydia Brown /Owner: Allan Stephanie & Lydia Brown IW #15-027 APPROVED

15 Industry Dr: Proposed to build a parking area totaling 0.69 acres. The site contains approximately 0.22 acre of wetlands located along the northern edge of the property and 0.76 acres of upland review area. The existing wetland area will be enhanced with wetland plantings as part of the proposed project. The construction of the parking area is proposed with the 100-year flood hazard zone, and has been designed to increase the flood carrying capacity of the property by 124 cubic yards. Applicant/Owner: 15 Industry Drive, LLC IW #15-029 CONTINUED

William Kane Chairman

PROBATE NOTICES

NOTICE TO CREDITORS

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DOBBS

Bull Dogs \$950+ Yorkies, \$550+ Chih. \$450+ Bengal Kittens \$250+ Health gear, Vet check sheets. 860-538-0001

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Affordable Washers, Dryers, Stoves, Refrigs. Delivery Available 203-284-8986

A HOME OF YOUR OWN

The Job of Your Dreams A Pet for the Children A Second Career Commencing A Big Sale/Buried Treasure Find these and more in the New Haven Register Classifieds.

Legal Notice Town of Orange

A certified list of Republican party-endorsed candidates for the Town of Orange for election as:

- First Selectman
Selectmen
Tax Collector
Board of Finance
Board of Education
Town Planning and Zoning
Town Planning and Zoning (deferred term)
Constable
Amity Regional School Board

is on file in my office at Orange Town Hall 617 Orange Center Rd., Orange, Connecticut, and copies thereof are available for public distribution. The certified list as received includes fewer names of party-endorsed candidates than the party is entitled to nominate for the following offices:

Table with 3 columns: Office, Number of Names Certified, Number Entitled to be Nominated. Rows include Town Clerk, Board of Education, and Amity Regional School Board.

A primary will be held September 16, 2015, for a particular office, the number of party-endorsed candidates plus the number of candidates filing petitions pursuant to Sections 9-362 to 9-450 of the Connecticut General Statutes exceeds the maximum number which the party is entitled to nominate for that office. Petitions must be filed not later than 4:00 p.m. on August 12, 2015. Petition forms, instructions and information concerning the procedure for filing of opposing candidates, including schedules, may be obtained from:

Fredrick Rendick, Republican Registrar of Voters Orange, Town Hall 617 Orange Center Rd., Orange, Connecticut.

Patrick B. O'Sullivan Orange Town Clerk

[Your Ad, Read Here.] Call to place your Classified ad. Ads can also be placed through our website newhavenregister.com or by emailing classifiedads@nhregister.com 800.922.7066 Mon-Fri • 8:00am-5:00pm NewHavenRegister.com

Make a list of those items you're not using anymore, then give us a call. We can help you sell them!

To place your ad, call toll-free 1-800-922-7066

The Classifieds in the NEW HAVEN REGISTER

NewHavenRegister.com

**HELP WANTED FULL TIME**

**CIRCULATION MANAGER NEWSPAPER (New Haven Area)**

Growing company based in LA with multiple sites nationwide is looking for a Circulation Manager to oversee 2 site warehouse, staff, and to force for a new site launch in New Haven area...

Duties include:

- Distributing 255K weekly newspapers are timely and professionally
- Recruit, contract, and administer Independent Contractor Delivery (IC) force
- Understand warehouse operating procedures and staging
- Ensure site staff are qualified, trained and QA product delivery
- Possess excellent client and customer service skills
- Experience with newspaper circulation and marketing/distribution industry must

Salary: \$50-55k

Please email resumes to ATTN: HR at cvandrey@cipsmarketing.com

**DISTRIBUTION CENTER FACILITATOR (DCF) NEWSPAPER (New Haven Area)**

Growing company based in LA with multiple sites nationwide is looking for a Distribution Center Facilitator for a new site launch in New Haven area...

Duties include:

- Assisting the Manager in ensuring all client product is distributed timely and professionally
- Responsible for quality assurance on routes checking Independent Contractor force.
- Understand warehouse operating procedures
- Ensure that site adheres to ethical business practices to the extent it depends on you.
- Must communicate well
- Be flexible and cooperative.
- Experience with newspaper circulation and marketing/distribution industry preferred.

Salary: \$13.50-\$15.00/hour, overtime paid at time + 1/2

Part-time & Full-time positions available

Must have own car and willing to use in QA distribution, mileage reimbursed at .31/mi driven.

Please email resumes to ATTN: HR at cvandrey@cipsmarketing.com

**DISTRICT MANAGER NEWSPAPER (New Haven Area)**

Growing company based in LA with multiple sites nationwide is looking for a District Manager for a new site launch in New Haven area...

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- Understand warehouse operating procedures and staging
- Ensure site staff are qualified, trained and QA product delivery
- Possess excellent client and customer service skills
- Experience with newspaper circulation and marketing/distribution industry must

Salary: \$35-38k

Please email resumes to ATTN: HR at cvandrey@cipsmarketing.com

**CAREER TRAINING**

**FAST COURSE STARTS 9-1 DAY - NIGHT PROGRAMS AVAILABLE**

Call Matt@203.692.9247 to register or for more info...

**CARPENTERS PAINTERS LANDSCAPERS**

Please your ad in our Business Card Section or our Service Directory. Our readers will not only thank our advertisers...

**LEGAL NOTICES**

**CITY OF ANSONIA**

Motor Vehicle, Real Estate and Personal Property Taxes on the Grand List of October 1, 2014 are due July 1, 2015 and payable during the month of July 2015. Tax payments may be made to:

Collector of Taxes  
Post Office Box 253  
Ansonia, CT

Payments may also be made in person between the hours of 8:30 - 4:30, M. T. W. THURSDAY 8:30 - 5:00 FRIDAY 8:30 - 1:00 at the Tax Collector's Office, 253 Main Street, Ansonia, CT.

Taxpayers who have not received a bill in July should contact Tax Office for a duplicate bill since failure to receive a bill does not invalidate the tax or respective penalties should the account become delinquent. Unpaid taxes will be considered delinquent as of August 4, 2015. On that date interest will be charged from the original date of July 2015. Interest is charged at the rate of 18% per year in accordance with the provisions of Connecticut General Statutes Sec 12-14c.

T. Blackwell, Tax Collector  
City of Ansonia  
253E16

**LEGAL NOTICE**

Pursuant to Conn. Gen. Stat. §16-243m, the Public Utilities Regulatory Authority (PURH) will conduct a public hearing at Ten Franklin Square, New Britain, Connecticut, on Tuesday, August 4, 2015, at 9:00 a.m. concerning Docket No. 15-01-24 - Annual Reconciliation of the Conservation Adjustment Mechanism. Filed by: The Connecticut Light and Power Company, The United Illuminating Company, Connecticut Natural Gas Corporation, The Southern Connecticut Gas Company and Yankee Gas Services Company.

**LEGAL NOTICE TO HAMDEN TAXPAYERS**

The first installment of taxes levied on the Grand List of October 1, 2014 is due and payable July 1, 2015.

If these taxes are not paid on or before August 3, 2015 they will be subject to interest at the rate of 1.2% or fraction thereof from the due date of July 1, 2015 to the date the tax installment is paid. The minimum interest charge is \$2.00.

These taxes become delinquent August 4, 2015. In accordance with a Town Ordinance, delinquent motor vehicle taxes requiring a release for motor vehicle registration must be paid by cash, certified check or money order.

Taxes will be received at the Office of the Tax Collector, Hamden Government Center, 2750 Dixwell Ave., Hamden, Monday through Friday 8:30 AM to 4:30 PM.

This is subject to change to conform to the latest Public Acts, General Statutes and local ordinances.

**JOHN STEELE, CMCA  
TAX COLLECTOR**

**LEGAL NOTICE:**

The Curran Foundation's Form 990-PF is available for public inspection by appointment only at the offices of Halsey Associates, 234 Church Street, 10th Floor, New Haven, CT, to make an appointment, please call 203-772-0740.

**LIQUOR PERMIT**

Notice of Removal

This is to give notice that I, THOMAS M SMITH, 145 PUTTING GREEN RD TRUMBULL CT 06611-2519

Have filed a request placarded 6/24/2015 with the Department of Consumer Protection for permission to move my PACKAGE STORE LIQUOR business now located at 100 RACKERON RD ORANGE, CT 06477

To: 374 BOSTON POST RD ORANGE, CT 06477

The business will be owned by TOMLIZ AND SONS LLC

Remonstrances/Objections must be filed by 06/01/2015

THOMAS M SMITH

**A HOME OF YOUR OWN**

The Job of Your Dreams  
A Plan for the Millionaire  
A Second Car for Commuting  
A Top Sale "Empire" Treasure  
Plus... there are more in the New Haven Register Classifieds.

**LEGAL NOTICES**

**NOTICE OF TAX WARRANT AND VEHICLE TAX AUCTION**

The Tax Collector of the City of New Haven, Connecticut, hereby gives Notice that a Tax Warrant has been issued on the taxpayer for failure to pay Personal Property Tax on their vehicle, and that a Tax Collector Auction has been scheduled by the Tax Collector through its agent, State Marshal John J. Daniels, (203) 215-7857, in accordance with (C.G.S.12-155)

**TIME AND PLACE OF AUCTION**

DATE: (SATURDAY) 6/15/15

TIME: 8:30 A.M. viewing 9:00 A.M. Auction starts 9:00 A.M.

PLACE: CROWN AUTO CENTER 388 Crown Street, New Haven, CT.

**VEHICLES**

454W1X82C764417735  
21K1832E63C042465  
16L275485F185540  
2H8E216552H350563  
104H484E3251433  
206H784275R434039  
1F8HP27136G141337  
1B8CR48K18C113652

The Property being auctioned pursuant to this notice is being sold "as is" and "where is"

**Public Notice:**

Northeast Medical Group, Inc. (NEMGI) and L&M Physician Association, Inc. are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-659 (a)(3) for the merger of the two Medical Foundations with NEMGI being the surviving entity. This transfer of ownership of a group practice is part of the larger transaction involving Yale-New Haven Health Services Corporation ("YNHSC") and Lawrence + Memorial Corporation ("L+M") for YNHSC to become sole member of L+M. There is no capital expenditure associated with this Application.

**Public Notice:**

Yale-New Haven Health Services Corporation ("YNHSC") and Lawrence + Memorial Corporation ("L+M") are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-659 (a) (2) and 19a-659 (a) (3). YNHSC and L+M will request CON approval for YNHSC to become the sole member of L+M, which will result in Lawrence + Memorial Hospital joining and becoming part of the Yale New Haven Health System. Lawrence + Memorial Hospital is currently located at 365 Montauk Avenue, New London, CT. This will not change as a result of this transaction. There is no capital expenditure associated with this Application.

**STATE OF CONN Superior Court Juvenile Matters**

**NOTICE TO Olivia Simmons-Darveau of Paris Unknown**

A petition has been filed seeking Termination of parental rights of the above named in minor child(ren). The petition, whereby the court's decision can affect your parental rights if any, regarding minor child(ren) will be heard on 09/21/15 at 10:00A.M. at 239 Whalley Avenue, New Haven, CT 06511.

Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the New Haven Register, a newspaper having a circulation in the town/city of New Haven, CT.

Hon. John Cronan  
Judge  
7/24/15

Right to Counsel: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your hearing is to be held.

**CLASSIFIEDS** hold many, many opportunities. They give opportunity for you to buy, meet people, sell unwanted items, and housing, save money, earn a couple bucks, and much, much more.

**HOW TO WRITE** a classified ad that sells: First - Be complete. Second - include the price. And third - Be available. Call today and we will be happy to help you write the most effective ad.

**LEGAL NOTICES**

**STATE OF CONN Superior Court Juvenile Matters**

**NOTICE TO Gerald Thomas of Parts Unknown**

A petition has been filed seeking Commitment of minor child(ren) of the above named or vesting of custody and care of said child(ren) of the above named in a lawful, private or public agency or a suitable and worthy person. The petition, whereby the court's decision can affect your parental rights, if any, regarding minor child(ren) will be heard on 09/21/15 at 10:00A.M. at 239 Whalley Avenue, New Haven, CT 06511.

Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the New Haven Register, a newspaper having a circulation in the town/city of New Haven, CT.

Hon. John Cronan  
Judge  
Kathryn A. Coppola  
7/24/15

Right to Counsel: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your hearing is to be held.

**PROBATE NOTICES**

**NOTICE TO CREDITORS**

ESTATE OF Anna Peia, AKA Anna Rapolos

The Hon. Beverly K. Street-Kelias, Judge of the Court of Probate, District of Milford - Orange Probate District, by decree dated July 7, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Nabil E. Valencia,  
Assistant Clerk

The fiduciary is:  
Claudia Bujold,  
a.k.a. Claudia Peia  
69 Point Beach Drive  
Milford, CT 06460  
572264

**NOTICE TO CREDITORS**

ESTATE OF Elizabeth McCabe Heron, late of Derby in said District deceased, AKA Elizabeth T. Heron

The Hon. Clifford B. Hoyce, Judge of the Court of Probate, District of Derby Probate District, by decree dated July 2, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Kay Jeanette,  
Chief Clerk

The fiduciary is:  
Kathleen H. Demers  
78 George Avenue  
Chester, CT 06430  
672891

**NOTICE TO CREDITORS**

ESTATE OF Leonard D'Antona

The Hon. John A. Keyes, Judge of the Court of Probate, District of New Haven Probate District, by decree dated July 2, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Edward Cleary,  
Assistant Clerk

The fiduciary is:  
Lori RJordan  
c/o Susan B. Nobleman, Esq.  
3127-3129 Whittney Ave  
Hamden, CT 06518  
686366

**NOTICE TO CREDITORS**

ESTATE OF

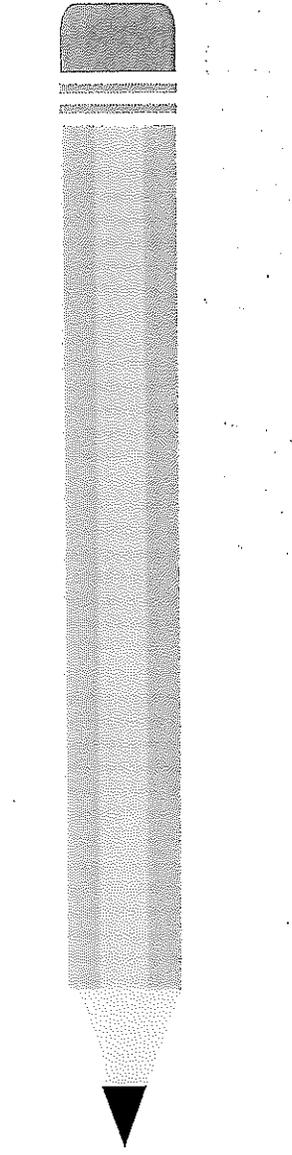
The Hon. John A. Keyes, Judge of the Court of Probate, District of New Haven Probate District, by decree dated July 2, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Edward Cleary,  
Assistant Clerk

The fiduciary is:  
Lori RJordan  
c/o Susan B. Nobleman, Esq.  
3127-3129 Whittney Ave  
Hamden, CT 06518  
686366

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The Classifieds in the  
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NewHavenRegister.com

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LEGAL NOTICES

NEW LONDON PUBLIC SCHOOLS

Is seeking applicants for the following administrative position: NATHAN HALE ARTS MAGNET SCHOOL PRINCIPAL New London, CT Grades K - 5

In only its second year as visual and performing arts magnet school in New London, the Nathan Hale Arts Magnet School provides students from kindergarten through grade 5 an integrated learning environment that combines traditional academics with an arts curriculum that includes vocal and instrumental music, visual art, dance, theatre, creative writing, and interdisciplinary arts.

The school boasts a variety of specialty rooms in which students can express their creative inner selves, including an outdoor art classroom, a music & instrument room, an art room, a state-of-the-art dance room, a recording studio, a choral & music room, a keyboard classroom, video editing room, and a science room.

New London has been designated by state legislation as the only "Magnet District" in Connecticut.

The Nathan Hale Arts Magnet School teaches all facets of the production cycle, and students create projects for their school-based and district-wide academic areas, as well as participation in live performances and public showcases of their work, provide students with challenging learning activities that will develop their ability to demonstrate creativity, communicate effectively, collaborate with others, and assume leadership roles.

The school seeks to transcend the work of a traditional elementary school. Teachers focus on nurturing the whole child and on developing a community of learners that values the work of all individuals.

The district is seeking a dynamic leader to join our journey. Qualified applicants will have:

- Possession of CT Administrative Certificate (092) or eligibility to obtain the CT 092
• Teaching and/or experience in a magnet school environment is a plus
• Certification and instructional or practical experience in one or more of the fine arts (music, visual arts, theater or dance) preferred
• A background in and demonstrated commitment to the arts

Please submit letter of intent, resume, application, three letters of reference, certification, a statement regarding educational philosophy and transcripts to:

Cherese Chery Chief Talent/Human Resources Officer New London Public Schools 134 Williams Street, New London, CT 06320

Closing Date for Applications: August 1, 2015 Applications must be submitted electronically through Applicant.com. http://www.applicant.com/newlondononlineapp/

New London Public School District is an Equal Opportunity/Affirmative Action Employer. Candidates from diverse racial, ethnic and cultural backgrounds are encouraged to apply.

Notice of Tentative Determination to Approve Stationary Source New Source Review Permit Applications and Notice of Public Informational Hearing

Applicant: CPV Towing, LLC Application No. 201408901, 201408904, 201408905, 201408906, 201408907 City/Town: Oxford, CT

The Commissioner of the Department of Energy and Environmental Protection (DEEP) hereby gives notice that a tentative determination has been reached to approve the following applications. The proposed activity will affect air resources. The Commissioner also gives notice that a hearing may be held on this application if the Commissioner determines that the public interest will best be served thereby, and shall hold a hearing as provided below.

Applicants Name and Address: CPV Towing, LLC, 50 Bealhouse Hill Office Park, Suite 300 Bealhouse, MA 02184

Contact Name/Phone/Email: Mr. Andrew Bazinet, (781) 848-3811, abazinet@cpv.com

Type of Permit: Plus (P) New Source Review permits for a 805 MW Combined Cycle Power Plant consisting of two GE 7HA.01 combustion turbines with duct firing, one auxiliary boiler and two emergency diesel fired engines

Relevant Statute(s)/Regulation(s): C062-22a-174, Clean Air Act Amendments of 1990

Facility Location: 16 Woodhill Hill Road, Oxford, CT 06478

The DEEP has tentatively determined that the Lowest Achievable Emission Rate (LAER) for NOx emissions shall be:

- 2.0 ppmvd and 5.0 ppmvd when combusting natural gas and silica low sulfur distillate (ULSD) for the turbines.
• 7 ppmvd for the auxiliary boiler burning only natural gas.
• Fuel limitation on hours of operation and latest required USEPA certified engines for the diesel emergency and five power engines
• The applicant is required to possess 284 tons of approved surplus non-attainment NOx emission reduction credits to offset the potential 194.7 annual tons of NOx that may be emitted from the facility.

According to the ambient air impact analysis, the proposed facility will not cause or contribute significantly to any violation of a National Ambient Air Quality Standard or Prevention of Significant Deterioration (PSD) increment. The predicted PSD multi-source ambient impacts for nitrogen dioxide (NO2), sulfur dioxide (SO2) and PM10 are presented in table below:

Table with 3 columns: PARAMETER, PSD INCREMENT (ug/m3), MAXIMUM IMPACT (ug/m3). Rows include SO2 annual arithmetic mean, SO2 24-hr average, SO2 3-hr average, NO2 annual, PM-10 annual arithmetic mean, PM-10 24-hr average, PM-2.5 annual arithmetic mean, PM-2.5 24-hr average.

INFORMATION REQUESTS/PUBLIC COMMENT

Interested persons may obtain copies of the application from the applicant at the applicant's address noted above. The application, proposed permits and supporting documentation are available for inspection at DEEP, Bureau of Air Management, 79 Elm Street, 5th floor, Hartford, CT from 8:30 AM to 4:30 PM Monday through Friday and at other times by appointment. Interested persons have thirty (30) days from publication of this notice to submit comments to the Department of Energy and Environmental Protection, Bureau of Air Management or request a public hearing concerning the commissioner's tentative determination to approve the permit applications, in accordance with the section 22a-3a-3(d) of the Regulations of Connecticut State Agencies and section 22a-174-29(c) of the Regulations of Connecticut State Agencies. Please note: The department has already determined it will hold a public information hearing as indicated in the remainder of this notice. Written comments on the application should be directed to Mr. James Griffin, Bureau of Air Management, DEEP, 79 Elm Street, Hartford, CT 06106-5127, no later than 30 days from the publication date of this notice. Comments regarding this application may be submitted via electronic mail to: james.griffin@dep.state.ct.us.

NOTICE OF PUBLIC INFORMATIONAL HEARING

As requested and pursuant to section 22a-174-29(c) of the RCSA, the commissioner will hold a Public Informational Hearing to take public comments concerning the tentative determination to approve the above referenced air permit applications.

The informational hearing will be held on August 27, 2015 at 6:30 pm at Oxford High School, 61 Quaker Farms Road, Oxford, CT 06478. Notice of the hearing is posted on the "Calendar of Events" on DEEP's website at http://www.deep.state.ct.us/calendar. The public hearing will be conducted if the weather results in closure of the facility at the hearing. Absence of the public should check the Calendar of Events for the date and time of the rescheduled hearing if inclement weather prevents the holding of the scheduled hearing.

The informational hearing will be moderated and recorded by a DEEP hearing officer and will proceed in the following order: presentations from the applicant and DEEP staff; a 15-minute oral record break for questions and answers between members of the public and presenters; and then the continuation of the informational hearing to receive oral and written comments from members of the public on the record. Comments will be heard in the order in which members of the public sign up at the informational hearing.

Written comments will be accepted at the informational hearing and until the close of business on September 3, 2015. Instructions on how and where to submit comments between August 27 and September 3 will be provided at the informational hearing. Persons seeking to intervene in the hearing process must file a request no later than 5 days prior to the start of the public hearing. Requests may be mailed or delivered to the Office of Adjudication, 79 Elm Street, Hartford, CT 06106 or filed electronically at depa.dms@state.ct.us. For additional information go to www.deep.state.ct.us/permits/air/.

ADA PUBLICATION STATEMENT The Department of Energy and Environmental Protection is an Affirmative Action and Equal Opportunity Employer that is committed to the requirements of the Americans with Disabilities Act. To request an accommo-

LEGAL NOTICES

LIQUOR PERMIT Notice of Application This is to give notice PRATIMA P PATEL, 7 PAPA LN, NORTH HAVEN, CT 06453-3822. Have filed an application placarded 07/29/2015 with the Department of Consumer Protection for a PACKAGE STORE LIQUOR PERMIT for the sale of alcoholic liquor on the premises at 7 PAPA LN, NORTH HAVEN, CT 06453-3822. The business will be owned by MELDI-MATA LLC. Objections must be filed by 09/09/2015.

LIQUOR PERMIT Notice of Application This is to give notice that Kiranraj Patel, 91 Robert Treat Dr, Apt C, Milford, CT 06460. Have filed an application placarded 07/17/2015 with the Department of Consumer Protection for a PACKAGE STORE LIQUOR PERMIT for the sale of alcoholic liquor on the premises at 332 Newhall St, New Haven, CT 06511. The business will be owned by MANSHI ASSOCIATES LLC. Objections must be filed by 08/28/2015.

NOTICE OF PUBLIC HEARING The Representative Policy Board of the South Central Connecticut Regional Water District will hold a public hearing to consider the South Central Connecticut Regional Water Authority Application for the Transfer of Interest in Real Property (Conservation Easement) to the State of Connecticut for 60+/- acres located off Great Hill Rd. in Guilford, CT, which is currently referred to as Land Unit GU 22A at 7:00 p.m. on Thursday, August 20, 2015 at the Nathanial B. Greene Community Center, 32 Church Street, Milford, CT 06460. The Public Hearing is being held pursuant to Section 10 and 18 of Special Act 7-9-08 as amended. The applications and accompanying information are available for public inspection between the hours of 8:00 a.m. and 5:00 p.m. at the office of the Regional Water Authority, 90 Sargent Drive, New Haven, Connecticut.

All users of the public water supply system, residential of the Regional Water District, owners of property served or to be served, and other interested persons shall have an opportunity to be heard concerning the matters under consideration. Thomas P. Clifford III, Chairman REPRESENTATIVE POLICY BOARD, South Central Connecticut Regional Water District, 90 Sargent Drive, New Haven, CT 06511.

Public Notice: Northeast Medical Group, Inc. (NEMG) and L&M Physician Association, Inc. are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 36a-638 (a)(3) for the merger of the two Medical Foundations with NEMG, which is the surviving entity. This transfer of ownership of a group practice is part of a group transaction involving Yale-New Haven Health Services Corporation ("YNHSC") and Lawrence + Memorial Corporation ("L+M") for YNHSC to become a member of L+M. There is no capital expenditure associated with this Application.

Public Notice: Yale-New Haven Health Services Corporation ("YNHSC") and Lawrence + Memorial Corporation ("L+M") are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 36a-638 (a) (2) and 36a-638 (a)(3) for the merger of the two Medical Foundations with NEMG, which is the surviving entity. This transfer of ownership of a group practice is part of a group transaction involving Yale-New Haven Health Services Corporation ("YNHSC") and Lawrence + Memorial Corporation ("L+M") for YNHSC to become a member of L+M. There is no capital expenditure associated with this Application.

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LEGAL NOTICES

STATE OF CONNECTICUT SUPERIOR COURT Judicial District of New Haven at New Haven Wilkowsk, Norma J. Plaintiff vs. Wilkowsk, Anthony T. Defendant. NOTICE TO: Wilkowsk, Anthony T. Return Date: 8/18/15. The Court has reviewed the Motion for Order of Notice and the complexity of the Application/Motion which asks for divorce (dissolution of marriage). The Court finds that the current address of the party to be notified is unknown and that all reasonable efforts to find him/her have failed. The Court also finds that the last known address of the party to be notified was 177 Daytorra St., West Haven, CT 06515. The Court orders that notice be given to the party to be notified by having a State Marshal or other proper officer place a legal notice in New Haven Register, a newspaper circulating in New Haven County, containing a true and correct copy of the Order of Notice, and, if accompanying a Complaint for divorce (dissolution of marriage), complaint for dissolution of civil union, legal separation or annulment, or if accompanying an Application for custody or visitation, a statement that automatic Court orders have been issued in the case as required by Section 25-5 of the Connecticut Practice Book and are a part of the Complaint/Application on file with the Court. The notice should appear once before 8/15/15 for one time publication and proof of service shall be filed with this Court. F. Nelson, Asst. Clerk 7/23/15

STATE OF CONNECTICUT SUPERIOR COURT Judicial District of New Haven at New Haven Wilkowsk, Norma J. Plaintiff vs. Wilkowsk, Anthony T. Defendant. NOTICE TO: Wilkowsk, Anthony T. Return Date: 8/18/15. The Court has reviewed the Motion for Order of Notice and the complexity of the Application/Motion which asks for divorce (dissolution of marriage). The Court finds that the current address of the party to be notified is unknown and that all reasonable efforts to find him/her have failed. The Court also finds that the last known address of the party to be notified was 177 Daytorra St., West Haven, CT 06515. The Court orders that notice be given to the party to be notified by having a State Marshal or other proper officer place a legal notice in New Haven Register, a newspaper circulating in New Haven County, containing a true and correct copy of the Order of Notice, and, if accompanying a Complaint for divorce (dissolution of marriage), complaint for dissolution of civil union, legal separation or annulment, or if accompanying an Application for custody or visitation, a statement that automatic Court orders have been issued in the case as required by Section 25-5 of the Connecticut Practice Book and are a part of the Complaint/Application on file with the Court. The notice should appear once before 8/15/15 for one time publication and proof of service shall be filed with this Court. F. Nelson, Asst. Clerk 7/23/15

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PROBATE NOTICES

NOTICE TO CREDITORS ESTATE OF George T. Middleton, Jr., AKA George Middleton. The Hon. Beverly K. Streif-Kefalas, Judge of the Court of Probate, District of Milford - Orange Probate District, by decree dated July 13, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Nabli E. Valencia, Assistant Clerk. The fiduciary is: Maryann Middleton c/o Joel C. Karp, Esq., Karp & Langerman, P.C., 335 Plains Rd., Ste. 209E Milford, CT 06460 690148.

NOTICE TO CREDITORS ESTATE OF Henrietta Veronica Cornely. The Hon. Edward C. Burt, Jr., Judge of the Court of Probate, District of Hartford - Bethany Probate District, by decree dated July 22, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Valerie A. Dondi, Clerk. The fiduciary is: Louis Scoppetto c/o Allison M. DePaola, Esq., Floman DePaola, LLC P.O. Drawer 983 378 Boston Post Rd. Orange, CT 06477 692057.

NOTICE TO CREDITORS ESTATE OF Mary Catherine Felton. The Hon. Edward C. Burt, Jr., Judge of the Court of Probate, District of Hartford - Bethany Probate District, by decree dated July 22, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Valerie A. Dondi, Clerk. The fiduciary is: Laura M. Vitello c/o Jeffrey J. Gorka, Esq., 323 Main Street, Wallingford, CT 06492 692076.

NOTICE TO CREDITORS ESTATE OF Mary Catherine Felton. The Hon. Edward C. Burt, Jr., Judge of the Court of Probate, District of Hartford - Bethany Probate District, by decree dated July 22, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Valerie A. Dondi, Clerk. The fiduciary is: Laura M. Vitello c/o Jeffrey J. Gorka, Esq., 323 Main Street, Wallingford, CT 06492 692076.

NOTICE TO CREDITORS ESTATE OF Mary Catherine Felton. The Hon. Edward C. Burt, Jr., Judge of the Court of Probate, District of Hartford - Bethany Probate District, by decree dated July 22, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Valerie A. Dondi, Clerk. The fiduciary is: Laura M. Vitello c/o Jeffrey J. Gorka, Esq., 323 Main Street, Wallingford, CT 06492 692076.

PROBATE NOTICES

NOTICE TO CREDITORS ESTATE OF Phan Au. The Hon. Beverly K. Streif-Kefalas, Judge of the Court of Probate, District of Milford - Orange Probate District, by decree dated July 14, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Elizabeth Davis, Chief Clerk. The fiduciary is: Kiet Dang 38 Clowden Street Milford, CT 06461 694991.

FORECLOSURES

LEGAL NOTICE FORECLOSURE AUCTION SALE Docket No.: NNI-CV-14-019588-S Case Name: Wells Fargo Financial America, Inc. vs. Penders, Adrienne G., et al. Property Address: 100 Edgar Street East Haven, CT Property Type: Residential Date of Sale: August 6, 2015 at 12:00pm Committee Name: Attorney Keith V. Slinick Phone Number: (203) 438-5022. See Foreclosure Sales at www.jud.ct.gov for more detailed information.

LEGAL NOTICE FORECLOSURE AUCTION SALE

LEGAL NOTICE FORECLOSURE AUCTION SALE Docket No.: CV-14-01896-S Case Name: J.P. Morgan Chase vs. Rameshwar R. Gaonkar, et al. Property Address: 875 Townsend Ave. Unit # 111 New Haven, CT 06512 Property Type: Single Family Residential Condominium Date of Sale: August 4, 2015 at 12:00 p.m. Required deposit: \$15,000. Committee Name: Carl V. Pantalone, Esq. Committee Phone Number: (203) 431-7472. See Foreclosure Sales at www.jud.ct.gov for detailed information.

LEGAL NOTICE FORECLOSURE AUCTION SALE

LEGAL NOTICE FORECLOSURE AUCTION SALE Docket No.: NNI-CV-15-8032720-S Case Name: Humphrey Place Condominium Association, Inc. vs. M&T Bank aka Manufacturers and Traders Trust Company Property Address: 55 Walnut Street, Unit S-3, New Haven, CT 06511 Property Type: Residential Condominium Date of Sale: August 6, 2015 Committee Name: Nicholas M. Trizzano Phone Number: (203) 552-1192. See Foreclosure Sales at www.jud.ct.gov for more detailed information.

LEGAL NOTICE FORECLOSURE AUCTION SALE Docket No.: NNI-CV-15-8032720-S Case Name: Humphrey Place Condominium Association, Inc. vs. M&T Bank aka Manufacturers and Traders Trust Company Property Address: 55 Walnut Street, Unit S-3, New Haven, CT 06511 Property Type: Residential Condominium Date of Sale: August 6, 2015 Committee Name: Nicholas M. Trizzano Phone Number: (203) 552-1192. See Foreclosure Sales at www.jud.ct.gov for more detailed information.

REMEMBER - when placing a classified to get best results be sure to include: 1) all the details 2) include the price 3) include the phone number 4) include the e-mail address

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Public Notices Public Notices

**REPRESENTATIVE MEETING**  
August 3, 2015

The members of the Representative Team Meeting, subject and other legal values of the Town of Waterford are the following:

- To consider and act upon the Minutes of the June 2, 2015 Regular Meeting.
- To consider and act upon an application to fill a vacancy on the Senior Citizens Committee by the nomination of Mrs. J. J. ...
- To consider and act upon an application to fill a vacancy on the Board of Public Works by the nomination of Mrs. J. J. ...
- To consider and act upon an application to fill two vacancies on the Board of Public Works by the nomination of Mrs. J. J. ...
- To consider and act upon a report from Robert ...
- To consider and act upon a report from the Board of Selectmen on behalf of the Chief Engineer, subject to the ...
- To consider and act upon a report from the Board of Selectmen on behalf of the Chief Engineer, subject to the ...
- To consider and act upon a proposed agreement to Section 8.22A-USA and C of the Waterford Code of Ordinances, subject to the ...
- To consider and act upon a proposed agreement to Section 8.22A-USA and C of the Waterford Code of Ordinances, subject to the ...

**TOWN OF LEYDARD**  
NOTICE TO BID - PUBLIC WORKS

The Town of Leydard invites sealed bids for Supply Vehicle and Equipment. A complete list is available on our web site under the menu.

All vehicles, equipment, and materials are offered in "as-is" condition and to be used only for the purpose of the project. All items must be removed by the contractor within 10 business days of the date of award.

Sealed bids will be received until 2:00 P.M. on Tuesday, August 11, 2015, at 743 G.L. ...

**CITY OF GASTON**  
Conservation Commission/ Board of Public Works

The City of Gaston Conservation Commission/ Board of Public Works will hold a public hearing on August 3, 2015 at 7:30 p.m. at the Municipal Building, 205 Madison Street, Gaston, to hear and act on the following matter:

Robert ... as Agent for 538 Eastern Field Road ... to install 700' of overhead ...

**QUALITY ASSURANCE**  
RESIDENTIAL INSPECTIONS

**INSPECTION**  
Home Inspection Services

**INSPECTION**  
Home Inspection Services

**INSPECTION**  
Home Inspection Services

**CITY OF NEW HAVEN**  
NOTICE OF PUBLIC HEARING

All a tax sale held on June 19, 2015 the City of New Haven sold the following property:

Chesler Street and City of New Haven for ...

**CITY OF NEW HAVEN**  
NOTICE OF PUBLIC HEARING

All a tax sale held on June 19, 2015 the City of New Haven sold the following property:

Chesler Street and City of New Haven for ...

**ADDITION**  
Home Addition Services

**ADDITION**  
Home Addition Services

**ADDITION**  
Home Addition Services

**INDEPENDENT CONTRACTORS**  
Home Improvement Services

**INDEPENDENT CONTRACTORS**  
Home Improvement Services

**INDEPENDENT CONTRACTORS**  
Home Improvement Services

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**Animals and Pets**  
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**Announcements**  
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**Announcements**  
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**Real Estate**  
Property Listings

**Real Estate**  
Property Listings

**Real Estate**  
Property Listings

**Animals and Pets**  
Pet Services and Supplies

**Animals and Pets**  
Pet Services and Supplies

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**Real Estate**  
Property Listings

**Real Estate**  
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Property Listings

**Animals and Pets**  
Pet Services and Supplies

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**Real Estate**  
Property Listings

**Real Estate**  
Property Listings

**Real Estate**  
Property Listings

**Animals and Pets**  
Pet Services and Supplies

**Animals and Pets**  
Pet Services and Supplies

**Animals and Pets**  
Pet Services and Supplies

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Advertiser: Mason Inc/Yale New Haven Hospital ...  
Section/Page/Zone: Daybreak/D005/  
Description: 19342 Public Notice Yale-New Haven

Ad Number: d00607989  
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**the day**



# EXHIBIT III

## Affidavit

Applicant: Northeast Medical Group, Inc.

Project Title: Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc.

I, Amit Rastogi, MD Interim Chief Executive Officer  
(Name) (Position – CEO or CFO)

of Northeast Medical Group, Inc. being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

  
\_\_\_\_\_  
Signature

9-22-15  
\_\_\_\_\_  
Date

Subscribed and sworn to before me on September 22, 2015

Rose Mauro DiCocco  
\_\_\_\_\_

Notary Public/Commissioner of Superior Court

My commission expires: 3-31-18

# Affidavit

Applicant: L&M Physician Association, Inc.

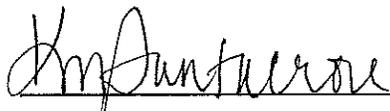
Project Title: Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc.

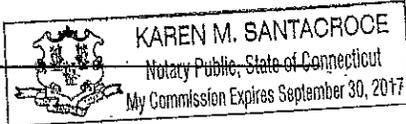
I, Christopher M. Lehrach, M.D., President  
(Name) (Position – CEO or CFO)

of L&M Physician Association, Inc. being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

 9.16.2015  
Signature Date

Subscribed and sworn to before me on 9.16.2015

  
Notary Public/Commissioner of Superior Court

My commission expires: 

# EXHIBIT IV

## Checklist

### Instructions:

1. Please check each box below, as appropriate; and
2. The completed checklist *must* be submitted as the first page of the CON application.
  - Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.
  - (\*New\*). A completed supplemental application specific to the proposal type, available on OHCA's website under "[OHCA Forms](#)." A list of supplemental forms can be found on page 2.
  - Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of \$500.
  - Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication*)
  - Attached is a completed Financial Attachment
  - Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.
  - The following have been submitted on a CD
    1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
    2. An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

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### For OHCA Use Only:

Docket No.: 15-32052-CON      Check No.: 1321105813  
 OHCA Verified by: (signature)      Date: 10/8/15

## General Information

<b>Main Site</b>	MAIN SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME	
	N/A		Medical Foundation	Northeast Medical Group, Incorporated	
	STREET & NUMBER				
	99 Hawley Lane				
	TOWN			ZIP CODE	
Stratford			06614		

<b>Project Site</b>	PROJECT SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME	
	New London, CT		Medical Foundation	L&M Physician Association, Inc.	
	STREET & NUMBER				
	365 Montauk Avenue				
	TOWN			ZIP CODE	
New London			06320		

<b>Operator</b>	OPERATING CERTIFICATE NUMBER		TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)	
	STREET & NUMBER				
	TOWN			ZIP CODE	

<b>Chief Executive</b>	NAME		TITLE		
	Amit Rastogi, M.D.		Interim Chief Executive Officer		
	STREET & NUMBER				
	99 Hawley Lane				
	TOWN			STATE	ZIP CODE
	Stratford			CT	06614
	TELEPHONE		FAX	E-MAIL ADDRESS	
203-502-6502		203-502-6556	amit.rastogi@ynhh.org		

Title of Attachment:

Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES	<input checked="" type="checkbox"/>	Attachment I
	NO	<input type="checkbox"/>	
Does the Applicant have non-profit status? If yes, attach documentation.	YES	<input checked="" type="checkbox"/>	Attachment II
	NO	<input type="checkbox"/>	

Identify the Applicant's ownership type.	PC <input type="checkbox"/>	Other: _____
	LLC <input type="checkbox"/>	
	Corporation <input checked="" type="checkbox"/>	
Applicant's Fiscal Year (mm/dd)	Start 10/1	End 9/30

**Contact:**

Identify a single person that will act as the contact between OHCA and the Applicant.

<b>Contact Information</b>	NAME		TITLE
	Nancy Rosenthal		Senior Vice President, Strategy and Regulatory Planning
	STREET & NUMBER		
	5 Perryridge Road		
	TOWN	STATE	ZIP CODE
	Greenwich	CT	06830
	TELEPHONE	FAX	E-MAIL ADDRESS
	203-863-3908	203-863-4736	nancy.rosenthal @ynhh.org
RELATIONSHIP TO APPLICANT	Employee		

Identify the person primarily responsible for preparation of the application (optional):

<b>Prepared by</b>	NAME		TITLE
	Karen Banoff, KMB Consulting, LLC		Principal
	STREET & NUMBER		
	91 Old Hollow Road		
	TOWN	STATE	ZIP CODE
	Trumbull	CT	06611
	TELEPHONE	FAX	E-MAIL ADDRESS
	203-459-1601	203-459-1601	kbanoff@kmbconsult.com
RELATIONSHIP TO APPLICANT	Consultant		

## Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

This Certificate of Need (CON) application is being submitted as required by Connecticut General Statute §19a-638 (a) (3) which requires CON approval for the merger of L&M Physician Association, Inc. ("L&MPA") with and into the Northeast Medical Group, Inc. ("NEMG") with NEMG being the surviving entity. This CON is a requirement of the decision to pursue an affiliation between Yale New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") whereby YNHHSC proposes to become the sole corporate member of L+M. Because Connecticut state law prohibits a health system such as YNHHSC from having more than one medical foundation, the only option for the transaction was to merge L&MPA into NEMG.

Access to care will be enhanced with the overall affiliation between YNHHSC and L+M as described in a separate CON application for the larger transaction. The overall affiliation will address existing physician shortages in key areas and the added physicians to the service area will enhance access to care. Residents in the L&MPA community will have better physician access locally and avoid unnecessary emergency room visits that can result from lack of access to primary care providers. Both applicants are committed to providing care to Medicaid recipients and uninsured individuals.

The proposed merger will also improve the overall coordination of patient care as the same electronic medical record, policies and processes will be in place at all YNHHSC facilities, all NEMG and L&MPA physician offices. A single infrastructure for all NEMG and L&MPA physician practices will facilitate physician to physician communication and provide consistency in the patient experience.

The merger of L&MPA into NEMG will also result in greater efficiencies. NEMG and YNHHSC have made significant investments in population health, information technology, data management and care coordination that can be utilized to enhance quality by improving patient management.

The proposed merger is financially feasible. Both NEMG and L&MPA further the charitable mission of their respective health systems by providing services that meet community needs, such as needs for certain specialty services, or primary care physicians. YNHHSC has the financial stability to continue to support NEMG after the merger, in order to achieve its charitable goals.

*Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a “§” indicates it is actual text from the statute and may be helpful when responding to prompts.*

## **Project Description**

1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.

### **Response:**

#### **Overview and Applicants:**

L&M Physician Association, Inc. (“L&MPA”) plans to merge with and into the Northeast Medical Group, Inc. (“NEMG”) with NEMG being the surviving entity. This Certificate of Need (CON) application is being submitted as required by Connecticut General Statute §19a-638 (a) (3) which requires CON approval for the transfer of ownership of a group practice. This transaction is required because of the affiliation between Yale New Haven Health Services Corporation (“YNHHSC”) and Lawrence + Memorial Corporation (“L+M”) whereby YNHHSC proposes to become the sole corporate member of L+M. L+M is the parent corporation of a delivery network known as L+M Healthcare, the main providers of which are L&MPA, L+M Hospital (“L+MH”), Westerly Hospital in Rhode Island (“Westerly”) and Visiting Nurse Association of Southeastern Connecticut. A separate CON application is being filed for the transfer of ownership of L+MH. YNHHSC is a Connecticut non-stock, tax-exempt corporation that was organized in 1983 to provide support services to a nonprofit network of affiliated health care providers known, collectively, as the Yale New Haven Health System (“YNHHS”).

NEMG is a Connecticut medical foundation established pursuant to Connecticut General Statute §33-182aa. NEMG, an affiliate of the YNHHS, is a multispecialty physician group with more than 100 practice locations and 600 medical experts, including top specialists in Fairfield and New Haven counties, as well as New York’s Westchester County through NEMG’s affiliate, Northeast Medical Group, PLLC (“NEMG NY”). NEMG has physicians and other health care providers in the following specialty areas; Allergy, Cardiology, Ear, Nose and Throat, Endocrinology, Family Medicine, Gastroenterology, General Surgery, Geriatrics, Hematology & Oncology, Infectious Disease, Internal Medicine, Nutritional Counseling, Obstetrics & Gynecology, Ophthalmology, Pain Management, Pediatrics, Pediatric Cardiology, Pediatric Pulmonary, Perinatology, Rehabilitation Medicine, Podiatry, Pulmonary, Radiation Oncology, Rheumatology, Urology, Walk-in/Immediate Care and Wound Care. In early 2015, NEMG was selected to participate in the Medicare Shared Savings Program as an accountable care organization (“ACO”) and is well positioned for success under a population health model of care and reimbursement. NEMG is also a certified medical home with multiple sites holding a Level III (highest level) Patient Centered Medical Home accreditation through the National Committee of Quality Assurance.

L&MPA, which does business under the name “L+M Medical Group”, is a

Connecticut medical foundation established pursuant to Connecticut General Statutes §33-182aa and an affiliate of L+M. L&MPA is a multispecialty group practice with multiple locations throughout southeastern Connecticut and southwestern Rhode Island. L&MPA includes approximately 70 physicians in the following specialties; Family Practice, Internal Medicine, Dermatology, Endocrinology, General Surgery, Orthopedic Surgery, Neurosurgery, Sleep Medicine, Neurology, Rehabilitation Medicine, Obstetrics, Gynecology, Cardiology and Interventional Pain Management. L&MPA is also a certified medical home with six sites holding a Level III (highest level) Patient Centered Medical Home accreditation through the National Committee of Quality Assurance. The six sites are located in Groton, New London, Niantic, Old Lyme, Mystic, and Stonington.

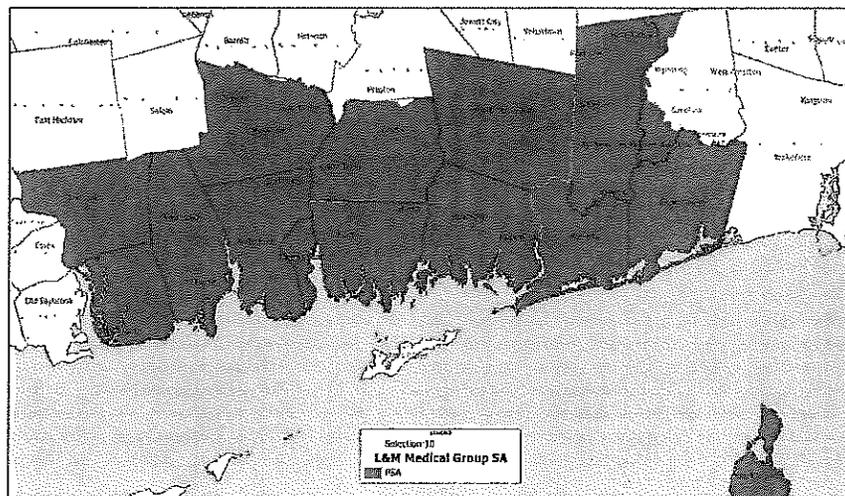
Based on the terms of the Affiliation Agreement and Plan of Merger (included in Attachment III), NEMG will be the surviving corporation of the merger and the NEMG Board of Trustees will be expanded to include two (2) physicians on the medical staffs of L+MH or Westerly, as well as the President of L+M or his or her designee.

**Geographic Area Served**

L&MPA's service area contains the following Connecticut and Rhode Island communities:

<b>Connecticut:</b>	<b>Rhode Island:</b>
East Lyme	Ashaway
Groton	Block Island
Ledyard	Bradford
Lyme	Charlestown
Montville	Hope Valley
New London	Hopkinton
North Stonington	Westerly
Old Lyme	Wood River Junction
Stonington	
Waterford	

The medical group does not differentiate between a primary and secondary service area. A map of L&MPA's service area is provided below.



The overall population size in the service area is estimated to be 215,194 in 2015 and projected to remain flat at 215,259 in 2020. However, service area residents in the 65+ age cohort are projected to increase significantly (~11%) between 2015 and 2020 as shown in the table below. Demand for health care services increases significantly in older adults.

**Population in Service Area (L&MPA)**

L&MPA	Population in Service Area				
	0-17	18-44	45-64	65+	Total
2015	42,393	73,232	62,473	37,096	215,194
2020	40,647	73,229	60,238	41,145	215,259
% Change	-4.1%	0.0%	-3.6%	10.9%	0.0%

Source: Claritas

L+MH's most recent Community Health Needs Assessment (CHNA), which can be found in Attachment IV, highlights the public's need for health care services offered by L&MPA physicians.

Significant health issues exist in the service area as outlined in the CHNA including:

- Higher cancer incidence than statewide and national levels for all cancers in particular, breast, colorectal (particularly in females), and lung;
- Higher cancer mortality than statewide and national levels for all cancer particularly in breast and lung cancer;
- High Chlamydia rates;
- Obesity levels higher than the state average;
- Increasing diabetes incidence; and
- High alcohol consumption as compared to national benchmarks.

L&MPA physicians along with L+MH currently offer a wide range of programs and services to address public health needs. The Applicants anticipate public need for L&MPA physicians' services will continue and increase due to existing and future health care issues as well as the aging of the population. L&MPA physicians will continue to provide needed services, but as part of NEMG.

Both Applicants as well as patients will benefit from the merger due to an increased ability to coordinate care across the region and enhanced clinical integration and collaboration among physicians.

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

**Response:**

Discussions regarding the merger of L&MPA and NEMG were part of discussions for the overall affiliation between YNHHS and L+M that began in early 2015. Specific discussions pertaining to the proposed affiliation and the merger of the medical foundations began formally in the first quarter of 2015 and were followed by a thorough due diligence process.

The due diligence process began in March 2015 and will continue through the closing. In addition to this Certificate of Need application, the following regulatory

process will be required:

- A Hart-Scott-Rodino filing was submitted to the Federal Trade Commission on August 7, 2015, and a courtesy copy of the filing was sent to the Connecticut Attorney General on August 10, 2015. On September 8, 2015, the FTC informed YNHHS and L+M that it would allow the waiting period outlined by the Hart-Scott-Rodino Antitrust Improvements Act to expire without further investigating the transaction;
- A Certificate of Need application for the overall corporate affiliation of L+M with YNHHS is being filed simultaneously with this application.
- A Notice of Material Change regarding the merger of L&MPA will be filed shortly with the Connecticut Attorney General.
- Regulatory approval filings with the Rhode Island Department of Health and the Rhode Island Attorney General are planned for October 2015.
- The closing will occur once all regulatory approvals are obtained.

Because Connecticut state law prohibits a health system such as YNHHS from having more than one medical foundation, the only option for the transaction was to merge L&MPA into NEMG.

The Boards of both L+M and YNHHS each approved execution of the Affiliation Agreement and seeking regulatory approval for the affiliation on July 9, 2015 and July 10, 2015 respectively. The NEMG Board of Directors approved the merger on July 7, 2015 and the L&MPA Board approval occurred on July 13, 2015. Copies of board resolutions were previously referenced (see Attachment I). Pursuant to Section §33-182bb(d) of the Connecticut General Statutes, a notification letter was sent to the Office of Health Care Access ("OHCA") informing the agency that the Board of Directors of L&MPA voted to approve the merger with and into NEMG.

3. Provide the following information:

- a. utilizing **OHCA Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

**Response:**

L&MPA provides physicians services. No physician services are planned to be terminated and the population to be served is expected to be the same geographic service area. There are no plans to modify existing hours of operation.

- b. identify in **OHCA Table 2** the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

**Response:**

Table 2 has been completed. L&MPA's service area consists of the communities where it draws the majority of its patients. As previously noted, the practice does not differentiate between a primary and secondary service area.

4. List the health care facility license(s) that will be needed to implement the proposal;

**Response:**

Not applicable. There are no health care facility licenses needed to implement the proposal.

5. Submit the following information as attachments to the application:

- a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);

**Response:**

L&MPA holds a State of Connecticut, Department of Public Health license for an Outpatient Clinic located at 437 Pequot Avenue in New London, CT. Primary care services have been provided in this clinic to Mitchell College students during the academic year.

A copy of this license is included in Attachment V.

- b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;

**Response:**

Key professional, administrative, clinical and direct service personnel related to the proposal are listed below.

**NEMG**

- Amit Rastogi, M.D., Interim Chief Executive Officer
- Michael Loftus, Chief Financial Officer, NEMG, Vice President, Finance, YNHHS
- Arnold DoRosario, M.D., Chief Medical Officer

**L&MPA**

- Anthony Carter, M.D., Medical Director
- Seth Van Essendelft, Chief Financial Officer/Vice President of Support Services, L+M and L&MPA
- Christopher M. Lehrach, M.D., President, L+MMG and Chief Transformation Officer

Please refer to Attachment VI for copies of the Curriculum Vitae.

- c. copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;

**Response:**

Not applicable. This CON application is not a request for establishment of a new service.

- d. letters of support for the proposal;

**Response:**

Please refer to Attachment VII for letters of support for this CON application.

- e. the protocols or the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet the protocols or guidelines.

**Response:**

Not applicable. This CON application does not request any change to specific clinical services where protocols or practice guidelines may apply.

- f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

**Response:**

The Agreement and Plan of Merger has been previously referenced in Attachment III.

## Public Need and Access to Care

§ *“Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;” (Conn.Gen.Stat. § 19a-639(a)(1))*

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

**Response:**

This proposal is consistent with all policies and standards in regulations adopted by the Connecticut DPH. The proposed merger requires Certificate of Need approval which is being pursued.

§ *“The relationship of the proposed project to the statewide health care facilities and services plan;” (Conn.Gen.Stat. § 19a-639(a)(2))*

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on [OHCA's website](#).

**Response:**

This proposal is consistent with the Connecticut DPH *Statewide Health Care Facilities and Services Plan* (the Plan). Specifically, the 2014 update stresses the changes that have occurred in the State of Connecticut since the passage and implementation of the Patient Protection and Affordable Care Act (PPACA). The Plan acknowledges that the PPACA has influenced providers to focus on creating new models of care that bring higher quality and greater value. The PPACA has led

to affiliations and mergers of health care providers throughout the State to maintain access to needed services, improve financial viability and enhance organizations' ability to meet technology needs.

§ "Whether there is a clear public need for the health care facility or services proposed by the applicant;" (Conn.Gen.Stat. § 19a-639(a)(3))

8. With respect to the proposal, provide evidence and documentation to support clear public need:

a. identify the target patient population to be served;

**Response:**

Please refer to the response to question 1.

b. discuss how the target patient population is currently being served;

**Response:**

The target population is currently served by L&MPA physicians throughout the service area.

c. document the need for the equipment and/or service in the community;

**Response:**

Not applicable. This proposal does not involve a specific service or piece of equipment.

d. explain why the location of the facility or service was chosen;

**Response:**

Not applicable. There is no new location being chosen as part of this proposal.

e. provide incidence, prevalence or other demographic data that demonstrates community need;

**Response:**

Please refer to question 1.

f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

**Response:**

Both NEMG and L&MPA provide physician services to low income persons, racial and ethnic minorities, disabled persons and underserved groups. The merger of these two entities should not impact this commitment.

g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

**Response:**

There are no planned changes to the clinical services offered by the Applicants.

- h. explain how access to care will be affected;

**Response:**

Access to care will be enhanced with the overall affiliation between YNHHS and L+M as described in a separate CON application for the larger transaction. The overall affiliation will address existing physician shortages in such areas as primary care, pediatric subspecialists, surgeons (thoracic, bariatric, vascular), and cardiology subspecialists such as electrophysiologists. The added physicians to the service area will enhance access to care.

- i. discuss any alternative proposals that were considered.

**Response:**

The decision to pursue an affiliation between YNHHS and L+M required the merger of the two medical foundations. Because Connecticut state law prohibits a health system such as YNHHS from having more than one medical foundation, the only option for the transaction was to merge L&MPA into NEMG.

*§ "Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (B) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program;" (Conn. Gen. Stat. § 19a-639(a)(5))*

9. Describe how the proposal will:

- a. improve the quality of health care in the region;

**Response:**

Both NEMG and L&MPA provide high quality physicians services. NEMG has a "culture of continuous improvement" which enables it to:

- Regularly monitor performance throughout NEMG to ensure the practice is reaching goals as well as identify any areas for improvement;
- Review performance to ensure physicians are making informed, timely decisions that lead to better patient outcomes; and
- Use performance data to prioritize programs designed to improve patient care.

NEMG has established standardized safety protocols and quality control measures that enable the delivery of consistently high quality, safe patient care.

NEMG has been recognized for its quality as evidenced by:

- 29 NEMG physicians were ranked among *Connecticut Magazine's* Top

Doctors for 2015

- 20 Sites recognized by National Committee for Quality Assurance (NCQA) Patient Centered Medical Home level three
- NEMG was selected to participate in the Medicare Shared Savings Program Accountable Care Organization (ACO)
- 26 practice sites are under the Diabetes Recognition Program by the National Committee for Quality Assurance (NCQA)
- NEMG cardiology sites accredited in Echocardiography, Vascular (Carotid) and Nuclear Testing
- Sleep Center, Fairfield – Accredited by the American Academy of Sleep Medicine (AASM)
- Endoscopy Center, Trumbull – Ambulatory surgery centers Joint Commission Accreditation

L&MPA physicians have provided high quality medical services. L&MPA has been recognized for its high quality services as evidenced by:

- 10 L&MPA physicians were ranked among *Connecticut Magazine's* Top Doctors for 2015;
- Quality Recognition Award Gaps in Care program for Medicare Advantage Plans for 2013 and 2014; and
- Patient Center Medical Home for Primary Care Offices in CT.

L&MPA physicians will benefit from NEMG's well-developed quality improvement infrastructure and resources. Patients who seek services from L&MPA physicians will benefit from continued high quality services. Continuity of care through implementation of the Epic electronic medical record (EMR) will also contribute to the advancement of quality health care services.

- b. improve accessibility of health care in the region; and

**Response:**

Please refer to the response to 8(h).

- c. improve the cost effectiveness of health care delivery in the region.

**Response:**

Greater efficiencies are expected to be achieved as a result of the proposed affiliation between YNHHS and L+M. The merger of L&MPA into NEMG will also result in greater efficiencies. NEMG and YNHHS have made significant investments in population health, information technology, data management and care coordination that can be utilized to enhance quality by improving patient management. Residents in the L&MPA community will have better physician access locally and avoid unnecessary emergency room visits that can result from lack of access to primary care providers.

10. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

**Response:**

The proposed merger will improve the overall coordination of patient care as the same EMR, policies and processes will be in place at all YNHHS facilities, all

NEMG and L&MPA physician offices. A single infrastructure for all NEMG and L&MPA physician practices will facilitate physician to physician communication and provide consistency in the patient experience.

11. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

**Response:**

Access to care for Medicaid recipients and indigent persons as a result of the proposed merger is not expect to change, as both NEMG and L&MPA are tax-exempt entities and are committed to serving the uninsured and underinsured, including Medicaid patients.

*§ "Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;" (Conn.Gen.Stat. § 19a-639(a)(10))*

12. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

**Response:**

Not applicable. The proposal does not reduce access or fail to provide services to Medicaid recipients or indigent persons.

*§ "Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care." (Conn.Gen.Stat. § 19a-639(a)(12))*

13. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

**Response:**

The proposal is not expected to affect patient health care costs. Rather, with greater access to care and care coordination, we expect that visits to the emergency department and duplication of services by physicians will be reduced.

## Financial Information

*§ "Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for*

the application," (Conn. Gen. Stat. § 19a-639(a)(4))

14. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.

**Response:**

This proposal will positively affect the financial strength of the state's health care system. The financial strength of the State of Connecticut's health care system is dependent on the strength of its health care providers. This proposal is fully consistent with state and national trends involving the affiliation and collaboration among providers to reduce costs, share resources and promote best practices. The merger of L&MPA into NEMG is related to the affiliation between the parent corporations of YNHSC and L+M. Providers need to form integrated networks, develop advanced care management capabilities, and partner with other providers across the care continuum to be successful in the future. The proposed merger between L&MPA and NEMG will strengthen the financial health of both organizations which in turn will positively impact the financial strength of the state's health care system.

15. Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3.**

**Response:**

There is no capital expenditure/cost specific to the merger of L&MPA and NEMG.

16. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

**Response:**

Not applicable. Please refer to the response to question 15.

17. Include as an attachment:

- a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books.). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

**Response:**

Audited financial statements for the most recently completed fiscal year (2014) for NEMG and L&MPA are provided in Attachment VIII.

- b. a complete **Financial Worksheet A (not-for-profit entity) or B (for-profit entity)**, available on OHCA's website under "**OHCA Forms**," providing a summary of revenue, expense, and volume statistics, "without the CON project,"

“incremental to the CON project,” and “with the CON project.” Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.

**Response:**

Financial Worksheet A has been completed for NEMG and L&MPA and can be found in Attachment IX.

18. Complete **OHCA Table 4** utilizing the information reported in the attached Financial Worksheet.

**Response:**

OHCA Table 4 has been completed for NEMG and L&MPA.

19. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.

**Response:**

All assumptions used in developing the financial projections reported in the Financial Worksheets are included in Attachment X.

20. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

**Response:**

Both NEMG and L&MPA further the charitable mission of their respective health systems by providing services that meet community needs, such as needs for certain specialty services, or primary care physicians. Medical foundations also provide health care services (such as geriatrics and patient-centered medical homes) that support health systems' moves to population health and outcomes-based reimbursement models, even if such services do not, on their own, generate sufficient revenue to cover their expenses. Because stand-alone physician practices cannot meet these community needs, medical foundations are typically supported by the affiliated health system, much like other clinical service lines. As a result of the merger, NEMG will take on the operating losses of L&MPA, but YNHHS has the financial stability to continue to support NEMG after the merger, in order to achieve its charitable goals.

21. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

**Response:**

Not applicable. Please refer to the response to question 20.

## Utilization

§ “The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;” (Conn. Gen. Stat. § 19a-639(a)(6))

22. Complete **OHCA Table 5** and **OHCA Table 6** for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level.

**Response:**

OHCA Tables 5 and 6 have been completed.

23. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Tables 4 and 5.

**Response:**

Assumptions regarding visit volume for L&MPA and NEMG are outlined below:

FY 2016

L&MPA incorporated into NEMG for second half of year. Visit volume is expected to remain flat from 2015.

FY 2017 - 2019

L&MPA visit volume now included into NEMG. Volume is projected to increase slightly at L&MPA practices.

24. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using **OHCA Table 7** and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues.**

**Response:**

Current and projected patient population mix has been provided in OHCA Table 7. Payer mix is not projected to change as L&MPA will continue to serve the same patient population that they currently serve.

§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;" (Conn, Gen. Stat. § 19a-639(a)(7))

25. Describe the population (as identified in question 8(a) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. **Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.**

**Response:**

Please refer to question 8(a). As outlined in L+MH's most recent Community Health Needs Assessment (CHNA), which was previously referenced (see Attachment IV), based on the 2010 census, the service area has a higher proportion of middle age and older adults than the State of Connecticut and the nation overall (see page 6 of the CHNA). The older population has a higher incidence of illness and disease, and therefore utilizes health care services at a higher rate than the younger population. As the population continues to age, the public need for health care services offered by L&MPA physicians will increase.

Other significant health issues exist in the service area as outlined in the CHNA including:

- Higher cancer incidence than statewide and national levels for all cancers in particular, breast, colorectal (particularly in females), and lung;
- Higher cancer mortality than statewide and national levels for all cancer particularly in breast and lung cancer;
- High Chlamydia rates;
- Obesity levels higher than the state average;
- Increasing diabetes incidence; and
- High alcohol consumption as compared to national benchmarks.

The population of L&MPA's service area is in need of physicians and other health care professionals to address these and other health issues.

26. Using **OHCA Table 8**, provide a breakdown of utilization by town for the most recently completed FY. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.

**Response:**

OHCA Table 8 has been completed based on visits.

§ "The utilization of existing health care facilities and health care services in the service area of the applicant;" (Conn. Gen. Stat. § 19a-639(a)(8))

27. Using **OHCA Table 9**, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.

**Response:**

OHCA Table 9 includes existing physician practices in the service area that could be identified. Hours of operation and current utilization for non L&MPA practices are not readily available information.

28. Describe the effect of the proposal on these existing providers.

**Response:**

The Applicants believe that the proposal will have little to no effect on existing providers in the service area. L&MPA is an existing physician group practice with an existing patient base. This proposal involves a change of ownership of L&MPA. L&MPA physicians will continue their existing practices serving their patient populations.

29. Describe the existing referral patterns in the area served by the proposal.

**Response:**

Existing referral patterns in the area served by the proposal are well established. L&MPA physicians refer to one another as well as other physicians in the service area and throughout Connecticut.

30. Explain how current referral patterns will be affected by the proposal.

**Response:**

Referral patterns are not expected to change significantly in that L+MH and YNHH have a long history of collaboration.

*§ "Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;"  
(Conn.Gen.Stat. § 19a-639(a)(9))*

31. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

**Response:**

Not applicable. This proposal involves a merger of two medical foundations.

*§ "Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region. . ."  
(Conn.Gen.Stat. § 19a-639(a)(11))*

32. How will the proposal impact the diversity of health care providers and patient choice or reduce competition in the geographic region?

**Response:**

The proposal will positively impact the diversity of health care providers and patient choice. The proposal will ensure the continuation of L&MPA physicians and the continued offering of a diverse group of health care providers. Patient choice will be maintained and honored.

## Tables

**TABLE 1  
APPLICANT'S SERVICES AND SERVICE LOCATIONS**

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
		L&MPA service area is listed in Table 2	Practices operate Monday through Friday, generally 9am – 5pm	N/A

Please see Attachment XI for a complete listing of L&MPA's physician practices.

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**TABLE 2  
SERVICE AREA TOWNS – L+MH**

List the official name of town\* and provide the reason for inclusion.

Town*	Reason for Inclusion
<u>Service Area includes:</u> Connecticut: <ul style="list-style-type: none"> <li>• East Lyme</li> <li>• Groton</li> <li>• Ledyard</li> <li>• Lyme</li> <li>• Montville</li> <li>• New London</li> <li>• North Stonington</li> <li>• Old Lyme</li> <li>• Stonington</li> <li>• Waterford</li> </ul> Rhode Island: <ul style="list-style-type: none"> <li>• Ashaway</li> <li>• Block Island</li> <li>• Bradford</li> <li>• Charlestown</li> <li>• Hope Valley</li> <li>• Hopkinton</li> <li>• Westerly</li> <li>• Wood River Junction</li> </ul>	L&MPA includes all primary service area towns from L+M Hospital and Westerly Hospital as its service area.

\* Village or place names are not acceptable.

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**TABLE 3  
TOTAL PROPOSAL CAPITAL EXPENDITURE**

Purchase/Lease	Cost
Equipment (Medical, Non-medical Imaging)	\$0
Land/Building Purchase*	
Construction/Renovation**	
Other (specify)	
<b>Total Capital Expenditure (TCE)</b>	<b>\$0</b>
Lease (Medical, Non-medical Imaging)***	\$0
<b>Total Capital Cost (TCO)</b>	<b>\$0</b>
<b>Total Project Cost (TCE+TCO)</b>	<b>\$0</b>

\* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

\*\* If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

\*\*\* If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

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**TABLE 4  
PROJECTED INCREMENTAL REVENUES AND EXPENSES - NEMG**

	FY 2016*	FY 2017*	FY 2018*	FY 2019
Revenue from Operations	\$20,172,000	\$41,238,000	\$41,246,000	\$41,254,000
Total Operating Expenses	\$30,139,000	\$60,003,000	\$60,568,000	\$61,325,000
<b>Gain/Loss from Operations</b>	<b>(\$9,967,000)</b>	<b>(\$18,765,000)</b>	<b>(\$19,322,000)</b>	<b>(\$20,071,000)</b>

\* Fill in years using those reported in the Financial Worksheet attached.

\*2016 represents 6 months of L&MPA being incorporated into NEMG.

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**TABLE 4  
PROJECTED INCREMENTAL REVENUES AND EXPENSES – L&MPA\***  
Note: L&MPA with the CON is incorporated into NEMG beginning April 1, 2016  
L&MPA no longer operates after 4/1/16

	FY 2016*	FY 2017*	FY 2018*	FY 2019
Revenue from Operations	(\$19,977,000)	N/A	N/A	N/A
Total Operating Expenses	(\$29,221,000)	N/A	N/A	N/A
<b>Gain/Loss from Operations</b>	<b>\$9,244,000</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>

\* Fill in years using those reported in the Financial Worksheet attached.

\*2016 represents 6 months of L&MPA being incorporated into NEMG.

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TABLE 5  
HISTORICAL UTILIZATION BY SERVICE – NEMG (Visits)

<b>NEMG</b>				
Historical "visits"				
<b>Specialty</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
Adult Primary Care	59,204	155,441	339,887	649,703
Cardiology	118,515	118,654	118,301	129,726
Endocrinology	4,269	5,330	7,471	6,996
Gastroenterology	2,254	2,904	20,372	19,899
Geriatrics	28,021	29,622	29,181	31,397
Internal Medicine	116,845	138,821	153,191	177,796
Oncology	15,262	19,869	20,696	20,865
Pain Management	877	1,142	1,366	1,197
Palliative Care	2,379	3,611	4,297	3,132
Podiatry	5,181	4,792	5,388	7,430
Psychiatric	14,356	16,410	15,385	16,943
Pulmonary	7,083	7,350	7,631	11,076
Rheumatology	4,154	5,408	5,824	5,887
Surgery	45,972	45,351	59,426	69,517
Women and Childrens	71,901	106,483	119,852	139,689
Wound care	3,004	4,455	4,777	4,897
<b>Grand Total</b>	<b>499,277</b>	<b>665,643</b>	<b>913,045</b>	<b>1,296,150</b>

2015 THROUGH 8/31/15

TABLE 5  
HISTORICAL UTILIZATION BY SERVICE – L&MPA (Visits)

L&MPA (SITE DESCRIPTION)	FY 2012	FY 2013	FY 2014	FY 2015 YTD	FY 2015 Annualized
	(Oct 2011 - Sept 2012)	(Oct 2012 - Sept 2013)	(Oct 2013 - Sept 2014)	(Oct 2014 - Jul 2015)	
Behavioral Health	-	13,850	21,884	16,551	19,861
Cardiology	36,313	67,994	68,736	51,864	62,237
Dermatology	-	3,265	11,292	8,569	10,283
Joslin Diabetes/Endocrinology	-	831	8,395	11,392	13,670
General Surgery	7,645	10,059	14,964	12,779	15,335
Infectious Disease	-	-	126	1,501	1,801
Neonatology	2	2	5,195	1,311	1,573
Neuropsychology	1	3	-	211	253
Neurology	710	2,804	2,879	2,430	2,916
Neurosurgery	7,892	8,240	6,142	5,424	6,509
OBGYN	5,496	11,082	17,089	13,266	15,919
Orthopedics	105	5,559	9,176	8,215	9,858
Pain Management	-	2,934	10,849	10,171	12,205
Palliative Care	-	98	481	52	62
Primary Care	53,947	60,792	70,848	59,893	71,872
Pediatrics	-	894	3,176	3,227	3,872
Physiatry	9,692	9,615	10,520	8,072	9,686
Plastic Surgery	1,528	10	-	-	-
Sleep Medicine	-	-	1,721	4,006	4,807
PA Surgery	4,406	5,975	6,707	5,366	6,439
Wound Care	-	-	-	29	35
Yale Vascular Surgery	-	-	-	2,672	3,206
<b>GRAND TOTAL</b>	<b>127,737</b>	<b>204,007</b>	<b>270,181</b>	<b>227,001</b>	<b>272,399</b>

(1) – Fiscal year is Oct 1- Sept. 30. FY 2015 annualized is based on 10 months actual.

\* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the

method of annualizing. For periods less than 6 months, report actual volume and identify the period covered.

\*\* Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.

\*\*\* Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

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**TABLE 6  
PROJECTED UTILIZATION BY SERVICE – L&MPA**

Note: L&MPA with the CON is incorporated into NEMG beginning April 1, 2016 (this volume is a subset of Table 6 for NEMG)

L&MPA (SITE DESCRIPTION)	FY 2016	FY 2017	FY 2018	FY 2019
Behavioral Health	9,945	19,934	19,978	20,021
Cardiology	31,164	62,466	62,603	62,740
Dermatology	5,149	10,321	10,343	10,366
Joslin Diabetes/Endocrinology	6,845	13,720	13,750	13,780
General Surgery	7,679	15,391	15,425	15,459
Infectious Disease	902	1,808	1,812	1,816
Neonatology	788	1,579	1,582	1,586
Neuropsychology	127	254	254	255
Neurology	1,460	2,927	2,933	2,940
Neurosurgery	3,259	6,533	6,547	6,562
OBGYN	7,971	15,977	16,013	16,048
Orthopedics	4,936	9,894	9,916	9,938
Pain Management	6,111	12,250	12,277	12,304
Palliative Care	31	62	62	63
Primary Care	35,989	72,136	72,294	72,453
Pediatrics	1,939	3,886	3,895	3,903
Physiatry	4,850	9,722	9,743	9,764
Plastic Surgery	-	-	-	-
Sleep Medicine	2,407	4,825	4,835	4,846
PA Surgery	3,224	6,463	6,477	6,491
Wound Care	18	35	35	35
Yale Vascular Surgery	1,605	3,218	3,225	3,232
<b>GRAND TOTAL</b>	<b>136,400</b>	<b>273,400</b>	<b>274,000</b>	<b>274,600</b>

(1) FY 2016 6 months of volume is as L&MPA and 6 months as NEMG

\* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.

\*\* If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

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**TABLE 7  
APPLICANT'S CURRENT & PROJECTED PAYER MIX - NEMG**

## NEMG

	Current		Projected							
	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Visits	%								
Medicare*	323,700	24.9%	374,242	26.1%	426,501	27.0%	428,218	27.0%	429,934	27.0%
Medicaid*	137,020	10.5%	158,921	11.1%	181,550	11.5%	182,279	11.5%	183,007	11.5%
CHAMPUS & TriCare	5,330	0.4%	9,506	0.7%	13,726	0.9%	13,769	0.9%	13,812	0.9%
<b>Total Government</b>	<b>466,050</b>	<b>35.9%</b>	<b>542,669</b>	<b>37.8%</b>	<b>621,777</b>	<b>39.4%</b>	<b>624,265</b>	<b>39.4%</b>	<b>626,753</b>	<b>39.4%</b>
Commercial Insurers	720,070	55.4%	775,891	54.0%	835,281	52.9%	838,850	52.9%	842,419	52.9%
Uninsured/Self Pay	111,280	8.6%	113,224	7.9%	115,691	7.3%	116,213	7.3%	116,735	7.3%
Workers Compensation	2,600	0.2%	4,615	0.3%	6,651	0.4%	6,672	0.4%	6,693	0.4%
<b>Total Non-Government</b>	<b>833,950</b>	<b>64.2%</b>	<b>893,731</b>	<b>62.2%</b>	<b>957,623</b>	<b>60.6%</b>	<b>961,735</b>	<b>60.6%</b>	<b>965,847</b>	<b>60.6%</b>
<b>Total Payer Mix</b>	<b>1,300,000</b>	<b>100.0%</b>	<b>1,436,400</b>	<b>100.0%</b>	<b>1,579,400</b>	<b>100.0%</b>	<b>1,586,000</b>	<b>100.0%</b>	<b>1,592,600</b>	<b>100.0%</b>

\* Includes managed care activity.

\*\* Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

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**TABLE 7  
APPLICANT'S CURRENT & PROJECTED PAYER MIX – L&MPA**  
Note: L&MPA is incorporated into NEMG beginning April 1, 2016

## L&amp;MPA

	Current		Projected - see NEMG							
	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Visits	%	Visits	%	Visits	%	Visits	%	Visits	%
Medicare*	100,936	37.1%	50,542	37.1%		0.0%		0.0%		0.0%
Medicaid*	43,737	16.1%	21,901	16.1%		0.0%		0.0%		0.0%
CHAMPUS & TriCare	8,340	3.1%	4,176	3.1%		0.0%		0.0%		0.0%
<b>Total Government</b>	<b>153,013</b>	<b>56.2%</b>	<b>76,619</b>	<b>56.2%</b>		<b>0.0%</b>		<b>0.0%</b>		<b>0.0%</b>
Commercial Insurers	111,478	40.9%	55,821	40.9%		0.0%		0.0%		0.0%
Uninsured/Self Pay	3,883	1.4%	1,944	1.4%		0.0%		0.0%		0.0%
Workers Compensation	4,024	1.5%	2,015	1.5%		0.0%		0.0%		0.0%
<b>Total Non-Government</b>	<b>119,386</b>	<b>43.8%</b>	<b>59,781</b>	<b>43.8%</b>		<b>0.0%</b>		<b>0.0%</b>		<b>0.0%</b>
<b>Total Payer Mix</b>	<b>272,399</b>	<b>100.0%</b>	<b>136,400</b>	<b>100.0%</b>		<b>0.0%</b>		<b>0.0%</b>		<b>0.0%</b>

\* Includes managed care activity.

\*\* Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

**TABLE 8  
UTILIZATION BY TOWN – L&MPA**

Town	Utilization – Visits FY 2014
<u>Service Area (SA) Towns:</u>	
<u>service Area includes:</u>	
Connecticut:	
• East Lyme	22,956
• Groton	53,140
• Ledyard	15,818
• Lyme	48
• Montville	11,900
• New London	35,082
• North Stonington	6,435
• Old Lyme	1,163
• Stonington	20,529
• Waterford	26,858
Rhode Island:	
• Ashaway	2,404
• Block Island	170
• Bradford	1,809
• Charlestown	2,682
• Hope Valley	1,734
• Hopkinton	571
• Westerly	24,184
• Wood River Junction	520
Other	42,176
<b>TOTAL</b>	<b>270,181</b>

\* List inpatient/outpatient/ED volumes separately, if applicable  
 \*\* Fill in year if the time period reported is not *identical* to the fiscal year reported on pg. 2 of the application; provide the date range using the mm/dd format as a footnote to the table.

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**TABLE 9**

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
				N/A	N/A

Please refer to Attachment XII for a listing of physician practices in L&MPA's service area.

\* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

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Supplemental CON Application Form  
**Transfer of Ownership of a Group Practice**  
Conn. Gen. Stat. § 19a-638(a)(3)

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**Applicant:** Northeast Medical Group, Inc. and L&M Physician Association, Inc.

**Project Name:** Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc.

# Affidavit

Applicant: Northeast Medical Group, Inc.

Project Title: Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc.

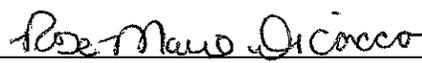
I, Amit Rastogi, MD Interim Chief Executive Officer  
(Name) (Position -- CEO or CFO)

of Northeast Medical Group, Inc. being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

  
Signature

9-22-15  
Date

Subscribed and sworn to before me on September 22, 2015



Notary Public/Commissioner of Superior Court

My commission expires: 3-31-18

# Affidavit

Applicant: L&M Physician Association, Inc.

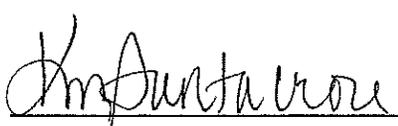
Project Title: Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc.

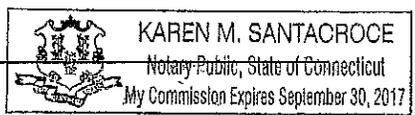
I, Christopher M. Lehrach, M.D., President  
(Name) (Position – CEO or CFO)

of L&M Physician Association, Inc. being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

 9.16.2015  
Signature Date

Subscribed and sworn to before me on 9.16.2015

  
Notary Public/Commissioner of Superior Court

My commission expires: 

## 1. Project Description: Transfer of Ownership of a Group Practice

- a. Is the proposed transfer the result of a request for proposal or other similar voluntary offer for sale? Please explain in detail and provide dates and documentation.

### Response:

The proposed merger of L&MPA with and into NEMG is required because of the affiliation of L+M with YNHHS where YNHHS proposes to become the sole corporate member of L+M.

Discussions regarding the merger of L&MPA and NEMG were part of discussions for the affiliation between YNHHS and L+M that began in early 2015. Specific discussions pertaining to the proposed affiliation and the merger of the medical foundations began formally in the first quarter of 2015 and were followed by a thorough due diligence process.

The due diligence process began in March 2015 and will continue through the closing. In addition to this Certificate of Need application, the following regulatory process will be required:

- A Hart-Scott-Rodino filing was submitted to the Federal Trade Commission on August 7, 2015, and a courtesy copy of the filing was sent to the Connecticut Attorney General on August 10, 2015. On September 8, 2015, the FTC informed YNHHS and L+M that it would allow the waiting period outlined by the Hart-Scott-Rodino Antitrust Improvements Act to expire without further investigating the transaction.
- A Certificate of Need application for the overall corporate affiliation of L+M with YNHHS is being filed simultaneously with this application.
- A Notice of Material Change regarding the merger of L&MPA will be filed shortly with the Connecticut Attorney General.
- Regulatory approval filings with the Rhode Island Department of Health and the Rhode Island Attorney General are planned for October 2015.
- The closing will occur once all regulatory approvals are obtained.

Because Connecticut state law prohibits a health system such as YNHHS from having more than one medical foundation, the only option for the transaction was to merge L&MPA into NEMG.

The Boards of both L+M and YNHHS each approved execution of the Affiliation Agreement and seeking regulatory approval for the affiliation on July 9, 2015 and July 10, 2015 respectively. The NEMG Board of Directors approved the merger on July 7, 2015 and the L&MPA Board approval occurred on July 13, 2015. Copies of board resolutions were previously referenced (see Attachment I). Pursuant to Section §33-182bb(d) of the Connecticut General Statutes, a notification letter was sent to the Office of Health Care Access ("OHCA") informing the agency that the Board of Directors of L&MPA voted to approve the merger with and into NEMG.

- b. Explain how each Applicant determined the public's need for the proposal to occur and discuss the benefits of this proposal for the public (discuss each separately).

**Response:**

As stated above, the transfer of ownership of L&MPA is required due to the larger affiliation of its parent, L+M with YNHHS. In response to health care reform, there are national and statewide trends where smaller health care providers are integrating with larger integrated delivery systems to gain the resources and expertise needed to succeed in the future. Larger health systems enjoy better access to capital and greater operating efficiencies. A cross continuum approach to care delivery is required to achieve the Institute for Healthcare Improvement's "Triple Aim" of:

- improving the population's health over time;
- improving patient experience (quality and service); and
- reducing per capita healthcare cost.

The focus of health care providers has shifted to accountable care, primary and outpatient care, an emphasis on population health management and integration of health care delivery systems.

L+M's goal, for its hospitals, physicians and other community based programs, is to become part of a clinically integrated, financially sustainable health system that improves the health of its communities, and preserves and enhances access to high quality patient care. It seeks to transform its organization to enable it to continue to thrive as the advent of population health strategies, value-based payment models, telehealth, and other significant forces reshape how healthcare is organized and delivered.

Pursuing this affiliation is necessary for L+M to maintain its community service commitments, continue to provide high quality healthcare services in the local community, and ensure its financial health. Today, healthcare reform at both the national and state levels is requiring providers to integrate service delivery and assume responsibility for achieving specific quality, cost, and service outcomes. L+M, on its own, lacks the clinical and financial resources to accomplish these goals. The proposed affiliation and integration will provide L+M with economies of scale as they relate to information technology, finance, insurance, equipment, supplies and other administrative services.

- c. Describe the transition plan and how the Applicants will ensure continuity of services to the patient population. Provide a copy of any transition plan, if available.

**Response:**

There will be no disruption in the continuity of medical services that are provided to the community. The L&MPA office locations will continue to provide the same level of access for patients who seek treatment for medical care.

Implementation teams with membership from NEMG and L&MPA will ensure there will not be any disruption in operations at or following the closing of the transaction. These teams will cover functional areas such as IT, finance, billing, human resources, operations, marketing, and supply chain. These teams will work to develop detailed

plans for the transition as well as longer term operational plans.

Additionally, there will be a thorough review of services and a planning process to determine any additional clinical needs going forward. This will include both short and long term planning for clinical services in an effort to provide high quality, accessible care in this area.

- d. For each Applicant (and any new entities to be created as a result of the proposal), provide the following information as it would appear **prior** and **subsequent** to approval of this proposal:
- i. Legal chart of corporate or entity structure including all affiliates.
  - ii. List of owners and the % ownership and shares of each.

**Response:**

Legal charts of corporate structure for L&MPA and NEMG prior and subsequent to approval of this proposal have been provided in Attachment A.

- e. Does this proposal avoid the corporate practice of medicine? Explain in detail.

**Response:**

This proposal will not result in the corporate practice of medicine. Both NEMG and L&MPA are medical foundations formed under Conn. Gen Stat. §33-182aa et seq., which allows hospitals and health systems to organize and become members of medical foundations “for the purpose of practicing medicine and providing health care services as a medical foundation through employees or agents of such medical foundation who are providers.” Id. The merger of L&MPA into NEMG is specifically permitted under Conn. Gen Stat. §33-182ff.

- f. Has the Applicant notified the Attorney General’s office in writing of the proposed “material change,” as defined Conn. Gen Stat. §19a-486i(c)?

**Response:**

A Notice of Material Change regarding the merger of L&MPA will be filed shortly with the Connecticut Attorney General.

Because the overall transaction requires a Hart-Scott-Rodino filing, the Attorney General received notice of the transaction on August 7, 2015 and a copy of the HSR filing on August 10, 2015 as required by Connecticut General Stat. Section §19a-486i(b).

## 2. Financial Information

- a. Describe how this proposal is cost effective and provide an itemization of anticipated cost savings that will result from this proposal.

**Response:**

Cost effectiveness is expected to improve as a result of the overall affiliation between YNHHS and L+M. The merger of L&MPA with and into NEMG will also result in some added cost efficiencies. Both L&MPA and NEMG will benefit from L+M's and YNHHS' review of areas of non-clinical shared savings that will be undertaken as part of the overall affiliation.

NEMG and YNHHS have also made significant investments in population health, information technology, data management and care coordination that can be utilized to manage patient care more cost effectively and improve the quality of care delivery for patients. The population health infrastructure created will permit NEMG and L&MPA to succeed under a population health model which will ultimately lead to reduced costs of healthcare throughout the region.

Cost effectiveness will also be improved in the region because this transaction will help L+M sustain and expand its primary care physician base in the service area. Residents in the community will have better physician access locally and therefore be able to receive cost-effective care in physician offices avoiding unnecessary emergency room visits that can result with lack of access.

**3. Clear Public Need**

- a. Is the proposal being submitted due to provisions of the Federal Sherman Antitrust Act and Conn. Gen Stat. §35-24 et seq. statutes? Explain in detail.

**Response:**

The merger of L&MPA with and into NEMG is being submitted to OHCA as required under the Connecticut Certificate of Need laws. The overall transaction between YNHHS and L+M did require a Hart-Scott-Rodino filing with the Federal Trade Commission ("FTC") under 18 USC S. 18a, however, and that filing was made on August 7, 2015. The Connecticut Attorney General also received a courtesy copy of that filing on August 10, 2015. The parties have met with the FTC and the Connecticut and Rhode Island Attorneys General to review the transaction, and intend to comply with all applicable federal and state antitrust laws in all respects.

On September 8, 2015, the FTC informed YNHHS and L+M that it would allow the waiting period outlined by the Hart-Scott-Rodino Antitrust Improvements Act to expire without further investigating the transaction.

- b. Is the proposal being submitted due to provisions of the Patient Protection and Affordable Care Act (PPACA)? Explain in detail.

**Response:**

The proposed affiliation is consistent with the PPACA in that the parties will strive to enhance quality, achieve efficiencies, avoid duplication of services and provide evidence-based health care services.

**ATTACHMENT I**

**L&M PHYSICIAN ASSOCIATION, INC.**

**Resolutions of the Board of Directors**

**adopted at meeting held on**

July 13, 2015

**LMPA Merger with NEMG:**

**WHEREAS**, LMPA's sole member, Lawrence + Memorial Corporation ("L+M"), is considering an affiliation with Yale-New Haven Health Services Corporation ("YNHHSC"); and

**WHEREAS**, L+M will be entering into an affiliation agreement with YNHHSC (the "Affiliation Agreement"), pursuant to which YNHHSC will become the sole member of L+M (the "Yale New Haven Affiliation"), effective upon the closing (the "Effective Date") of the transactions contemplated by the Affiliation Agreement; and

**WHEREAS**, pursuant to LMPA's Bylaws, the Board has the power to recommend to L+M, as the sole Member of LMPA, any merger involving LMPA; and

**WHEREAS**, pursuant to LMPA's Bylaws, L+M has the right and power, in its capacity as the sole member of LMPA, to approve any merger involving LMPA; and

**WHEREAS**, the Affiliation Agreement contemplates that LMPA will merge with and into YNHHSC's medical foundation, Northeast Medical Group, Inc. ("NEMG"), effective upon the Effective Date and as a result of the Yale New Haven Affiliation; and

**WHEREAS**, an agreement and plan of merger (the "Plan"), setting forth the terms and conditions of the merger of LMPA with and into NEMG (the "Merger") will be attached to the Affiliation Agreement as an exhibit; and

**WHEREAS**, L+M, in its capacity as the sole member of LMPA, intends to approve the Plan and the Merger prior to the execution of the Affiliation Agreement; and

**WHEREAS**, in accordance with the LMPA Bylaws, this Board wishes to approve the Merger and adopt the Plan, and to recommend the Merger and the Plan to L+M as the sole member of LMPA.

**NOW, THEREFORE**, it is hereby

**RESOLVED**, that the Board hereby approves the Merger, effective as of the Effective Date; and further

**RESOLVED**, that the Board hereby approves and adopts the Plan of Merger (the "Plan") attached to the minutes of this meeting as Exhibit A; and further

**RESOLVED**, that the Board hereby recommends to L+M that it approve the Merger and the Plan to be attached to the Affiliation Agreement; and further

**RESOLVED**, that the Board authorizes any officer of LMPA to execute and deliver the Plan, and to take or cause to be taken any and all such actions necessary to obtain any regulatory approvals required in connection with the Merger and to carry out the terms of the Plan; and further

**RESOLVED**, that, in the event that LMPA may be required to execute and deliver any documents or take any actions in connection with the transactions contemplated by the Affiliation Agreement, the Board hereby authorizes the President of LMPA to execute and deliver any and all such documents, and to take or cause to be taken any and all such steps and other actions, as the President may deem necessary, advisable, desirable or appropriate in order to effectuate the full intent and purposes of the preceding resolutions, the execution and delivery of any such document and the taking of any such action to be conclusive evidence of the President's determination of such necessity and the Board's approval thereof; and further

**RESOLVED**, that all actions heretofore taken by any of the officers of LMPA in furtherance of any of the foregoing resolutions and the transactions contemplated thereby are hereby approved, ratified and confirmed in all respects.

### CERTIFICATION

I, Maureen Anderson, the Assistant Secretary of L&M Physician Association, Inc., do hereby certify that the foregoing is a true and correct copy of the resolutions adopted by the Board of Directors of L&M Physician Association, Inc. at a duly noticed and convened meeting of said Board held on July 13, 2015, at which a quorum was present and voting throughout, and said resolutions have not been repealed or amended, and remain in full force and effect.

7/30/15

Date



Maureen J. Anderson, Assistant Secretary

**NORTHEAST MEDICAL GROUP, INC.****BOARD OF TRUSTEES****RESOLUTIONS RELATING TO THE MERGER OF L&M PHYSICIAN  
ASSOCIATION, INC. WITH AND INTO NORTHEAST MEDICAL GROUP, INC.**

July 7, 2015

**WHEREAS**, Yale-New Haven Health Services Corporation ("HSC") is the parent of the health care delivery system known as the Yale New Haven Health System (the "System") and the sole member of Northeast Medical Group, Inc. ("NEMG"); and

**WHEREAS**, the System includes various affiliates, including but not limited to Yale-New Haven Hospital, Inc. ("YNHH"), Bridgeport Hospital ("BH"), Greenwich Hospital ("GH"), and NEMG; and

**WHEREAS**, Lawrence + Memorial Corporation ("L+M") is the parent of the health care delivery system known as L+M Healthcare (the "L+M System"); and

**WHEREAS**, the L+M System includes various affiliates, including but not limited to Lawrence & Memorial Hospital, Inc. ("L+M Hospital"), LMW Healthcare, Inc. d/b/a Westerly Hospital ("WH"), and L&M Physician Association, Inc. d/b/a L+M Medical Group ("LMMG"); and

**WHEREAS**, HSC and L+M seek an affiliation that will drive broader efficiencies while increasing high quality outcomes, address increasing consumer demands for integrated collaborative care, manage risk more effectively, enhance the population health infrastructure, improve the efficient access to capital, and maintain and grow provider diversity, consumer choice and access to quality and affordable care; and

**WHEREAS**, at a meeting to be held on July 10, 2015, the Board of Trustees of HSC will consider resolutions (the "HSC Resolutions") authorizing HSC to execute and negotiate an Affiliation Agreement with L+M (the "Affiliation Agreement") pursuant to which, inter alia, the L+M System would become a member of the System; and

**WHEREAS**, both LMMG and NEMG are non-stock, tax-exempt medical foundations organized pursuant to the Connecticut Medical Foundations Law and, pursuant to the Connecticut Medical Foundations Law, a health system may operate only a single affiliated medical foundation; and

**WHEREAS**, recognizing that LMMG and NEMG share a mission to promote a high quality of medical care and other services for the benefit of all persons in the communities each serves, and in furtherance of the affiliation contemplated by the Affiliation Agreement, the Board of Trustees has determined that it is in the best interest of NEMG for LMMG to merge with and into NEMG, and for NEMG to execute and implement the Agreement and Plan of Merger,

substantially in the form attached hereto as *Exhibit A*, following which NEMG remains the surviving corporation and LMMG shall cease to exist; and

**WHEREAS**, in furtherance of the Affiliation Agreement and said merger, the Board of Trustees has determined that it is in the best interests of NEMG to adopt the Amended and Restated Certificate of Incorporation and Bylaws, substantially in the form attached hereto as *Exhibit B* and *Exhibit C*, respectively; and

**WHEREAS**, in accordance with NEMG's Bylaws, HSC approval is required for NEMG's merger with another entity and for the amendment or restatement of NEMG's Certificate of Incorporation and Bylaws; and

**WHEREAS**, the Board of Trustees of HSC will consider, through the HSC Resolutions, authorizing the merger of LMMG with and into NEMG and, in furtherance thereof, NEMG's execution and implementation of the Agreement and Plan of Merger substantially in the form attached hereto as *Exhibit A*, following which NEMG remains the surviving corporation and LMMG shall cease to exist, and authorizing the adoption of the Amended and Restated NEMG Certificate of Incorporation and Bylaws substantially in the form attached hereto as *Exhibit B* and *Exhibit C*, respectively.

**NOW, THEREFORE, BE IT RESOLVED AS FOLLOWS:**

**Section 1.** The Board of Trustees hereby authorizes the merger of LMMG with and into NEMG pursuant to, and the execution by NEMG of, the Agreement and Plan of Merger substantially in the form attached hereto as *Exhibit A*, subject to the approval of the HSC Board of Trustees and Certificate of Need approval from the State Office of Health Care Access.

**Section 2.** The Board of Trustees hereby authorizes the adoption of the Amended and Restated Certificate of Incorporation and Bylaws of NEMG substantially in the form attached hereto as *Exhibit B* and *Exhibit C*, respectively.

**Section 3.** The HSC President and Chief Executive Officer, the HSC Executive Vice President Corporate and Financial Services, Executive Vice President and Chief Operating Officer, and the HSC Senior Vice President and General Counsel, and their designees (the "**Authorized Officers**") are, and each of them hereby is, authorized and directed to do the following as related to the transactions contemplated by these resolutions: (a) negotiate, conclude terms with, execute and deliver, for and on behalf of NEMG the Agreement and Plan of Merger, and any agreements, documents or instruments, including any amendments to such documents that such Authorized Officer determines are appropriate to accomplish the intent and purposes expressed in these resolutions and the Affiliation Agreement; (b) finalize an Amended and Restated Certificate of Incorporation and Bylaws of NEMG as appropriate to accomplish the intent and purposes expressed in these resolutions, the Affiliation Agreement and the Agreement and Plan of Merger; (c) approve the preparation and execution of any and all notices and submissions, oral and written, necessary to seek and obtain all government and regulatory approvals required to accomplish the intent and purposes expressed in these resolutions, including without limitation the merger of LMMG with and into NEMG; and (d) to perform and

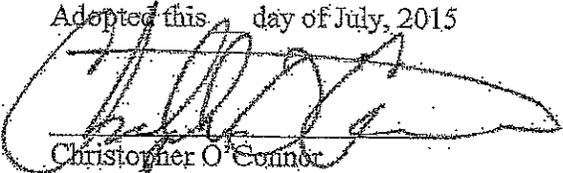
take any actions that such Authorized Officer determines are appropriate to accomplish the intent and purposes expressed in these resolutions and a definitive Affiliation Agreement.

Section 4. Any and all actions previously taken by the Authorized Officers and the officers or employees of HSC and NEMG or any of its and their corporate affiliates in connection with the foregoing resolution are hereby ratified, approved and confirmed in all respects.

**CERTIFICATION**

The undersigned secretary of Northeast Medical Group, Inc. hereby certifies that the foregoing resolution was adopted by the Board of Trustees and remains in full force and effect without amendment as of the date hereof.

Adopted this      day of July, 2015

  
Christopher O'Connor  
Secretary

**ATTACHMENT II**

**IRS** Department of the Treasury  
Internal Revenue Service  
P.O. Box 2508, Room 4010  
Cincinnati OH 45201

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NORTHEAST MEDICAL GROUP INC  
AARON G BOWMAN  
PULLMAN & COMLEY LLC  
850 MAIN STREET  
BRIDGEPORT CT 06604

030096

CUT OUT AND RETURN THE VOUCHER AT THE BOTTOM OF THIS PAGE IF YOU ARE MAKING A PAYMENT,  
EVEN IF YOU ALSO HAVE AN INQUIRY.

The IRS address must appear in the window.

BODCD-TE

4077552422

Use for payments

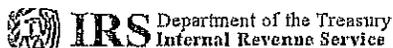
Letter Number: LTR4168C  
Letter Date : 2010-06-02  
Tax Period : 000000



\*061330992\*

INTERNAL REVENUE SERVICE  
P.O. Box 2508, Room 4010  
Cincinnati OH 45201  


NORTHEAST MEDICAL GROUP INC  
AARON G BOWMAN  
PULLMAN & COMLEY LLC  
850 MAIN STREET  
BRIDGEPORT CT 06604



Department of the Treasury  
Internal Revenue Service

P.O. Box 2508, Room 4010  
Cincinnati OH 45201

In reply refer to: 4077552422  
June 02, 2010 LTR 4168C C3  
06-1330992 000000 00 X  
00031451  
BODC: TE

NORTHEAST MEDICAL GROUP INC  
AARON G BOWMAN  
PULLMAN & COMLEY LLC  
850 MAIN STREET  
BRIDGEPORT CT 06604

0096

Employer Identification Number: 06-1330992  
Person to Contact: Mr. R. Molloy  
Toll Free Telephone Number: 1-877-829-5500

Dear Taxpayer:

This is in response to your Mar. 26, 2010, request for information regarding your tax-exempt status.

Our records indicate that your organization was recognized as exempt under section 501(c)(3) of the Internal Revenue Code in a determination letter issued in September 1993.

Our records also indicate that you are not a private foundation within the meaning of section 509(a) of the Code because you are described in section 509(a)(2).

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

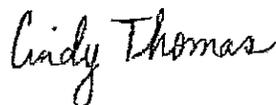
Beginning with the organization's sixth taxable year and all succeeding years, it must meet one of the public support tests under section 170(b)(1)(A)(vi) or section 509(a)(2) as reported on Schedule A of the Form 990. If your organization does not meet the public support test for two consecutive years, it is required to file Form 990-PF, Return of Private Foundation, for the second tax year that the organization failed to meet the support test and will be reclassified as a private foundation.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

4077552422  
June 02, 2010 LTR 4168C C3  
06-1330992 000000 00 X  
00031452

NORTHEAST MEDICAL GROUP INC  
AARON G BOWMAN  
PULLMAN & COMLEY LLC  
850 MAIN STREET  
BRIDGEPORT CT 06604

Sincerely yours,



Cindy Thomas  
Manager, ED Determinations

INTERNAL REVENUE SERVICE  
P. O. BOX 2508  
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

Date: **AUG 24 2010**

L&M PHYSICIAN ASSOCIATION INC  
365 MONTAUK AVE  
NEW LONDON, CT 06320

Employer Identification Number:  
27-1094375  
DLN:  
17053364436009  
Contact Person: JOHN J MCGEE ID# 31169  
Contact Telephone Number:  
(877) 829-5500  
Accounting Period Ending:  
September 30  
Public Charity Status:  
509(a) (2)  
Form 990 Required:  
Yes  
Effective Date of Exemption:  
October 13, 2009  
Contribution Deductibility:  
Yes  
Addendum Applies:  
No

Dear Applicant:

We are pleased to inform you that upon review of your application for tax exempt status we have determined that you are exempt from Federal income tax under section 501(c) (3) of the Internal Revenue Code. Contributions to you are deductible under section 170 of the Code. You are also qualified to receive tax deductible bequests, devises, transfers or gifts under section 2055, 2106 or 2522 of the Code. Because this letter could help resolve any questions regarding your exempt status, you should keep it in your permanent records.

Organizations exempt under section 501(c) (3) of the Code are further classified as either public charities or private foundations. We determined that you are a public charity under the Code section(s) listed in the heading of this letter.

Please see enclosed Publication 4221-PC, Compliance Guide for 501(c) (3) Public Charities, for some helpful information about your responsibilities as an exempt organization.

**COPY**

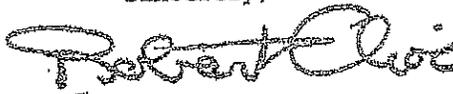
Letter 947 (DO/CG)

-2-

L&M PHYSICIAN ASSOCIATION INC

We have sent a copy of this letter to your representative as indicated in your power of attorney.

Sincerely,

A handwritten signature in cursive script that reads "Robert Choi".

Robert Choi  
Director, Exempt Organizations  
Rulings and Agreements

Enclosure, Publication 4221-PC

**COPY**

Letter 947 (DO/CG)

**ATTACHMENT III**

**AGREEMENT AND PLAN OF MERGER**

of

**L&M PHYSICIAN ASSOCIATION, INC.**  
a Connecticut medical foundation

with and into

**NORTHEAST MEDICAL GROUP, INC.,**  
a Connecticut medical foundation**ARTICLE I**  
**PARTIES**

The parties to the merger (the "Merger") are L&M Physician Association, Inc., a Connecticut medical foundation (the "Merging Corporation"), and Northeast Medical Group, Inc., a Connecticut medical foundation (the "Surviving Corporation" and, together with the Merging Corporation, the "Constituent Corporations"). The Merging Corporation shall merge with and into the Surviving Corporation in accordance with the Connecticut Medical Foundations Law and the Connecticut Revised Nonstock Corporation Act (together, the "Act").

**ARTICLE II**  
**SURVIVING CORPORATION NAME**

Northeast Medical Group, Inc. shall be the surviving corporation of the Merger. The Constituent Corporations shall cause an appropriate Certificate of Merger (the "Certificate of Merger") reflecting the Merger to be filed with the Secretary of the State of the State of Connecticut. Upon the Effective Time (as defined below) of the Merger, the name of the Surviving Corporation shall continue to be Northeast Medical Group, Inc.

**ARTICLE III**  
**EFFECTIVE TIME AND DATE**

The Constituent Corporations shall do all acts and things as shall be necessary or desirable to effect the Merger. The effective time and date of the Merger provided for herein shall be the time and date on which the Certificate of Merger is filed with the Secretary of the State of the State of Connecticut (the "Effective Time").

**ARTICLE IV**  
**PURPOSES OF THE PLAN OF MERGER**

(a) L&M Physician Association, Inc. is a corporation without capital stock organized and existing under the Act. Northeast Medical Group, Inc. is a corporation without capital stock organized and existing under the Act.

(b) This Agreement and Plan of Merger (the "Plan") is intended to accomplish the merger of L&M Physician Association, Inc. with and into Northeast Medical Group, Inc., with Northeast Medical Group, Inc. as the surviving corporation, in the manner stated in this Plan and in accordance with the provisions of the Act.

**ARTICLE V**  
**MEMBERSHIP, CERTIFICATE OF INCORPORATION, BYLAWS, OFFICERS AND TRUSTEES**

At the Effective Time, the following shall happen automatically and immediately, without the need for any other action by the board of directors of the Merging Corporation, the board of trustees of the Surviving Corporation, or the respective members of either of the Constituent Corporations, and without any filing other than the filing of the Certificate of Merger:

(a) As of the Effective Time, the separate existence of the Merging Corporation shall cease, and the membership of the Merging Corporation shall not convert into membership of the Surviving Corporation.

(b) The Certificate of Incorporation and the Bylaws of Northeast Medical Group, Inc. shall each be amended and restated at the Effective Time as a result of the Merger. The Amended and Restated Certificate of Incorporation and the Amended and Restated Bylaws of the Surviving Corporation, are set forth as Exhibit A and Exhibit B, respectively, to this Plan, and shall be effective from and after the Effective Time, until further amended pursuant to the Act and in the manner prescribed therein.

(c) The officers and trustees of Northeast Medical Group, Inc. in office immediately prior to the Effective Time shall be the officers and trustees of the Surviving Corporation until such time as they may be changed in accordance with the Bylaws of the Surviving Corporation and other applicable law.

**ARTICLE VI**  
**EFFECT OF MERGER**

Upon the Effective Time of the Merger, the separate existence of L&M Physician Association, Inc. shall cease. The effect of the Merger shall be as set forth in §33-1158 of the Act.

**ARTICLE VII**  
**OTHER TERMS AND CONDITIONS**

If, at any time after the Effective Time, the Surviving Corporation or its successor or assigns determines that any documentation, action or other things are necessary or desirable to further carry out the purposes of this Plan or to vest the Surviving Corporation with all right, title and interest in to and under all of the assets, properties, rights, claims, privileges, immunities, powers, franchises and authority of each of the Constituent Corporations, the officers and directors of the Surviving Corporation shall be authorized to execute and deliver, in the name of and on behalf of any Constituent Corporation or otherwise, all such documentation, and to take and do, in the name and on behalf of any Constituent Corporation or otherwise, all such other actions and things.

**END OF PLAN OF MERGER**

\* \* \* \* \*

*[Signature page follows.]*

IN WITNESS WHEREOF, each of the Constituent Entities has caused this Agreement and Plan of Merger to be executed on its behalf by its duly authorized officers on this \_\_\_\_ day of \_\_\_\_\_.

L&M PHYSICIAN ASSOCIATION, INC.

By: \_\_\_\_\_  
Name: Christopher M. Lehrach, M.D.  
Title: President

NORTHEAST MEDICAL GROUP, INC.

By: \_\_\_\_\_  
Name: Amit Rastogi, M.D.  
Title: Interim President

EXHIBIT A  
to  
AGREEMENT AND PLAN OF MERGER

Amended and Restated Certificate of Incorporation  
of  
Northeast Medical Group, Inc.

**AMENDED AND RESTATED  
CERTIFICATE OF INCORPORATION**

**NORTHEAST MEDICAL GROUP, INC.**

§1. Name. The name of the Corporation shall hereafter be: NORTHEAST MEDICAL GROUP, INC. (the "Corporation").

§2. Purposes. The nature of the activities to be conducted and the purposes to be promoted or carried out by the Corporation shall be exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and shall include the following:

(a) to operate and maintain one or more offices or facilities for the study, diagnosis and treatment of human ailments and injuries by licensed persons;

(b) to render medical and surgical treatment, consultation or advice by duly licensed employees or agents of the Corporation to patients without regard to race, color, creed, sex, age or ability to pay for such care and services;

(c) to promote, enhance, improve, and develop medical, surgical and scientific research at providers affiliated with Yale-New Haven Health Services Corporation, including, for so long as such providers are affiliated with Yale-New Haven Health Services Corporation, Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Corporation, Yale-New Haven Hospital and such other providers that may affiliate with Yale-New Haven Health Services Corporation in the future (the "Affiliated Delivery Networks") and throughout the communities they serve;

(d) to promote, enhance, improve and augment the quality of medical and clinical education and patient care at Affiliated Delivery Networks and at any other sites determined by the Corporation;

(e) to promote and enhance a high quality of medical care and other human services for the benefit of all persons in the communities it serves;

(f) to augment the planning process for the promotion of the general well-being and human health needs of the communities it serves;

(g) to solicit, accept, hold, invest, reinvest, and administer any contributions, grants, donations, gifts, bequests, devises, benefits of trusts (but not to act as trustee of any trust), and property of any sort, without limitation as to amount or value, and to use, disperse or donate the income or principal thereof for exclusively charitable and educational purposes in such manner as, in the judgment of the Board of Trustees and the member of the Corporation, will best promote the purposes of the Corporation;

(h) to contract for, purchase, receive, own, manage, operate or lease property, real, personal and mixed, wheresoever situated, as may be necessary to promote and further the purposes and objectives of the Corporation; and

(i) to engage in any lawful act or activity for which a medical foundation may be organized under Chapter 594b of the General Statutes of Connecticut or for which a nonstock corporation may be organized under Chapter 602 of the General Statutes of Connecticut.

The member of the Corporation has elected to bring the Corporation within the provisions of Chapter 594b of the General Statutes of Connecticut.

In furtherance of the purposes set forth herein, the Corporation shall (i) participate as an integral part of the integrated health care delivery system known as the Yale New Haven Health System (the "System"), which System provides, through the corporation and its affiliates, comprehensive, cost effective, advanced patient care characterized by safety and clinical and service quality; and (ii) fund and promote activities and programs of the System, including activities and programs of its affiliates, consistent with and in furtherance of the corporation's charitable purposes and the charitable purposes of all System affiliates.

§3. Nonprofit. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions.

§4. Member. The Corporation shall have but one voting member. The member shall be Yale-New Haven Health Services Corporation, a "Health System" as defined in Section 33-182aa of the Connecticut General Statutes. The member shall have the rights, powers and privileges provided in the Corporation's Bylaws and by Connecticut law, including certain expressly reserved powers and retained rights described in the Bylaws.

§5. Duration. The duration of the Corporation shall be perpetual.

§6. Board of Trustees. Subject to the rights, powers and privileges of the member, the Corporation shall operate under the management of its Board of Trustees. The Bylaws may provide that certain persons occupying certain positions within or without the Corporation shall be ex-officio trustees, who may be counted in determining a quorum and may have the right to vote as may be provided in the Bylaws. As may be further provided in the Bylaws, the terms of elected trustees may be staggered by dividing the elected trustees into up to three groups so that approximately an equal number of such trustees have terms that expire each year. Trustees may be removed by the member for cause as set forth in the Bylaws.

§7. Restrictions. No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, the Corporation's trustees, officers or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Section 2 hereof. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of "statements")

any political campaign on behalf of any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

§8. Dissolution. Upon the dissolution or termination of the existence of the Corporation, all of its property and assets, after payment of the lawful debts of the Corporation and the expenses of its dissolution or termination, shall be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to Yale-New Haven Health Services Corporation, or, if at the time of the dissolution or termination of the existence of the Corporation, Yale-New Haven Health Services Corporation is not in existence or does not qualify as exempt under Section 501(c)(3) of the Code, to any organization (or organizations) that qualifies as an organization exempt under Section 501(c)(3) of the Code, in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Trustees may determine.

§9. Limitation of Liability of Trustees. In addition to and not in derogation of any other rights conferred by law, a Trustee shall not be personally liable for monetary damages for breach of duty as a Trustee in an amount greater than the amount of compensation received by the Trustee for serving the Corporation during the year of the violation, provided that such breach did not (a) involve a knowing and culpable violation of law by the Trustee, (b) enable the Trustee or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain, (c) show a lack of good faith and a conscious disregard for the duty of the Trustee to the Corporation under circumstances in which the Trustee was aware that his/her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (d) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the Trustee's duty to the Corporation. Any lawful repeal or modification of this Section 9 or the adoption of any provision inconsistent herewith by the Board of Trustees or member of the Corporation shall not, with respect to a person who is or was a Trustee, adversely affect any limitation of liability, right or protection of such person existing at or prior to the effective date of such repeal, modification or adoption of a provision inconsistent herewith. The limitation of liability of any person who is or was a Trustee provided for in this Section 9 shall not be exclusive of any other limitation or elimination of liability contained in, or which may be provided to any person under, Connecticut law.

§10. Indemnification. The Corporation shall provide its Trustees with the full amount of indemnification that the Corporation is permitted to provide pursuant to the Connecticut Revised Nonstock Corporation Act. In furtherance of the foregoing, the Corporation shall indemnify its Trustees against liability as defined in Section 33-1116(4) of the Connecticut General Statutes to any person for any action taken, or any failure to take any action, as a Trustee, except liability that (1) involved a knowing and culpable violation of law by the Trustee, (2) enabled the Trustee or an associate to receive an improper personal economic gain, (3) showed a lack of good faith and a conscious disregard for the duty of the Trustee to the Corporation under circumstances in which the Trustee was aware that his or her conduct or omission created an

unjustifiable risk of serious injury to the Corporation, or (4) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Trustee's duty to the Corporation.

The Corporation may indemnify and advance expenses to each officer, employee or agent of the Corporation who is not a Trustee, or who is a Trustee but is made a party to a proceeding in his or her capacity solely as an officer, employee or agent, to the same extent as the Corporation is permitted to provide the same to a Trustee, and may indemnify and advance expenses to such persons to the extent permitted by Section 33-1122 of the Connecticut General Statutes.

Notwithstanding any provision hereof to the contrary, the Corporation shall not indemnify any Trustee, officer, employee or agent against any penalty excise taxes assessed against such person under Section 4958 of the Internal Revenue Code.

§11. Amendment of Bylaws. The Bylaws of the Corporation may be amended or repealed, and new Bylaws may be adopted, only with the approval of the Board of Trustees and the member.

EXHIBIT B  
to  
AGREEMENT AND PLAN OF MERGER

Amended and Restated Bylaws  
of  
Northeast Medical Group, Inc.

**NORTHEAST MEDICAL GROUP, INC.  
AMENDED AND RESTATED BYLAWS**

Amended and Restated as of \_\_\_\_\_, 201\_\_

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**NORTHEAST MEDICAL GROUP, INC.  
AMENDED AND RESTATED BYLAWS**

**ARTICLE I. NAME AND GENERAL PURPOSES**

**Section 1.1 Name.** The name of the corporation is **Northeast Medical Group, Inc.** (the "Corporation").

**Section 1.2 General Purposes.** The purposes of the Corporation shall be as set forth in the Corporation's Certificate of Incorporation as in effect from time to time. These Bylaws, the powers of the Corporation, its member, trustees and officers, and all matters concerning the conduct and regulation of the affairs of the Corporation shall be subject to the Certificate of Incorporation.

**ARTICLE II. MEMBERSHIP**

**Section 2.1 Member.** The Corporation shall have a single member, Yale-New Haven Health Services Corporation (the "Member"), a "Health System" as defined in Section 33-182aa of the Connecticut General Statutes.

**Section 2.2 Rights, Powers and Privileges.** The Member shall have all the rights, powers and privileges usually or by law accorded to the member of a medical foundation under the Chapter 594b of the Connecticut General Statutes (as it may be amended from time to time, the "Foundation Act") and of a Connecticut nonstock, nonprofit corporation under the Connecticut Revised Nonstock Corporation Act (as it may be amended from time to time, the "Nonstock Act") and not conferred thereby or by the Certificate of Incorporation or these Bylaws upon the Board of Trustees of the Corporation (the "Board"), including the right to elect the members of the Board in accordance with these Bylaws.

Notwithstanding anything in these Bylaws to the contrary:

(a) Neither the Board, nor any officer or employee of the Corporation, may take any of the actions set forth in Exhibit A of these Bylaws, nor may the Board or any officer or employee of the Corporation approve the taking of any such action by an Affiliate (as hereafter defined), without the prior approval of the Member. For purposes hereof, an "Affiliate" of the Corporation shall mean, unless otherwise determined by the Member, any entity which at the time Affiliate status is being determined is directly or indirectly controlling or controlled by or under the direct or indirect common control with the Corporation. "Control" shall mean the legal power to (a) elect or cause the election of a majority of the governing body of the subject entity, or (b) direct or cause the direction of the subject entity's operations or management, whether the foregoing power(s) exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means.

(b) In addition to the approval rights reserved to the Member set forth in Exhibit A, the Member expressly retains the rights to take the actions set forth in Exhibit B on

behalf of and in the name of the Corporation, directly and without the approval of the Board of this Corporation.

(c) The Board shall have the authority, from time to time, to delegate to the Member any rights, powers and privileges that would otherwise be exercised by the Board to the fullest extent permitted by applicable law.

**Section 2.3 Liability and Reimbursement of Expenses.** Unless the Member expressly agrees otherwise in writing, the Member shall not be liable for the debts or obligations of the Corporation. The Member may be reimbursed for expenses reasonably incurred on behalf of the Corporation.

### ARTICLE III. BOARD OF TRUSTEES

**Section 3.1 Powers and Duties.** Subject to the powers retained by, conferred upon, or reserved to the Member by law or under these Bylaws, the Board shall have charge, control and management of the affairs, property and funds of the Corporation in the manner and subject to the limitations set forth in these Bylaws. Each Trustee shall discharge his or her duties in good faith with the care an ordinarily prudent person in like position would exercise under similar circumstances, and in a manner he or she reasonably believes to be in the best interests of the Corporation.

**Section 3.2 Composition.** The Board shall consist of two classes of voting Trustees, the Elected Trustees and the Ex Officio Trustees (collectively, the "Trustees").

(a) **Elected Trustees.** Elected Trustees shall be the persons elected by the Member for terms as set forth in these Bylaws, following nomination and approval pursuant to Section 3.4 of this Article III. Elected Trustees will represent a cross section of major segments of the community served by the Corporation and shall be selected, on the basis of demonstrated skill and ability, for their potential contribution to the governance of the affairs of the Corporation.

(b) **Ex Officio Trustees.** In addition to the Elected Trustees, there shall be the following Ex Officio Trustees, each of whom shall serve automatically by virtue of and while holding the designated office:

- (i) the President of the Corporation; and
- (ii) the President of each Affiliated Delivery Network, or his or her designee.

For purposes hereof, "Affiliated Delivery Network" shall mean Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Corporation, Yale-New Haven Hospital and such other providers that may affiliate with the Yale New Haven System in the future, as designated by the Member.

**Section 3.3 Number.** The Board shall consist of no fewer than thirteen (13) nor more

than twenty-four (24) Trustees, inclusive of Ex Officio Trustees. The number of Trustees within the range set forth in the preceding sentence shall be determined from time to time by the Member.

**Section 3.4 Election of Trustees.** At the annual meeting of the Member, the Member shall elect successors to the Elected Trustees whose terms are then expiring. The Member shall elect such successors consistent with the following Board composition:

(a) two (2) representatives of senior management of the Member (each, a "YNHHSC Board Member");

(b) one (1) representative from each Affiliated Delivery Network other than Lawrence + Memorial Corporation (in addition to the President, or his or her designee, who shall serve Ex Officio as set forth in Section 3.2(b));

(c) two (2) physicians employed by the Corporation, each of whom is a member in good standing on the medical staff of Lawrence + Memorial Hospital or Westerly Hospital;

(d) up to eight (8) individuals, each of whom is either (1) nominated by a majority vote of the Board and approved by the Member; or (2) self-nominated and appointed by the Member; provided, however, that each such individual, whether nominated by a majority vote of the Board or self-nominated, shall be a Provider (as defined in the Foundation Act) employed or engaged by the Corporation and a member in good standing on the medical staff of one or more Affiliated Delivery Network;

(e) two (2) representatives of Yale School of Medicine;

(f) such other individuals nominated Yale School of Medicine and approved by the Member; provided, however, that each such other individual shall be a Provider employed or engaged by the Corporation and a member in good standing on the medical staff of one or more Affiliated Deliver Network.

Notwithstanding anything herein to the contrary: (x) in accordance with the Foundation Act, the number of Trustees on the Board who are Providers shall equal or exceed the number of Trustees on the Board who are nonprovider employees of the Member; and (y) the number of Trustees appointed to the Board as representatives of, or on the nomination of, Yale School of Medicine shall constitute twenty-five percent (25%) of the total number of Trustees on the Board.

**Section 3.5 Term and Term Limits.** There shall be three (3) classes of Elected Trustees, with approximately one-third of the Elected Trustees in each class, and the terms of all Trustees in the same class shall expire at the adjournment of the same annual meeting of the Member at which Trustees are elected. Elected Trustees shall take office at the close of the meeting of the Member at which they were elected or at such later date as may be established by the Member and, subject to Section 3.6 of this Article III, shall hold office for a term of three (3) years and until a successor is duly elected and qualified.

Notwithstanding anything herein to the contrary:

(a) No person shall be elected a Trustee for a term beginning after the date of his or her seventy-sixth birthday, provided that an Elected Trustee who is seventy-six (76) years of age or older may be re-elected for another term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(b) An Elected Trustee who has served three (3) consecutive full terms (provided that for the purposes of this Section 3.5 a term of service of more than one-half of a full term shall be considered a full term) shall not be eligible for re-election for a period of one year, provided that a Trustee may be re-elected for an additional consecutive term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such additional term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board, which such determination shall be made only in limited circumstances and shall be made prior to each proposed re-election after the Trustee's completion of three (3) consecutive full terms. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(c) The provisions of paragraphs (a) and (b) of this Section shall not apply to an Elected Trustee in the event such Trustee also serves as a trustee of Yale-New Haven Health Services Corporation at the time such person is elected to serve as an Elected Trustee for a term otherwise prohibited by such paragraphs (a) and (b). In the instance of re-election as a Trustee for an additional term as provided in this paragraph (c), Board membership shall be coterminous with said Trustee's service as a trustee of Yale-New Haven Health Services Corporation.

**Section 3.6 Resignation.** Any Elected Trustee may resign at any time by giving written notice of such resignation to the Secretary of this Corporation. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective. Any Ex Officio Trustee who for any reason ceases to hold the office or position from which his or status as an Ex Officio Trustee derives shall automatically be deemed to have resigned as a Trustee of the Corporation and from any position held by virtue of such office with any Affiliate.

**Section 3.7 Removal.** One or more Elected Trustees may be removed from the Board with cause by action of the Member, which action may be taken upon its own initiative or upon the recommendation of the Board.

**Section 3.8 Vacancies.** In the event of the death, resignation or removal of an Elected Trustee, the vacancy resulting therefrom may be filled only by the Member in accordance with Section 3.4 of these Bylaws. An individual elected to fill a vacancy shall serve the remainder of the term of the Trustee replaced.

**Section 3.9 Meetings.**

(a) **Annual Meetings.** The annual meeting of the Board shall be held on such date and time as the Board or the President shall designate.

(b) **Regular Meetings.** Regular meetings of the Board shall be held on such dates and at such times and places as the Board or President shall designate.

(c) **Special Meetings.** Special meetings of the Board may be called at any time by the President and shall be called by the President upon the written request of the Member or any Trustee.

**Section 3.10 Notice of Meetings.** Notice of the date, time and place of any meeting of the Board shall be given to each Trustee and to the Member at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule established at the beginning of the fiscal year and provided to the Board and the Member in writing. Any notice of a meeting required under these Bylaws may be communicated to a Trustee in person, by mail or other delivery service, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic email address at which a Trustee has consented to receive notice. Notice to the Member shall be directed to the President/Chief Executive Officer of the Member and may be provided in person, by mail, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic mail address at which the President/Chief Executive Officer of the Member has consented to receive notice.

**Section 3.11 Waiver of Notice.** Notice of any meeting of the Board may be waived in writing by all the Trustees and, if any Trustee present at a meeting of the Board does not protest prior to or at the commencement of the meeting the lack of proper notice, he or she shall be deemed to have waived notice of such meeting.

**Section 3.12 Action by Unanimous Written Consent.** Any action required or permitted to be taken by the Board may be taken without a meeting if all the Trustees unanimously consent to such action in writing. Such written consent(s) shall be filed with the minutes of the Corporation and shall have the same force and effect as a vote of Trustees at a duly convened meeting. For purposes of this section, a Trustee may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an email communication from the Trustee to the Corporation from an email address provided by the Trustee to the Corporation.

**Section 3.13 Participation by Conference Call.** The members of the Board may participate in a meeting of the Board by means of conference telephone or similar communications equipment (including, without limitation, video conferencing equipment) affording all persons participating in the meeting the ability to hear one another, and such participation in the meeting by means of such equipment shall constitute presence in person at such meeting.

**Section 3.14 Quorum and Voting.** A majority of the number of Trustees in office at the time shall constitute a quorum for the transaction of business at all meetings of the Board, provided

that if less than a majority of the Trustees is present at said meeting, a majority of the Trustees present may adjourn the meeting from time to time without further notice. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the act of a greater number is required by these Bylaws, by the Certificate of Incorporation or by law. Notwithstanding the foregoing, in the event that any Trustee has a conflict of interest with respect to any transaction to be undertaken by the Corporation, such transaction shall require the approval of the Board or the Member consistent with Article VII.

#### ARTICLE IV. OFFICERS

**Section 4.1 Officers.** The officers of the Corporation shall consist of a Chair, a President, a Secretary, a Treasurer and such other officers, including Vice Chairs, as may be appointed from time to time consistent with Section 4.6. The Chair and any Vice Chair shall be members of the Board.

**Section 4.2 Election and Term of Office.** The President shall be appointed in accordance with Section 4.3(a) of this Article IV. The Chair, any Vice Chairs, the Secretary and the Treasurer shall be nominated by the Nominating and Governance Committee and elected annually by the Board for a term of one year and until their successors are duly elected and qualified. The Board may create and fill such other offices as it deems necessary consistent with Section 4.6.

**Section 4.3 Powers.** The officers shall have the powers and perform the duties commonly incident to their respective offices, including the powers and duties listed below.

(a) **President.** The President of the Corporation shall be appointed by the Member, following consultation with the Board. The appointed President shall serve at the pleasure of the Member.

The President shall be a person who in the judgment of the Member has the combination of education, experience, professional standards and demonstrated leadership ability to fulfill successfully the responsibilities of the position and to command the confidence and respect of the Board, employees and the community.

The President shall be delegated the responsibility for overall management of the Corporation and shall have all authority necessary to carry out this responsibility, subject only to such policies as may be adopted by the Board. The President shall act as the duly authorized representative of the Board in all matters in which the Board has not formally delegated some other person to so act. The duties, responsibilities and authority of the President shall be defined in a written statement adopted by the Member in consultation with the Board.

The President shall be a voting member of all standing committees except as otherwise specified in these Bylaws.

(b) **Chair.** The Chair of the Board shall preside at meetings of the Board. The Chair shall perform such other duties as the Board may from time to time prescribe.

(c) **Vice Chair.** The Board may designate one or more Vice Chairs, who shall exercise the powers and duties of the Chair during absence or disability. The Vice Chair(s), if any, shall perform such other duties as the Board or the Chair may from time to time prescribe.

(d) **Secretary.** The Secretary shall have the custody of the records of the Corporation pertaining to the Secretary's office, shall keep minutes of the meetings of the Board, and shall cause notice of such meetings to be given as required by law or these Bylaws. The Secretary shall perform such other duties as the Board or the Chair may from time to time prescribe.

(e) **Treasurer.** The Treasurer of the Corporation shall be responsible for the safekeeping of all funds and securities of the Corporation, shall see that proper records showing all financial transactions of the Corporation are maintained, and shall present financial reports to the Board.

#### **Section 4.4 Resignation and Removal.**

(a) An officer of the Corporation may resign at any time by giving written notice of such resignation to the Secretary. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective.

(b) The Board may remove from office any officer with or without cause; provided, however, that the President may be removed from office by the Member following consultation with the Board. Removal of an officer shall be without prejudice to the officer's contract rights, if any.

**Section 4.5 Vacancies.** In the case of the death, resignation or removal of any officer, except the President, the vacancy may be filled by the Board for the unexpired term. A vacancy in the office of President shall be filled in accordance with Section 4.3(a).

**Section 4.6 Other Officers.** The Corporation may have such other officer or officers, including assistant officers, as the Board may from time to time determine. Any such officer or assistant officer shall be appointed or elected in the manner and for the term determined by the Board, and the officer shall have the duties assigned by the Board.

### **ARTICLE V. COMMITTEES**

**Section 5.1 Classification.** There shall be such standing committees as may be provided for, from time to time, in this Article V and such other committees as shall be established by Board resolution from time to time. Standing committees shall have the powers and duties set forth in this Article V and in a charter approved by the Board. Other committees shall have the powers and duties set forth in the resolution establishing them and in a charter approved by the Board. Each committee shall periodically review its charter and revise it as necessary; provided, however, that no amendment shall become effective until approved by the Board.

**Section 5.2 Appointment of Committee Members.** Except as otherwise provided in

these Bylaws, members and chairs of all standing committees shall be appointed by the Board on nomination of the Nominating and Governance Committee. All such committee members and chairs shall serve at the pleasure of the Board until the next annual meeting of the Board and until their successors shall be chosen. All committees shall have the power to choose their own secretaries. Unless otherwise provided, individuals who are not Trustees may be appointed to committees and each such person so appointed shall have a vote and be included for purposes of determining a quorum; provided, however, that if a committee is authorized to act on behalf of the Board, any such action must be approved by a majority of the committee members who are Trustees.

### **Section 5.3 Committee Governance.**

(a) **Quorum and Voting.** A majority of the committee members shall constitute a quorum at committee meetings except as otherwise provided in these Bylaws. The act of a majority of the committee members present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board or by law.

(b) **Meetings.** Except as otherwise provided in these Bylaws or by resolution of the Board, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board upon request.

### **Section 5.4 Standing Committees.**

(a) **Executive Committee.** The Executive Committee shall consist of the Chair, who shall act as chair of the committee, the President, the Treasurer, and any other member of the Board that the Board may choose to appoint. The Executive Committee shall possess and may exercise in the intervals between meetings of the Board all such powers of the Board, except as may otherwise be provided by law, these Bylaws or resolution of the Board.

(b) **Nominating and Governance Committee.** The Nominating and Governance Committee shall consist of Trustees elected by the Board. The Nominating and Governance Committee shall, after consultation with the President and other Trustees, nominate candidates to be voted upon in electing officers and members of the Board and nominate for appointment by the Board the chairs and members of all standing committees. The Nominating and Governance Committee shall also review Board governance matters and recommend enhancements to strengthen the Board and ensure the comprehensiveness and efficiency of its governance process.

(c) **Finance Committee.** The Finance Committee shall have such duties as are established by the Member and set forth in the Finance Committee charter. These duties shall include, but not be limited to, approval of local operating and capital budgets and examination and monitoring of other operating and capital budgets involving the Corporation.

**Section 5.6 Other Committees.** The Board may establish and appoint from among the Trustees or others, such other committees with such powers and authority as the Board shall designate, except that no such committee may exercise the authority of the Board.

**Section 5.7 Powers of Committees.** No committee established by the Board shall have power to fill vacancies on the Board or on any of its committees, to amend the Certificate of Incorporation of the Corporation or these Bylaws, to approve a plan of merger, to approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation other than in the usual and regular course of affairs of the Corporation, to approve a proposal to dissolve, or to authorize any other action inconsistent with the Certificate of Incorporation or these Bylaws.

#### ARTICLE VI. INDEMNIFICATION

The Corporation shall indemnify and defend the Corporation's Member, Trustees, officers and employees as set forth in the Certificate of Incorporation.

#### ARTICLE VII. CONFLICTS OF INTEREST

The Trustees and officers of the Corporation shall comply with any Conflicts of Interest policy adopted by the Corporation, as any such policy may be amended from time to time, and with the provisions of the Nonstock Act related to disclosure and approval of "Director's conflicting interest transactions" (as such term is defined in the Nonstock Act). Consistent with the requirements of the Nonstock Act, any "Director's conflicting interest transaction" shall, when possible, be approved and authorized by either (i) the Member or (i) a majority of the disinterested Trustees voting on the transaction at a meeting at which a majority (but no fewer than two (2)) of all disinterested Trustees on the Board shall constitute a quorum, in each case following any required disclosure of the facts of the conflicting interest transaction.

#### ARTICLE VIII. MISCELLANEOUS PROVISIONS

**Section 8.1 Fiscal Year.** The fiscal year of the Corporation shall begin on the first day of October and end on the last day of September in each year unless the Board of Trustees shall otherwise determine.

**Section 8.2 Execution of Deeds and Contracts.** Except as otherwise directed by the Board, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the President or such other officers or officers as may be specified by the Board or authorized by the President.

**Section 8.3 Execution of Negotiable Instruments.** All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President or such officer or officers of the Corporation as the Board may specify from time to time.

## ARTICLE IX. AMENDMENTS

Subject to approval by the Member, these Bylaws may be amended, altered, or repealed at any meeting of the Board by a majority vote of the Trustees present and voting, a quorum being present. The general nature and purpose of such proposed amendment(s) shall be set forth in the notice of the meeting, and the actual language of the proposed amendments need not be included in the notice. No amendment, alteration or repeal shall take effect until it shall have been approved by the Member.

EXHIBIT A

**Actions Requiring Approval of the Member**

Notwithstanding anything in these Bylaws to the contrary, neither the Board nor any officer or employee of the Corporation may take any of the following actions, or approve an Affiliate taking any of the following actions, without the prior approval of the Member:

- A. Merger, consolidation, reorganization or dissolution of this Corporation or any Affiliate and the creation or acquisition of an interest in any corporate entity, including joint ventures;
- B. Amendment or restatement of the Mission, Certificate of Incorporation or the Bylaws of this Corporation or any Affiliate, or any new or revised "doing business as" name;
- C. Adoption of operating and cash flow budgets of the Corporation or any Affiliate, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);
- D. Adoption of capital budgets and capital allocations of this Corporation or any Affiliate (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);
- E. Incurring aggregate operating or capital expenditures on an annual basis that exceed operating or capital budgets of the Corporation adopted by the Member by a specified dollar amount to be determined from time to time by the Member;
- F. Long-term or material agreements including, but not limited to, equity financings, capitalized leases, operating leases and installment contracts; and purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance of any asset, real or personal, with a fair market value in excess of a dollar amount to be determined from time to time by the Member, which shall not be less than 10% of the total annual capital budget of this Corporation;
- G. Approval of any new relationships or agreements for undergraduate or graduate medical education programs or any material amendments to or terminations of existing agreements for undergraduate or graduate medical education programs;
- II. Contracting with an unrelated third party for all or substantially all of the management of the assets or operations of this Corporation or any Affiliate;

- I. Approval of major new programs and clinical services of this Corporation or any Affiliate or discontinuation or consolidation of any such program. The Member shall from time to time define the term "major" in this context;
- J. Approval of strategic plans of this Corporation or any Affiliate;
- K. Adoption of safety and quality assurance policies not in conformity with policies established by the Member; and
- L. Adoption of any policies relating to compensation of employed physicians or the taking of any other action to establish or adjust compensation of employed physicians. For purposes hereof, compensation shall include salary, fringe benefits and deferred compensation.

Other Major Activities

- A. In addition, the Member shall have the authority, except as otherwise provided by the Member and after consultation with this Corporation, to require the prior review and approval of those activities of this Corporation or any subsidiary or affiliate entity that the Member determines to be "major activities."
- B. "Major activities" shall be those which the Member by a vote of not less than two-thirds (2/3) of its Board of Trustees has declared major, by written notice to this Corporation, delivered personally or transmitted by registered or certified mail return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of the Member, and shall refer to this Bylaw provision granting such approval rights to the Member. Notices received pursuant to this section shall be recorded in the minutes of this Corporation and shall be filed with the minutes of this Corporation.

Nothing in these Bylaws shall be construed in a manner that is inconsistent with the authorities with respect to the Corporation that are reserved or retained by the Member pursuant to these Bylaws and the Bylaws of the Member.

**EXHIBIT B****Actions Direct Authority Retained by the Member**

Notwithstanding anything in these Bylaws to the contrary, the Member retains authority to take the following actions on behalf of and in the name of this Corporation, directly and without the approval of the Board of this Corporation:

- A. Adoption of targets for the annual operating and cash flow budgets of this Corporation and its Affiliates, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation;
- B. Adoption of targets for the annual capital budgets and capital allocations of this Corporation and any Affiliate;
- C. Adoption of annual operating, cash flow and annual capital budgets for the Corporation and any Affiliate within the targets established by the Member in the event of any failure of the Corporation to do so;
- D. Issuance and incurrence of indebtedness on behalf of this Corporation;
- E. Management and control of the liquid assets of this Corporation, including the authority to cause such assets to be funded to the Member or as otherwise directed by the Member;
- F. Appointment of the independent auditor for this Corporation and each Affiliate and the management of the audit process and compliance process and procedures for this Corporation and each Affiliate; and
- G. Appointment of the President consistent with Section 4.3(a).

**ATTACHMENT IV**



# 2012 REPORT:

## COMMUNITY HEALTH NEEDS ASSESSMENT



LAWRENCE  
+ MEMORIAL  
HOSPITAL

100  
1912-2012

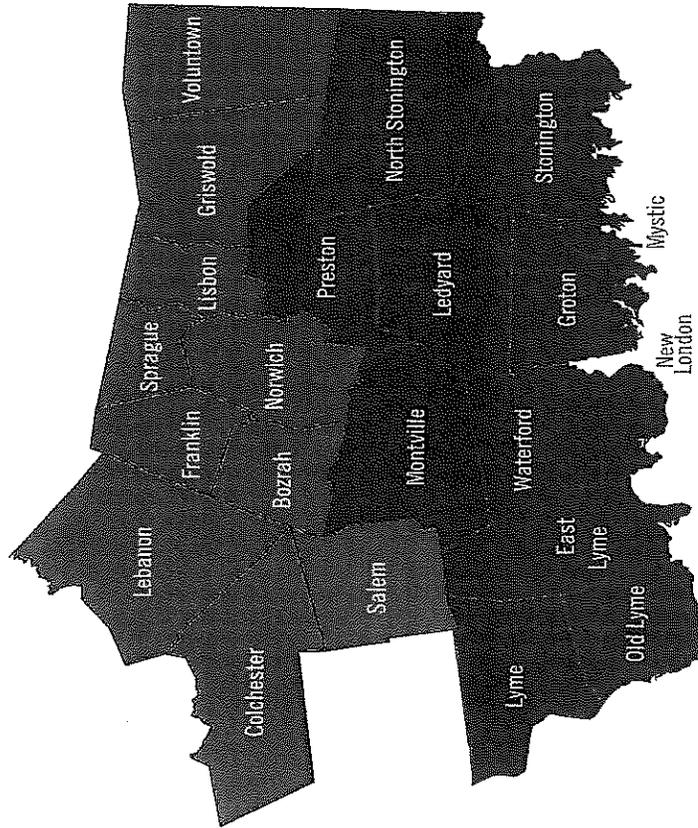


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## COMMUNITY HEALTH NEEDS ASSESSMENT PLANNING COMMITTEE

<b>Gindy Barry,</b> Senior Health Program Coordinator, Ledge Light Health District	<b>Jennifer Muggio,</b> Supervisor, Health Education and Community Outreach, Ledge Light Health District
<b>Tim Bates,</b> Attorney, former L+M Chairman of the board	<b>Mary Ann Nash,</b> Nutrition Program Coordinator, L+M Community Cancer Center
<b>Stephanie Clarke,</b> Health Program Coordinator, Ledge Light Health District	<b>Jennifer O'Brien,</b> Program Officer, Community Foundation of Eastern Connecticut
<b>Marcy Covsar,</b> VP of Planning, United Community & Family Services	<b>Shradidha Patel,</b> Director of Planning, L+M
<b>Andrew Haffey,</b> Manager, L+M Waterfall Rehabilitation and Sports Medicine	<b>Tracee Reiser,</b> Associate Dean of Community Learning, Connecticut College
<b>Mary Lerczai,</b> President, Visiting Nurse Association of Southeastern CT	<b>Bina Sears-Graves,</b> VP, Community Investment, United Way of Southeastern CT
<b>Alejandra Melendez-Suoper,</b> Site Director, Community Health Center of Groton and New London	<b>Chris Sobb,</b> Community Activist, Director, College Access Program
<b>Russell Mejnert,</b> Epidemiologist, Ledge Light Health District	



The Lawrence + Memorial Hospital primary service area includes the following Connecticut towns: New London, East Lyme, Lyme, Groton, Ledyard, Montville, North Stonington, Stoughton, Old Lyme, and Waterford.

## EXECUTIVE SUMMARY

Lawrence + Memorial Hospital (L+M) has been serving New London County, Connecticut for over 100 years and has been involved in ongoing community needs assessment and community health collaborations working to improve the health of area residents. In 2012, L+M contracted with Holleran Consulting, an independent research and consulting firm located in Lancaster, Pennsylvania, to execute a summary of trends and comparisons highlighted in their primary service area by the various regional and county assessments that have been conducted over the last five years. The following Connecticut towns are included in the primary service area: East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Stonington, and Waterford. (see map, page 2)

The assessment process included a review and analysis of data from four source types:

- Secondary Data (compiled from the Centers for Disease Control (CDC), Local and National health departments, the U.S. Census, and Healthy People 2020)
- Community Needs Assessments conducted by the United Way of Southeastern Connecticut (2010), and New London County Health Collaborative (2007)
- Hospital discharge data from 2008 through 2010
- Key informant interviews (Winter-Spring 2012)

This report is not necessarily a detailed representation of all the data that has been collected, but rather highlights the data and conclusions worth noting throughout the previous reports and research. Areas that have raised concern in the past and in which there are continued negative health outcomes reported include:

- **Cancer**  
Cancer incidences along with behavioral risk factors for cancer are higher in New London County than in Connecticut and in some instances the Nation.

- **Sexually transmitted diseases**  
Chlamydia rates were high in L+M's primary service area.
- **BMI and Obesity**  
The percentage of adults who reported a BMI indicating obesity in New London County was higher than that reported for the state.
- **Asthma**  
The incidence of Asthma within L+M's service area has remained constant over the previous three years and is much higher than the rates set forth by Healthy People 2020.
- **Diabetes**  
Diabetes incidence within the primary service area has steadily increased since 2008, and is much higher than the Healthy People 2020 goal.
- **Tobacco use**  
The percentage of adults currently smoking is higher in New London County than recommended by Healthy People 2020, a fact that raises concern due to its link to so many chronic diseases such as cancer.
- **Health status and access to care**  
Multiple sources report that residents of New London County face barriers to care such as delaying care due to cost and affordability of prescription medications.
- **Alcohol consumption**  
The percentage of adults who reported excessive drinking is high in both the state of Connecticut and New London County when making comparisons to the National Benchmark. As with tobacco use, higher than normal alcohol consumption is linked to many chronic conditions.

These areas of concern can have negative ramifications in many aspects of the community's health care and hospital systems. Many of these issues are behavioral risk factors for a variety of chronic health conditions, which place a heavy burden on local emergency departments, primary care centers, and disease management services.

It is also important to note that social determinants such as income and education can significantly impact health status, health behaviors, and health outcomes. Research has shown that lower educational attainment, poverty, and race/ethnicity are risk factors for certain health conditions. The demographic profile of the L+M service area correlates with the higher incidence of the negative health outcomes listed above.

Upon completion of data collection and analysis, in May 2012 L+M invited a team of hospital and community representatives to a community health strategic planning session. The purpose of the strategic planning session was to share the results of the community health needs assessment, to discuss and prioritize community health needs, and to develop community health goals and strategies to guide the L+M Community Health Implementation Plan. Holleran Consulting also facilitated this session. An asset mapping process was also undertaken in order to identify existing resources, services, and initiatives in the hospital service area.

Based on the quantitative results of the CHNA study, the qualitative feedback garnered from key informant interviews, and the expert knowledge of the group participants, a list of community health needs was refined and prioritized. The following list outlines the key health issues that were identified and prioritized.

## PRIORITIZED COMMUNITY HEALTH NEEDS

RANK

ISSUE

- 1 Overweight & Obesity
- 2 Access to Care
- 3 Cancer
- 4 Sexual Health
- 5 Mental & Behavioral Health
- 6 Asthma

# DEMOGRAPHICS POPULATION

The population in the Lawrence and Memorial (L+M) primary service area is over 174,000, with a male to female ratio very close to the state and national ratios as seen in Figure A1. Actual numbers are displayed in Table 1.

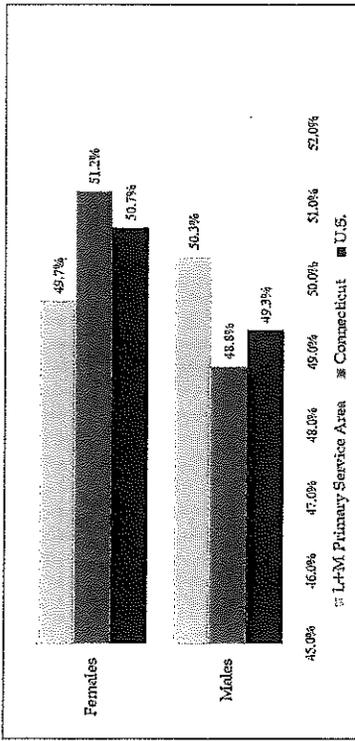


Figure A1: Gender breakdown for the United States, Connecticut, and the L+M primary service area, 2009

Table 1: Overall Population and Gender Breakdown (2009)

Population Gender	U.S. <sup>a</sup>		Connecticut		L+M Service Area	
	n	%	n	%	n	%
Male	151,449	49.3	1,717,636	48.8	87,915	50.3
Female	155,557	50.7	1,800,652	51.2	86,969	49.7

Source: Connecticut Department of Health, U.S. Census

<sup>a</sup> National data obtained from 2010 U.S. Census

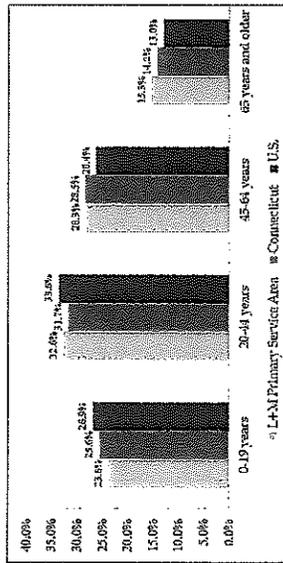


Figure A2: Age breakdown for the United States, Connecticut and L+M's primary service area, 2010 (U.S. Census)

The age breakdown in L+M's primary service area is similar to the associated breakdowns in Connecticut and the United States. There does seem to be a proportionally higher population of 45-64 year olds within the County.

The population change of all races in New London County from 2000 to 2010 is shown below in Table 2. The total population increased by 5.8 percent during that time. This growth was primarily due to increases in minority populations.

Table 2: Population change of all races in New London County (2000-2010)

Race	2000	2010	Change
Total Population	259,088	274,055	5.8
White	225,406	225,213	-0.1
Black/African American	13,705	16,025	17.0
American Indian/Alaskan Native	2,487	2,505	0.7
Asian	5,075	11,383	124.3
Native Hawaiian/Pacific Islander	151	180	19.2
Other	5,319	8,722	64.0
Two or more races	6,997	10,027	44.3
Hispanic/Latino of any race	13,236	23,214	75.4

The racial breakdown of the primary service area is a mix between Hispanic/Latino, Black, and White. According to Figure A3, the service area's White population is much higher than National and State comparisons, while the proportion of Black and Hispanic/Latino residents is much lower. However, the City of New London has a much higher proportion of Hispanic/Latino and Black residents than the State and Nation.

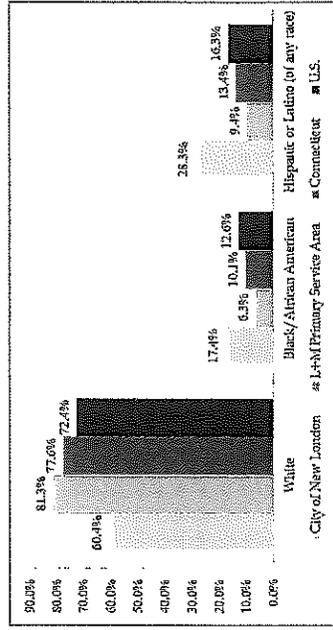


Figure A3: Race breakdown for the United States, Connecticut, the City of New London, and L+M's primary service area, 2010 (U.S. Census)



According to the CDC Office of Minority Health & Health Equity (2012), race and ethnicity correlate with significant health disparities. Specifically, Hispanic/Latinos are at higher risk for asthma, diabetes, HIV/AIDS, cervical cancer, lack of prenatal care, and infant mortality. Blacks/African Americans are at higher risk for heart disease, hypertension, diabetes, and infant mortality. Both populations are also at higher risk for overweight/obesity issues.

# DEMOGRAPHICS

## HOUSEHOLD

Household statistics for the primary service area, including the number of families, married couple families, families with children under age 18 and households with only a female guardian, while similar are all slightly below the State and National numbers. These figures are displayed in Figure B1.

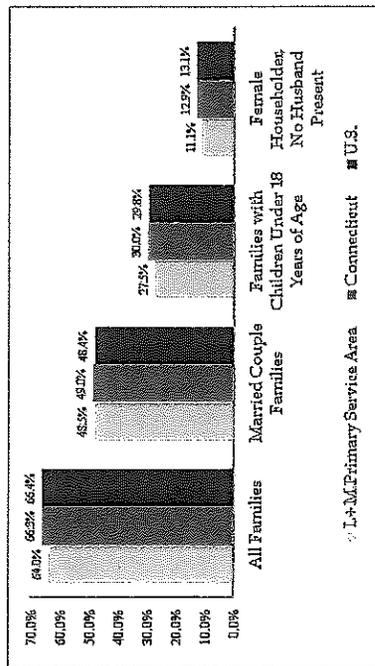


Figure B1: Household Type Breakouts for the United States, Connecticut, and L+M's primary service area, 2010 (U.S. Census)

Regarding marital status, the primary service area has a smaller percentage of people who have never been married compared to the State and the Nation. The percent of the population that is divorced is also slightly higher in the service area than compared to the State and Nation. These marital status statistical comparisons are displayed in Figure B4.

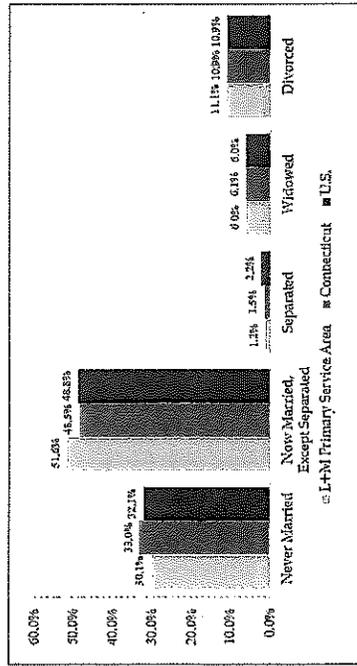


Figure B4: Marital Status Statistics for the United States, Connecticut, and L+M's primary service area, 2010 (U.S. Census)

# DEMOGRAPHICS

## INCOME

The poverty statistics for New London County are lower than Connecticut and the United States in terms of percentages across the board. These statistics are displayed in Figure C3. However, poverty among all families and families with children are higher in the City of New London than compared to the State and the Nation.

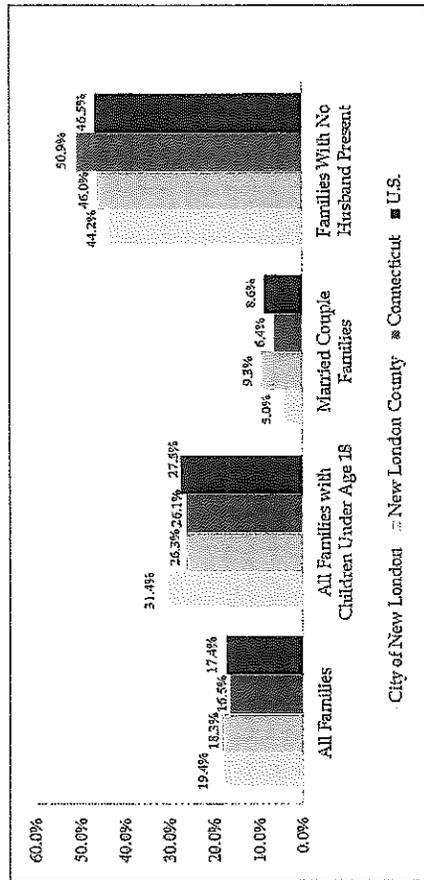


Figure C3: Poverty Statistics for the United States, Connecticut, the City of New London, and New London County, 2010 (U.S. Census)

\*Data not available for primary service area

According to the CDC Office of Minority Health & Health Equity (2012), socioeconomic status is also a major factor leading to health disparities. Individuals living in poverty have higher rates of morbidity and mortality for a number of health issues, including chronic diseases like diabetes, cancer, and heart disease.



# DEMOGRAPHICS

## HEALTH INSURANCE COVERAGE

The percent of those with health insurance coverage overall and those with private insurance is higher in New London County compared to both the State and National percentages. The proportion of those who reported having no health insurance was lower than the State and much lower than the Nation. These statistics are shown in Figure D1.

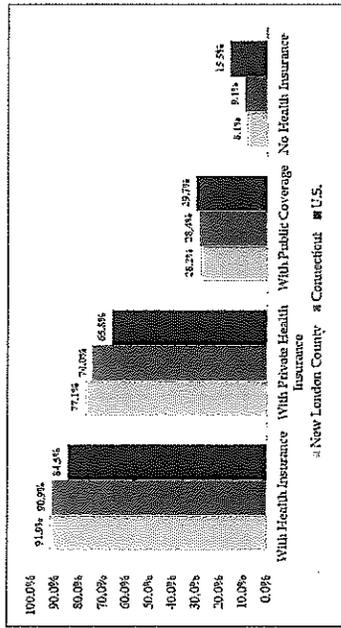


Figure D1: Employment Statistics for the United States, Connecticut, and New London County, 2010 (U.S. Census)

\*Data not available for primary service area

# DEMOGRAPHICS

## EDUCATION

Regarding educational attainment, the percentage of New London County's population with a bachelor's degree or higher is lower than the State, but still remains above the National figure (Figure E1). New London County has a slightly higher percentage of high school graduates than the State and Nation. Educational attainment for the City of New London is lower than the County, State and Nation.

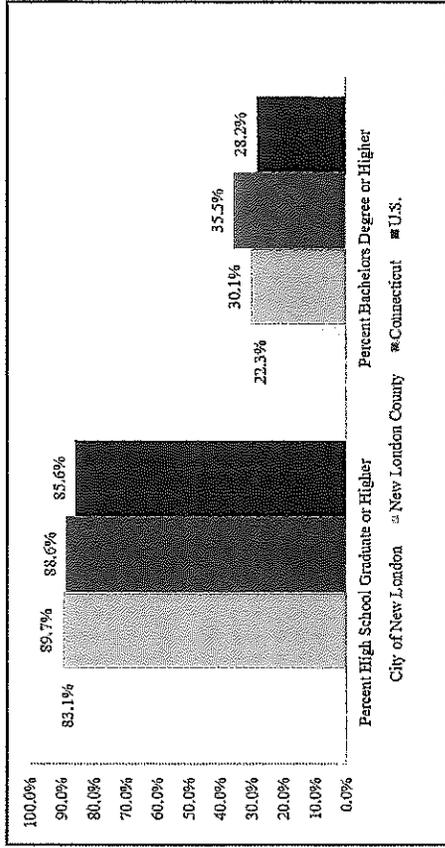
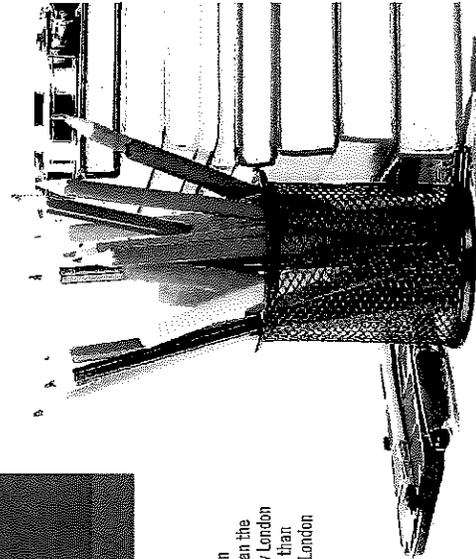


Figure E1: Educational Attainment for 25 years and older population in the United States, Connecticut, and New London County, 2010 (U.S. Census)\* \*Data not available for primary service area

Figure E2 further highlights educational status regarding only L-HM's primary service area.

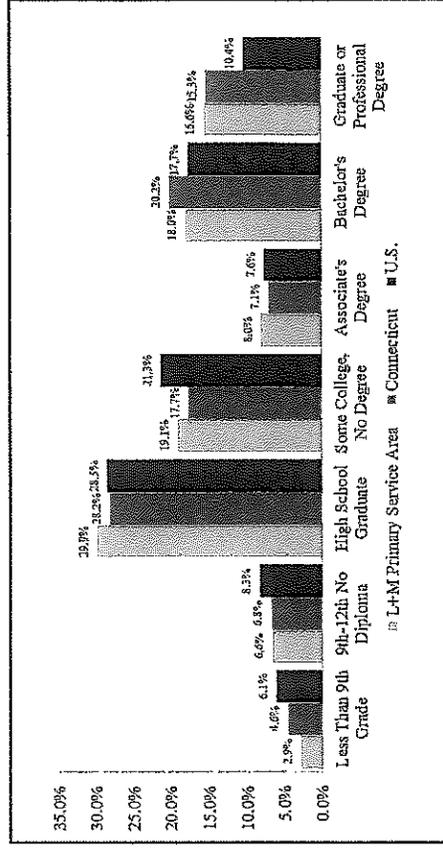


Figure E2: Educational Attainment for 25 years and older population in the United States, Connecticut, and L-HM's primary service area, 2010 (U.S. Census)

# HEALTH INDICATORS

## CANCER STATISTICS

The incidence rates for selected leading cancers at the National, State, and Local level are displayed in Table 3. Additionally, incidence for childhood cancers is shown in Table 4 in the same fashion.

Table 3: Selected Cancer Incidence by Site and Gender (2004-2008)<sup>a</sup>

	U.S. <sup>b</sup>		Connecticut		New London County	
	Number	Rate	Number	Rate	Number	Rate
Breast (female only)	121.0	136.2	137.8	137.8	137.8	137.8
Colorectal	47.6	49.2	49.3	49.3	49.3	49.3
Male	55.6	57.4	56.7	56.7	56.7	56.7
Female	41.4	42.9	43.7	43.7	43.7	43.7
Lung and Bronchus	67.9	68.1	74.1	74.1	74.1	74.1
Male	84.3	80.2	90.3	90.3	90.3	90.3
Female	55.8	60.0	63.0	63.0	63.0	63.0
Prostate (male only)	152.7	162.1	139.5	139.5	139.5	139.5
All Sites	465.0	504.7	520.4	520.4	520.4	520.4
Male	543.4	582.0	588.6	588.6	588.6	588.6
Female	410.4	453.8	477.0	477.0	477.0	477.0

Source: SEER National Cancer Registry, National Cancer Institute

<sup>a</sup>Age-Adjusted rates per 100,000

<sup>b</sup>Rates based on 2008 data

Table 4: Childhood (Ages 0-19 years) Cancer Incidence<sup>a</sup>

2004 - 2008	U.S.		Connecticut		New London County	
	Number	Rate	Number	Rate	Number	Rate
	N/A	16.9	166	17.8	14	20.9

Source: SEER National Cancer Registry, National Cancer Institute

<sup>a</sup>Rates per 100,000 population

Table 5: Selected Cancer Mortality by Site and Gender (2004-2008)<sup>a</sup>

	U.S. <sup>b</sup>		Connecticut		New London County		Healthy People 2020	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Breast (Female only)	22.5	23.2	24.0	24.0	24.0	24.0	20.6	20.6
Colorectal	16.4	16.4	14.5	14.5	14.5	14.5	14.5	14.5
Male	19.7	18.1	18.3	18.3	18.3	18.3	14.5	14.5
Female	13.8	13.8	11.5	11.5	11.5	11.5	14.5	14.5
Lung and Bronchus	49.6	46.9	39.4	39.4	39.4	39.4	45.5	45.5
Male	64.0	58.5	47.9	47.9	47.9	47.9	45.5	45.5
Female	39.0	39.1	43.4	43.4	43.4	43.4	45.5	45.5
Prostate	22.8	25.7	23.6	23.6	23.6	23.6	21.2	21.2
All Sites	175.8	176.9	185.8	185.8	185.8	185.8	160.6	160.6
Male	215.7	216.4	233.4	233.4	233.4	233.4	160.6	160.6
Female	148.4	152.5	152.5	152.5	152.5	152.5	160.6	160.6

Sources: SEER National Cancer Registry, National Cancer Institute, 2008, Healthy People 2020

<sup>a</sup>Age-adjusted rates per 100,000

<sup>b</sup>Rates based on 2008 data

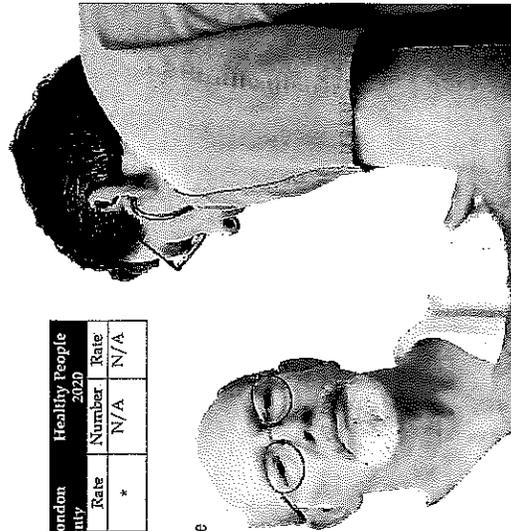
Table 6: Childhood (Ages 0-19 years) Cancer Mortality

2004 - 2008	U.S.		Connecticut		New London County		Healthy People 2020	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
	N/A	16.9	16	1.7	*	*	N/A	N/A

Source: SEER National Cancer Registry, National Cancer Institute

<sup>a</sup>Rates per 100,000 population

<sup>b</sup>\*3 or fewer cases reported



# HEALTH INDICATORS

## SEXUALLY TRANSMITTED DISEASES

Displayed below in Table 7 is the reported number of cases of Chlamydia at the National, State, and Local level. Also included in the Table, is data pertaining only to the Lawrence + Memorial primary service area and for comparison purposes, the 2011 National Benchmark for reported cases of Chlamydia. Figure 61 further illustrates the differences between these regions and the Benchmark. Displayed in Tables 8 and 9 are the rates of chlamydia by age and race/ethnicity among females for the City of New London and Groton in 2007. Females have much higher rates of Chlamydia. Age and Race/Ethnicity are also risk factors for Chlamydia.

Table 7: Number of Chlamydia Infections per 100,000 (2008)

U.S.	Connecticut	New London County	L+M Primary Service Area	2011 National Benchmark
Number	398.1	236.0	245.4	89.0

Source: CDC STD Surveillance Report, 2010

Connecticut Department of Health, STD Statistics, 2009  
County Health Rankings, 2011

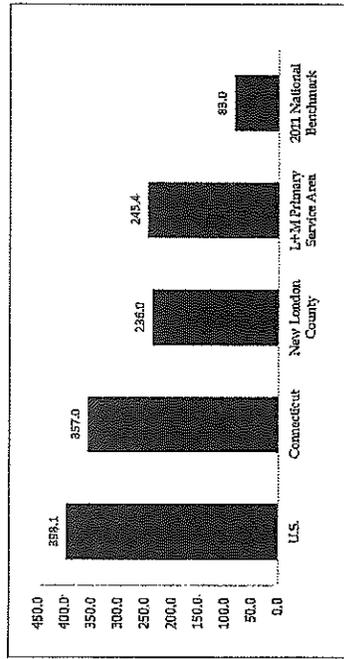
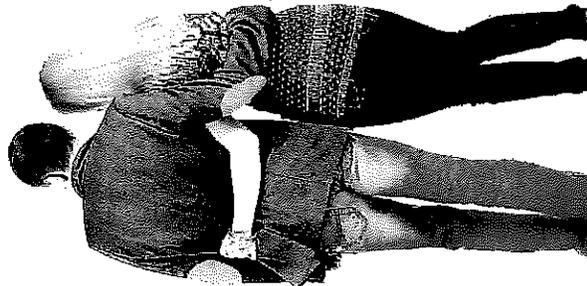


Figure 61: Number of Reported Chlamydia Cases per 100,000

Table 8: Chlamydia Infections per 100,000 in Groton by Race/Ethnicity and Age group: 15-29 Year Old Females (2007)

Race	15-19	20-24	25-29
White, Non-Hispanic	1504.8	1030.0	396.0
Hispanic	1033.6	3816.8	678.0
Black, Non-Hispanic	8000.0	4621.8	613.5

Source: Ledge Light Health District Epidemiology Program, 2010

Table 9: Chlamydia Infections per 100,000 in City of New London by Race/Ethnicity and Age group: 15-29 Year Old Females (2007)

Race	15-19	20-24	25-29
White, Non-Hispanic	1060.6	1097.8	623.3
Hispanic	0.0	1212.1	1036.3
Black, Non-Hispanic	3960.4	5494.5	0.0

Source: Ledge Light Health District Epidemiology Program, 2010

# HEALTH INDICATORS

## BMI AND OBESITY

The data regarding Obesity collected in 2007 pointed to childhood obesity as a major issue. These data are shown here in Table 10 along with the Healthy People 2020 objective for the percentage of the population that is obese. More recent data collected on the percentage of adults who reported BMI's above 30, indicating they were obese, are displayed in Table 11 along with the Healthy People 2020 target for that age group.

Table 10: Percent of Children in New London Public Schools who are Overweight or Obese

Grade/Gender	Percent Overweight or Obese	Healthy People 2020
Pre-K Girls	36.4	9.6
Pre-K Boys	41.0	9.6
Grade 4 Girls	58.6	15.7
Grade 4 Boys	44.9	15.7

Source: 2007 CHPPR NLC Community Health Assessment, Healthy People 2020

# HEALTH INDICATORS

## ASTHMA

The following data regarding the crude incidence of Asthma within the primary service area is based upon hospital discharge data supplied by Lawrence + Memorial Hospital. Looking at Table 12, the crude incidence of Asthma within the primary service area far exceeds the goal set forth by Healthy People 2020. Additionally, data spanning three years, 2008 through 2010, is displayed in figure 11 below.

Table 12: Asthma Crude Incidence by Age Group for the L+M Primary Service Area (2010)

Age Group	L + M Service Area	Healthy People 2020
0-4 Years	234.4	18.1
5-64 Years	188.8	8.6
65 and Over	84.5	20.3

Source: Healthy People 2020, U.S. Census, L+M hospital discharge data  
 \*Rates per 10,000 population

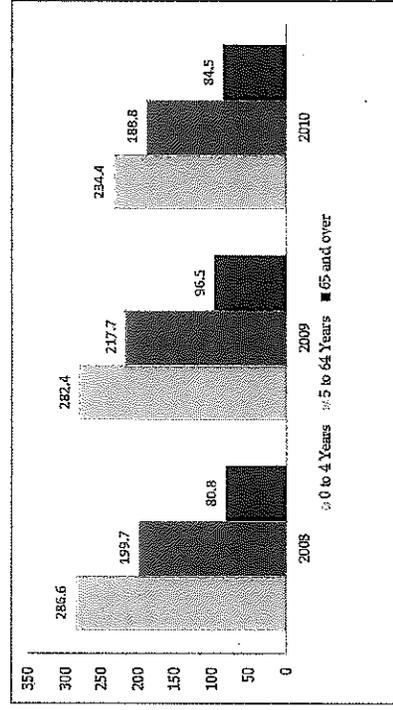


Figure 11: Crude Incidence of Asthma by Age Group from 2008 to 2010, L+M Primary Service Area (L+M hospital discharge data, U.S. Census)  
 \*Rates per 10,000 population

Table 11: Percent of Adults in New London County who Reported a BMI of 30 or Greater (2010)

	New London County	Healthy People 2020
Connecticut	23.1	30.6

Source: Health Indicators Warehouse, Healthy People 2020

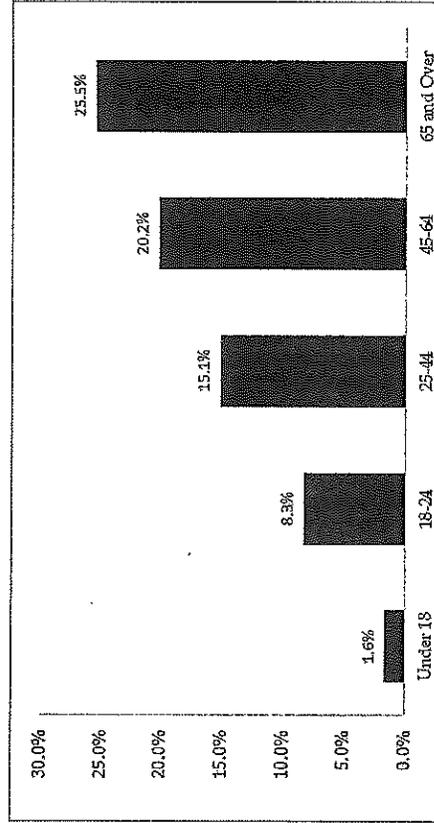
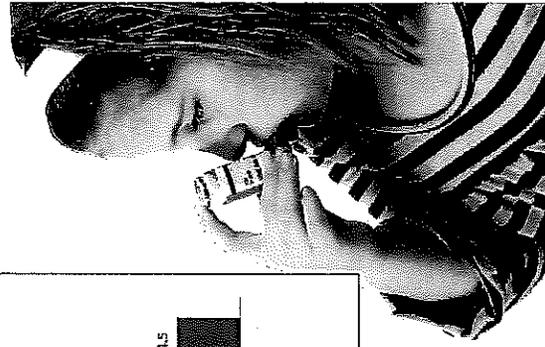


Figure 11: Percent Obese by age group in New London County, 2010 (Achieve New London)



# HEALTH INDICATORS

## DIABETES

The following data regarding the crude incidence of Diabetes in the primary service area was derived using hospital discharge data as was the case with Asthma (Table 13). The crude rate of Diabetes in L+M's primary service area is much higher than the goal determined by Healthy People 2020 for the 18 to 84 age group. Furthermore, looking at Figure 11, the rate of Diabetes within the 18 to 84 age group is increasing each year from 2008 through 2010.

Table 13: Crude Incidence of Diabetes in the L+M Primary Service Area for Ages 18-84

Year	L+M Service Area	Healthy People 2020
2008	27.4	
2009	31.3	7.2
2010	33.7	

Source: Healthy People 2020, U.S. Census, L+M hospital discharge data

\*Rates per 1,000 population

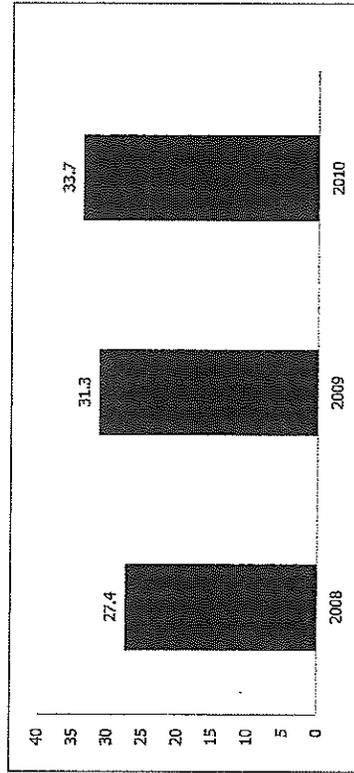


Figure 11: Crude Incidence of Diabetes for Ages 18 to 84 in L+M's Primary Service Area (L+M hospital discharge data, U.S. Census)  
\*Rates per 1,000 population

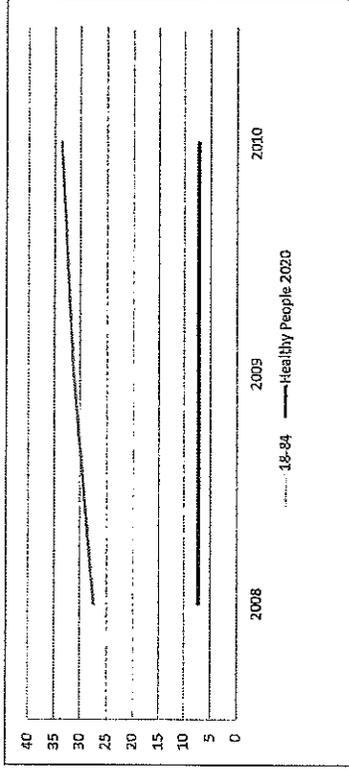


Figure 12: Crude Incidence of Diabetes in the L+M Primary Service Area Compared to HP2020 Goal Over Three Years (L+M hospital discharge data, U.S. Census)

\*Rates per 1,000 population

# HEALTH INDICATORS

## TOBACCO USE/SMOKING

The following data represents survey results of those who smoke from the 2007 Connecticut SMART BRFS for New London County, and the 2010 United Way of Southeastern Connecticut survey with comparisons to Healthy People 2020 (Table 14).

Table 14: Smoking Status of County and Regional Residents

Smoking Status	BRFSS 2007	UWSC 2010	Healthy People 2020
Every day	15.7	11.3	N/A
Some days	1.6	4.1	N/A
Currently smoking	17.3	15.4	12.0

Source: Connecticut SMART BRFS of New London County, Healthy People 2020, United Way of Southeastern Connecticut 2010



# HEALTH INDICATORS

## HEALTH STATUS AND ACCESS

Table 15 presents data regarding respondent's health status or condition by race. A greater percentage of Hispanics reported asthma, high cholesterol, and diabetes as primary health conditions compared to both Blacks and Whites. The highest reported percentage of high blood pressure was recorded in the Black population.

Table 15: Percentage of Health Conditions Reported by Race/Ethnicity

Health Condition	Race/Ethnicity		
	White (%)	Black (%)	Hispanic (%)
Heart Disease	6.1	4.7	4.6
Asthma	9.9	14.1	17.9
High Blood Pressure	17.9	26.4	14.1
High Cholesterol	14.6	4.1	16.0
COPD	4.0	2.8	0.3
Diabetes	6.0	6.9	7.2
Overweight/Obesity	16.5	13.8	15.5

Source: 2010 ACHIEVE New London Healthy Resident Survey results

The remaining tables report access to services and prescription medicines. It is important to note that the ratio of primary care physicians to residents in New London County (1,096:1) is poor when compared to the National Benchmark (651:1) and Connecticut (729:1).

Table 16: Access to a Primary Source of Care within Southeastern Connecticut

Response	UWSC 2010		Healthy People 2020
	Yes	No	
Yes	95.5	4.2	95.0
No	4.2	N/A	N/A

Source: Healthy People 2020, United Way of Southeastern Connecticut 2010

Table 17: Percent of Population Who Delayed Medical Care Due to Cost in New London County and Southeastern Connecticut

HIW* 2008-2010	HIW* 2010	UWSC 2010	Healthy People 2020
7.4	5.9	14.2	4.2

Source: Healthy People 2020, Health Indicators Warehouse, United Way of Southeastern Connecticut 2010

Table 18: Percent of Those Who Could not Receive Prescription Medicines Due to Cost

UWSC 2010	Healthy People 2020
12.9	2.8

Source: Healthy People 2020, United Way of Southeastern Connecticut 2010

# HEALTH INDICATORS

## ALCOHOL CONSUMPTION

Data regarding the percent of those who had at least one drink within the past 30 days is displayed below in Table 19. The results come from the New London County SMART BRFSS questionnaire from 2007 and the United Way of Southeastern Connecticut 2010 Survey. The percent of those who reported excessive drinking is found in Table 20. This data is reported by the County Health Rankings website and is compiled from the annual BRFSS administered by the CDC.

Table 19: Percent of Those Who Had at Least One Drink Within the Past 30 Days

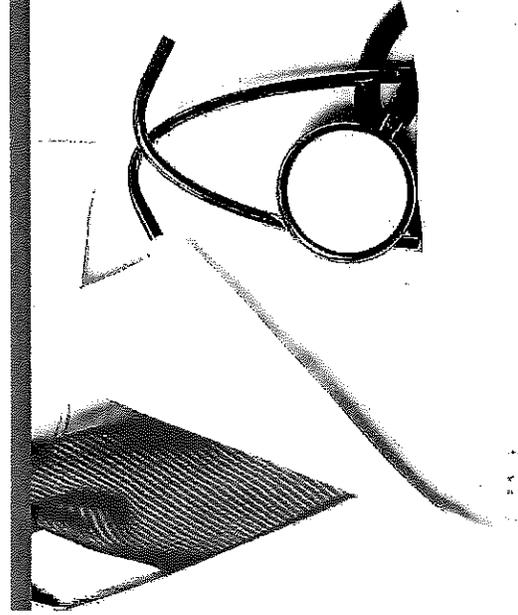
BRFSS 2007	UWSC 2010
62.5	43.1

Source: Connecticut SMART BRFSS for New London County, United Way of Southeastern Connecticut

Table 20: Excessive Drinking in Adults Age 18 and Over (2012)

National Benchmark	Connecticut	New London County
8.0%	18.0%	18.0%

Source: County Health Rankings 2012



# CONCLUSIONS

## STRENGTHS

### Demographics

- The percent of families living in poverty with no husband present is much lower in New London County (13.3) than the U.S. (30.3) and Connecticut (22.2).
- The percent of individuals with health insurance is higher in New London County (91.9) than in the U.S. (84.5) and Connecticut (90.9).
- The percent of those that have graduated high school is highest in New London County (89.7) compared to National (85.6) and State (88.6) averages.
- When looking at the primary service area (15.6), the percent of individuals who have received a graduate or professional degree is higher than both the State (15.3) and Nation (10.4).

### Cancer Statistics

- Prostate Cancer among males is lowest in New London County (139.5) compared to the State (162.1) and National statistics (192.7).
- Mortality due to Colorectal Cancer in both males and females is lowest in New London County (14.5) and has met the Healthy People 2020 goal of 14.5.
- Although higher than the State and Nation, mortality due to Lung and Bronchus Cancer in females (49.4) has reached and surpassed the Healthy People 2020 goal of 45.5. The same can be said for Cancer in females of all sites (155.0) which has reached and surpassed the Healthy People 2020 goal of 160.6.

### BMI and Obesity

- The percent of adults who reported a BMI of 30 or greater in New London County (26.0) was lower than the Healthy People 2020 goal of 30.6. However, it was still higher than that reported for the State (23.1).

### Asthma

- The crude incidence of Asthma in the 0 to 4 age group has seen a slight decline from 2008 through 2010.
- A decline in crude incidence was also seen from 2009 to 2010 in the 5 to 64 and 65 and over age groups.

### Alcohol Consumption

- The number of those who reported at least one drink within the past 30 days has decreased from 2007 to 2010.

### Tobacco Use

- The percent of those currently smoking has decreased from the 2007 survey (17.3) compared to both of the 2010 surveys (NLC 13.5, SE CT 15.4).

### Health Status and Access

- According to the United Way survey of Southeastern Connecticut, 95.5% of residents surveyed have access to a primary source of care. This exceeds the Healthy People 2020 goal of 85.0%.

### Cancer Statistics

- Incidence of the following Cancers was higher in New London County than the State and Nation: Breast (female only), Colorectal in both males and females, Lung and Bronchus in both males and females, all sites in both males and females.
- The incidence of childhood Cancer was higher in New London County (20.9) than it was in the State (17.8) and Nation (16.9).
- Mortality for the following Cancers was higher in New London County compared to the State and Nation: Breast (female only), Lung and Bronchus in males, all sites in Males.

### Sexually Transmitted Diseases

- The rate of Chlamydia infections per 100,000 people was higher in the L+M primary service area (245.5) compared to New London County (236) and the 2011 National Benchmark (83).
- In the city of New London and Groton, Chlamydia infections are highest among Blacks and Hispanics.

### BMI and Obesity

- The percent of children in 2007 that were overweight or obese is much higher than recommended by Healthy People 2020. For example, the percent of Pre-K girls was 36.4, while the Healthy People 2020 goal is 9.6. The same was true for Pre-K boys, and both girls and boys in Grade 4.
- The 65 and over age group reported the highest percent (25.5) of obese individuals in 2010.

# CONCLUSIONS

## OPPORTUNITIES

### Asthma

- Crude incidence rates for Asthma in the primary service area were much higher than those recommended by Healthy People 2020. In the 0 to 4 age group, the rate is 234.4, while Healthy People 2020 sets the goal at 18.1.

### Diabetes

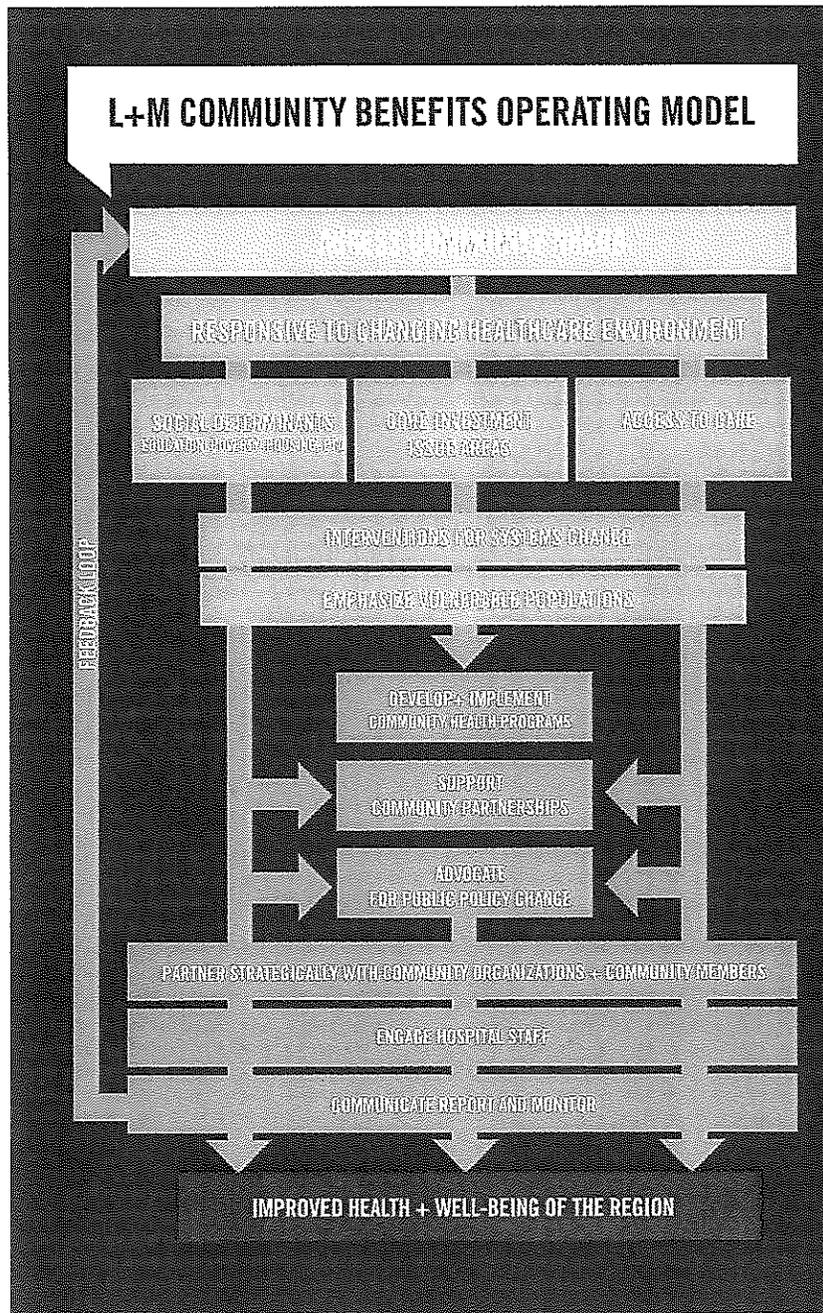
- The crude incidence of Diabetes in the L+M primary service area was much higher from 2008 through 2010 than recommended by Healthy People 2020. For example, in 2010, the rate for the service area was 33.7, while the Healthy People 2020 goal is 7.2.
- Another major concern in this area is the fact that hospitalizations, due to Diabetes, have been steadily increasing from 2008 through 2010 for the 18 to 84 age group.

### Tobacco Use

- Looking at data from the 2007 survey compared to both of the 2010 surveys, the percent of those who are currently smoking in the county and region has decreased, but has still not reached the Healthy People 2020 goal.

### Health Status and Access

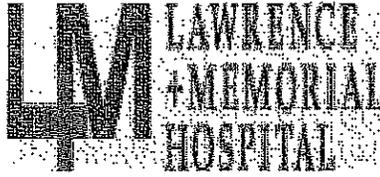
- According to two sources, Health Indicators Warehouse and the United Way Survey, in 2010, the percent of the population who delayed medical care due to cost (5.9-14.2) was still higher than that recommended by the Healthy People 2020 goal of 4.2.
- According to the United Way Survey, 12.3 percent of those surveyed could not receive prescription medications due to cost. This is higher than the recommended 2.8 percent set by Healthy People 2020.



Facilitators provided a framework showing the relationship between assessing community needs and hospital community benefit planning to help guide the group discussion of health issues.



Community Health, Outreach + Partnerships  
234 State Street | New London, CT 06320  
860.442.0733 | lmhospital.org



[Home](#) / [About L+M](#) / [Community Benefits](#)

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## L+M in the Community

At L+M Hospital, doctors, nurses and staff are also your neighbors and friends, so it's no wonder we're deeply committed to the health of our region far beyond the doors of our buildings.

At L+M, we're determined to make southeastern Connecticut a better, healthier place to live, and that includes an array of outreach programs. In fact, L+M's "Community Benefits" totaled over \$15 million last year, and our services are aimed at those who need it most, such as expectant mothers, infants, senior citizens, and those who are homeless.

There are many reasons for what we do, but the most obvious is quite simple: we believe in giving each other a hand up. Because we live here, too. And, like you, we care.

The broad range of L+M Hospital's **community benefit activity** includes educational programs, community disaster preparedness, health promotion, faith community outreach, and collaborative school programs. Furthermore, there are services for the homeless, injury prevention programs, student internships, and many other programs that simply wouldn't exist if not for the staff and resources provided by Lawrence + Memorial.

When it comes to community benefits, it's often the little things that make the biggest differences. Consider what happens each day at the Homeless Hospitality Center in New London: an employee from the shelter drops off dirty sheets at L+M Hospital; they return to the shelter with clean ones. It happens every day, all year, free of charge, thanks to L+M. The service saves the shelter time, boosts the moral of the guests who always sleep on clean linens, and, most importantly of all, the service saves the shelter many thousands of dollars.

Another such program is a collaboration between L+M and the Gemma E. Moran United Way Labor Food Center, to collect and distribute disposable diapers and baby wipes to families in need. When the program first kicked off in 2009, more than 7,000 diapers were delivered in the first two months.

Organizers found that in some cases, children were being left in dirty diapers all day until needy families could afford to buy more. For many families, the program helped bridge that gap until the next paycheck, improving the health and quality of life for both the child and family. Said one organizer: "The diaper bank program is a much-needed addition to the region's safety net and has made a tremendous impact."

But L+M's community commitment doesn't stop with infants. Outreach programs in schools also include such things as pediatric weight management to help children fight obesity, and health and exercise programs to encourage physical fitness.

Another major aspect of L+M's community involvement is subsidized healthcare services for those in need, ranging from emergency and trauma visits to neonatal intensive care. The OB Clinic at the hospital provides education and testing for expectant mothers, and women who qualify can also receive free exams for breast and cervical cancer as part of a community benefit.

**ATTACHMENT V**

**STATE OF CONNECTICUT****Department of Public Health****LICENSE****License No. 0361****Outpatient Clinic**

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

**\*L&M Physician Associations, Inc.\*** of New London, CT, d/b/a **\*L&M Physician Associations, Inc.\*** is hereby licensed to maintain and operate an Outpatient Clinic.

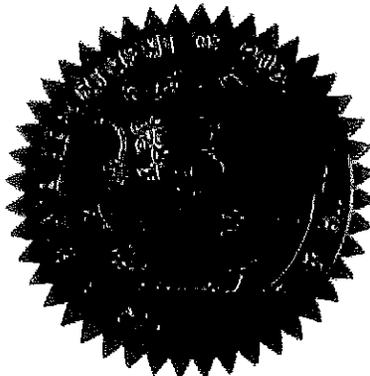
**\*L&M Physician Association, Inc.\*** is located at 437 Pequot Avenue, New London, CT 06320.

This license expires **June 30, 2017** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2013. RENEWAL

Services:  
Primary Care Services

**\*Licensee and d/b/a name change eff: 7-1-13\***



Handwritten signature of Jewel Mullen in cursive script.

Jewel Mullen, MD, MPH, MPA  
Commissioner

**ATTACHMENT VI**

## Amit Rastogi, MD

### Curriculum Vitae

#### Administrative Office:

Northeast Medical Group  
 99 Hawley Lane, 3<sup>rd</sup> floor  
 Stratford, CT 06610  
 Phone: 203-502-6502 Fax: 203-502-6556  
[Amit.Rastogi@ynhh.org](mailto:Amit.Rastogi@ynhh.org)

#### Private Practice (Internal Medicine):

PriMed, LLC  
 112 Quarry Road, Suite 220  
 Trumbull, CT 06617 07/1998-06/2014

#### Research Consultant:

Clinical Research Consultants, Inc.  
 Trumbull, CT 06611 1998-2002

#### Executive Appointments:

Northeast Medical Group (Yale New Haven Health System)

- Interim Chief Executive Officer 03/2015-present
- Chief Executive Officer Accountable Care Organization 01/2015-present
- Chief Medical Officer 06/2014-present
- Chief Operating Officer 06/2014-present
- Vice-President 06/2014-present

PriMed, LLC

- President and Chief Executive Officer 03/2009-03/2015
- Board of Directors (Chairman) 03/2009-03/2015
- ACO: Chief Executive Officer 07/2012-03/2015
- Executive Committee (Secretary/Treasurer) 03/2007-04/2009
- PriMed Finance Committee (Chairperson) 03/2007-04/2009
- PriMed Osteoporosis Center (Medical Director) 01/2006-04/2009
- PriMed Management Committee 01/2002-03/2015

St. Vincent's Medical Center

- Chief of Medical Staff 07/2013-02/2014
- Hospital Board of Directors 07/2013-02/2014
- Chairman, Medical Executive Committee 07/2013-02/2014
- Medical Staff, Vice President 07/2010-06/2013
- Medical Executive Committee 07/2007-02/2014
- Chairman, Peer Review Committee 07/2010-06/2013
- Performance Improvement Committee 07/2010-06/2013
- By-laws Committee 07/2010-06/2012
- EMR Committee 07/2009-06/2010
- Information Technology Physicians Advisory Group 07/2009-06/2010
- Medical Staff, Secretary/Treasurer 07/2008-05/2010
- Graduate Medical Education Committee 1998-2002

**Curriculum Vitae – Amit Rastogi, MD****Page 2****Fairfield County Medical Association**

- Board of Directors 05/2013-present

**NorthBridge Health Care**

- Medical Director 07/2006-11/30/2007

**Academic Appointments:**

- UCONN School of Medicine, Farmington, Connecticut  
Clinical Instructor of Medicine 09/2006- 2011
- College of Physicians and Surgeons; Columbia University, Presbyterian Hospital, New York, NY  
Clinical Instructor of Medicine 2004 - 2006

**Post Graduate Training**

St. Vincent's Medical Center-Yale School of Medicine

Bridgeport, CT

Internal Medicine, 1996-1998

Brigham and Women's Hospital-Harvard Medical School

Boston, MA

Anesthesiology, 1995-1996

St. Vincent's Medical Center-Yale School of Medicine

Bridgeport, CT

Internal Medicine, 1994-1995

**Education:**

- Harvard University  
Boston, MA  
Master in Healthcare Management  
Degree candidate, 2016
- UMDNJ-New Jersey Medical School  
Newark, NJ  
Medical Degree, 1990-1994
- Farleigh Dickinson University  
Teaneck, NJ  
BS (Biology), Summa Cum Laude, 1986-1989

**Professional Memberships:**

- Fairfield County Medical Association 1998-present
- American Medical Association 1991-2001
- American College of Physicians 1996-2015
- American Society of Anesthesiology 1995-1996
- Massachusetts Medical Society 1995-1996
- American Medical Student Association 1990-1994

**Curriculum Vitae – Amit Rastogi, MD****Page 3****Speaking Engagements:**

“Value Based Healthcare – The Innovator’s Dilemma” National Webinar	April 2014
“Accountable Care Organizations – Their role in post-acute care” National Senior Living Business Webinar	January 2014
“Value Based Healthcare – The Innovator’s Dilemma” National Healthcare Leadership Conference Orlando, Florida	October 2013
“The Role of Medical Groups in the era of Healthcare Reform” National Healthcare Technology Conference Las Vegas, Nevada	May 15, 2013
“The Roadmap for Successfully Developing a Physician Led ACO: The Journey from Volume to Value based healthcare” American College of Physician Executives Annual Meeting New York, NY	April 27, 2013
“What is an Accountable Care Organization” Northeast Sleep Society Annual Meeting Trumbull, CT	April 5, 2013
“ACO’s: Bringing Accountability to the Bedside” Connecticut State Medical Society New Haven, CT	October 23, 2012
“The Roadmap for Successfully Developing a Physician-led Accountable Care Organization: The Journey From Volume to Value-based Healthcare” 2012 National HealthCare Leadership Conference St. Thomas, Virgin Islands	October 11, 2012
“The Impact of the ACO’s on Disease Management” Vitaphone International Shelton, CT	May 7, 2012
“Creating a Culture of Success Within a Physician Led ACO” National MGMA Annual Conference Las Vegas Convention Center Las Vegas, Nevada	October 23, 2011
"Physician Led Organizations at the Forefront of Healthcare Reform" National Healthcare Leaders Conference Palm Springs, CA	September 21, 2011

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- "The Advantages of a Physician Owned, Physician Governed Multispecialty Group"  
 Norwalk, CT July 20, 2011
- "Why ACOs Should Be Physician Led"  
 Nationally Syndicated Webinar June 01, 2011
- "Metric based Medical Peer Review"  
 St. Vincent's Medical Center  
 Bridgeport, CT June 2011
- "Accountable Care Organizations"  
 Fairfield County Medical Association Annual Meeting  
 Stamford, CT April 28, 2011
- "Medical Staff Leadership: Shaping the Future of Healthcare"  
 St. Vincent's Medical Center  
 Bridgeport, CT April 2011
- "Healthcare Reform and Its Impact on Medical Practice"  
 Hudson County Medical Association  
 Jersey City, NJ March 16, 2011
- "Medical Peer Review: Bringing Accountability to the Process"  
 St. Vincent's Medical Center  
 Bridgeport, CT November 2010
- "Medical Staff Leadership: A Real Life Perspective"  
 St. Vincent's Medical Center Annual Retreat  
 Mystic, CT January 2009
- "Healthcare Reform: A Primer"  
 PriMed Annual Conference  
 Trumbull, CT October 2009

**Research Experience:**

- Department of Internal Medicine, St. Vincent's Medical Center, Bridgeport, CT  
 Once Daily vs. Multiple Daily Aminoglycoside Dosing  
 Principal Investigator: Amit Rastogi, MD (1997-1998)
- Department of Internal Medicine, New Jersey Medical School  
 Amlodipine Study of the Angina Population  
 Principal Investigator: Bunyad Haider, MD (1993)

- Department of Internal Medicine, New Jersey Medical School  
Trials of Hypertension Prevention (Phase II)  
Principal Investigator: Norman Lasser, MD, Ph.D. (1991)

**Sub-investigator for the following protocols at Clinical Research Consultants:**

- New Compound to Inhibit Cartilage Degradation in Patients with Osteoarthritis of the Knee (II) (1998-1999)
- OTC Switch Study to Investigate the Consumer Usage Patterns of a New Heartburn Medication (1999)
- Topical Anti-Inflammatory Treatment for Osteoarthritis of the Knee (1999)
- New Treatment for Heartburn Symptoms Following a Provocative Meal (1999)
- Searle-Comparison of COX-2 Inhibitors in Relieving Pain and Morning Stiffness of Osteoarthritis of the knee (1999)
- Medicated Patch for Treatment of Pain Associated with Osteoarthritis of the Knee or Hip (1999)
- Angiotensin II Receptor Antagonist for Treatment of Essential Hypertension as Determined by Ambulatory Monitoring of Blood Pressure (1999-2000)
- Solvent/Detergent Plasma Pharmacovigilance Study Healthy Volunteers (1999-2000)
- Anti-TNF in the Treatment of Patients with Rheumatoid Arthritis (1999-2000)
- Oral Interferon in the Treatment of Sjogren's Syndrome (1999-2000)
- New Compound for Treatment of Chronic Low Back Pain (1999-2000)
- New Compound for the Treatment of Subjects with Viral Respiratory Infections (1999-2000)
- New Compound for the Treatment of Rheumatoid Arthritis in Patients Receiving Methotrexate (1999-2000)
- Glaxo Wellcome-Alosetron for Male Subjects with Irritable Bowel Syndrome (1999-2000)
- Glaxo Wellcome-Alosetron for Female Subjects with Alternating Diarrhea/Constipation Irritable Bowel Syndrome (1999-2000)
- New Treatment for Hyperlipidemia in Post-Menopausal Women with Osteopenia (1999-2001)
- Long-Term Safety Study of New Treatment for Patients with Clinical Depression (1999-2000)
- Comparison of COX-2 Inhibitors in Treating Patients with Osteoarthritis and Hypertension (1999-2000)
- New Compound in Combination with Metformin for Treatment of Subjects with Diabetes Mellitus Type II) (1999-2001)
- Comparison of COX-2 Inhibitors in Treating Patients with Osteoarthritis of the Knee or Hip (2000)
- New Compound for the Treatment of Pain Associated with Diabetic Peripheral Polyneuropathy (2000-2001)
- New Compound for Treatment of Patients with Chronic Lower Back Pain (2000)
- Comparison Study to Investigate the Efficacy and Safety of a New Compound in the Treatment of Males with Erectile Dysfunction (2000-2001)
- An Open-Label Study of the Long-Term Safety of a New Compound for the Treatment of Rheumatoid Arthritis in Patients Receiving Methotrexate (2000-2001)
- Angiotensin II Receptor Antagonist for Treatment of Patients with Mild-to-Moderate Hypertension as Determined by Ambulatory Monitoring of Blood Pressure (2000-2001)
- A Single Dose Study of a New Compound for the Treatment of Subjects with Acute Migraine Attacks (2000)
- Evaluation of Solvent/Detergent-Treated Plasma in Normal Healthy Volunteers (2000-2001)
- Medicated Patch for the Treatment of Osteoarthritis of the Knee (2000)
- Human Anti-TNF Monoclonal Antibody in the Treatment of Patients with Active Rheumatoid Arthritis (2000-2001)

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- New Compound for the Treatment of Viral Respiratory Infections in Adults (2000)
- A Comparison Study of a New Compound in the Acute Treatment of Major Depression (2000-2001)
- New Compound Versus Enalapril for the Treatment of Hypertensive Patients (2000-2001)
- A Study of the Safety and Efficacy of a New Compound for the Prevention of Bone Loss and for Lipid Lowering in Postmenopausal Women at risk for Osteoporosis (2000)
- A DNA Sampling Study to Determine the Efficacy of a New Test for the Evaluation of Patients with Breast Cancer (2000)
- A Study to Evaluate the Efficacy and Safety of Ranging Doses of a New Compound for the Treatment of Mild to Moderate Hypertension (2000-2001)
- Comparison of COX-2 Inhibitors in Treating Patients with Osteoarthritis and Hypertension (SUCCESS VII) (2000-2001)
- New Compound for Relief of Pain Associated with Diabetic Peripheral Neuropathy (2000-2001)
- Clinical Protocol to Evaluate the Safety and Effectiveness of a Device in the Treatment of Patients with Acute Epicondylitis (2000-2001)
- Clinical Protocol to Confirm the Safety and Efficacy of a Topical Lotion for the Treatment of the Osteoarthritic Knee (2000-2001)
- Long-Term Safety Study of a Human anti-TNF Antibody Administered as a Subcutaneous Injection in Patients with Rheumatoid Arthritis (2000)
- A Study to Evaluate the Effectiveness of a New Test as an Aid in the Early Detection of Prostate Cancer or in Monitoring Men with Prostate Cancer (2001-2001)
- Study of a New Topical Medication for the Treatment of Chronic Low Back Pain (2001)
- The Study of a Combination Therapy for the Treatment of Hyperlipidemia in Type 2 Diabetic Men and Women (FACTOR) (2001)
- Study of a New Compound in Combination with Metformin in Previously Treated OHA Monotherapy Obese Subjects with Type 2 Diabetes (2001)
- A Study of a New Narcotic Patch in the Management of Patients with Chronic Non-Malignant Pain Syndromes Responsive to Opioid Combination Therapy (2001)
- A Forced Titration Study of a New Angiotensin II Receptor Antagonist in Patients with Essential Hypertension (2001)
- Study of a New Compound as Monotherapy in Patients with Primary Hypercholesterolemia (2001)
- Merck Comparison of COX-2 Inhibitors in Treating Patients with Osteoarthritis of the Knee (2001)
- A Pilot Study to Evaluate the Efficacy and Safety of an Immediate-Release Opioid in Patients with Moderate to Severe Non-Malignant Pain (2001)
- An Open-Label Study of Drug Response in Relationship to Gene Variants in Adults with Primary Hypercholesterolemia (the STRENGTH Study) (2001)
- A Study of the Analgesic Efficacy and Safety of a New Compound for the Treatment of the Pain of Diabetic Neuropathy (2001)
- An Open-Label Comparison Study of a New Compound Versus Atorvastatin, Cerivastatin, Pravastatin and Simvastatin in Subjects with Hypercholesterolemia (2001)
- A Study to Evaluate the Safety and Efficacy of a New Compound in Subjects with Acute Migraine Attacks (2001)
- A Comparison Study of a New Compound in the Treatment of Chronic Pain in Patients with Diabetic Neuropathy (2001)

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- A Dose Finding Study to Evaluate the Efficacy and Safety of a New Compound for the Treatment of Mild-to-Moderate Essential Hypertension (2001)
- A Study Comparing the Effects of Study Drug to Amlodipine and Benazepril on Systolic Blood Pressure and Pulse Pressure in Patients with Systolic Hypertension (2001)
- An Open-Label Study of Drug Response in Relationship to Gene Variants in Adults with Primary Hypercholesterolemia (The STRENGTH II Study) (2001)
- Clinical Protocol for the Study of the Analgesic Effect of a New Compound in Patients with Chronic Low Back pain (2001)
- A Study to Evaluate the Effectiveness of a Muscle Re-education Biofeedback Device for Home Use in Patients with Osteoarthritis of the Knee (2001)
- A Crossover Study Comparing Study Drug to Acetaminophen and Placebo in Patients with Osteoarthritis of the Hip or Knee (2001-2002)
- A Comparison Study of Two Medications for the Treatment of Osteoporosis in Postmenopausal Women (2001)
- Study of a New Topical Gel for the Treatment of Anogenital Herpes to Prevent Recurrences (2001)
- A Study Investigating the Clinical Effects of a New Compound in Patients with Perennial Allergic Rhinitis (2001-2002)
- Twelve-Week Study of the Analgesic Effect of a New Compound in Patients with Low Back Pain (2002)
- Clinical Protocol for the Study of a New Compound in the Treatment of Patients with Osteoarthritis Pain of the Hip or Knee (2002)
- Comparison Study of a New Compound to Treat Erectile Dysfunction in Males with a Diagnosis of Diabetes Mellitus and/or Hypertension and/or Hyperlipidemias (2002)
- Clinical Protocol for the Assessment of the Bone Resorption Activity of a Compound in Women with Osteopenia (2002)
- Clinical Study of the Weight Reducing Effect and Safety of a New Compound in Obese Patients with and without Comorbidities (2002)
- A Fifteen-Week Study of a New Compound for Efficacy and Quality of Life in Patients with Painful Diabetic Neuropathy (2002)
- Twelve-Week Study of the Analgesic Efficacy of a New Compound Compared to Placebo in Patients with Chronic Low Back Pain (2002)
- Clinical Study to Determine the Safety, Efficacy, Pharmacokinetics and Pharmacodynamics of a New Compound in Subjects with Moderate to Severe Rheumatoid Arthritis on a Stable Dose of Methotrexate (2002)
- Clinical Protocol to Assess the Efficacy and Safety of Middle of the Night Administration of a New Compound in Patients with Primary Insomnia (2002)
- Clinical Study to Evaluate the Tolerability and Efficacy of a Combination Therapy Compared to a Single Therapy for Treatment in Patients with Combined Hyperlipidemia (SAFARI) (2002)
- A Protocol for Blood Sample Collection from Healthy Subjects To Aid in the Study of In Vitro Diagnostic Devices (2002)
- A Second Crossover Study Comparing Study Drug to Acetaminophen and Placebo in Patients with Osteoarthritis of the Hip or Knee (2002)

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**HealthCare Finance Executive**

Experienced Leader with track record of motivating teammates at all levels of the organization. Utilize strong analytical skills to solve problems, drive improvements and accomplish goals. Superior interpersonal skills capable of resolving multiple and complex problems under differing levels of pressure. Utilize a well honed sense of humor to enjoy work and projects even under difficult circumstances. Develop long lasting, fulfilling relationships with teammates and clients.

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**Current Work Experience**

**Yale-New Haven Health System**, New Haven, CT 1995 to Present  
Teaching Hospital System with over 2000 Beds and revenues over \$3B, including Yale-New Haven Hospital, Bridgeport Hospital, Greenwich Hospital, and North East Medical Group

**Chief Financial Officer, Northeast Medical Group**

**Vice President, Finance-Physician Relations** 2013 to Present  
Work as a strategic partner to the Chief Executive Officer and to the System Senior leadership team. Responsible for directing and supporting the financial operations for a large multi-specialty physician organization. Works closely with the management team to drive the financial vision, direction, guidance and compliance to support successful operations. Provides administrative oversight for all financial reporting and billing initiatives at NEMG. Oversees all financial activities, coordinate the development of NEMG's budgets, forecasts and business plans. The CFO maintains appropriate internal controls throughout NEMG including general accounting, practices, physician compensation and administration

**Director, Financial Operations, Yale-New Haven Children's Hospital** 2012 to Present

Financial Partner to Senior Vice President. Responsible for all financial aspects of Yale-New Haven Children's Hospital. Directed strategic financial planning for various development and partnership options, including negotiation of potential divestiture. Developed and approved all related business plans. Successfully negotiated asset acquisition from Yale School of Medicine in a complex academic environment. Developed team of employees to support all client requests.

**Director, Financial Operations, Smilow Cancer Hospital** 2009 to Present

Essential Team member working daily with Physician in Chief, Vice President of Operations and Nursing Director, in managing Hospital operations. Responsible for all financial aspects of Smilow Cancer Hospital at Yale-New Haven Hospital. Directed financial transition into new hospital. Developed and approved all related business plans. Successfully negotiated asset acquisition of several group practices. Developed team of employees to support all client requests. Developed executive dashboard for volume, quality, and financial reporting.

**System Director, Financial Planning and Analysis** 2005 to 2012

Direct budget and financial planning functions for the three system hospitals, and the Health System Corporation. Direct annual and multi-year operational and capital budget cycles. Support revenue cycle management functions at Yale-New Haven Hospital. Train and develop staff for improved internal consulting capacity. Support Certificate of Need filings throughout the health system. Continue to improve accuracy and accessibility of decision support system. Support the development and review of business plans to best support operational and capital investment decisions. Direct internal and external consulting projects to improve operational performance.

**Continued Work Experience, Yale New Haven Health System****Director of Reimbursement**

2002 to 2005

Directed Reimbursement departments for Yale-New Haven Hospital, and Bridgeport Hospital. Directed government reimbursement, net revenue measurement, and cost reporting support, audits, appeals and related negotiations for \$1B in annual net revenue. Support revenue cycle management functions at Yale-New Haven. Supported the recognition and receipt of \$90M in revenue enhancements over five years. Worked with senior management, physicians, regulators, attorneys and Hospital Operational Staff.

**Manager, Revenue Systems & Network Initiatives**

2000 to 2002

Managed the completion of third party cost reports, third party cost report audits, appeals and all required federal and state revenue filings. Responsible for monthly calculation of net revenue, revenue budgets, and analyzing the impact of legislative changes. Worked in concert with contracting department to optimize net revenue during contract negotiations. Converted a dysfunctional department into a high functioning team.

**Various Finance Positions**

1995 to 2000

**The Hospital of Saint Raphael, New Haven, CT**

Teaching hospital with 700 Beds and over \$350m in revenue.

**Reimbursement/Financial Analyst**

1993 to 1995

**Volunteer Work****CHAIN Fund Treasurer**

2009 to 2014

New Haven Based Charity Organization focused on providing financial assistance to families of cancer patients.

**Closer to Free Ride**

2012 to Present

Ride Committee Member and Participant

**Habitat for Humanity**

2009 to Present

Volunteer with Financial Planning team for days of building at New Haven sites

**Education**

**MBA**, Concentration of studies in Finance

**University of New Haven, CT**

**BS/BA**, Major Health Systems Management/Minor MIS

**University of Connecticut**

**Green Belt**, Six Sigma Training

**Yale New Haven Health System**

**Teaching Experience**

Yale School of Nursing, Associate Clinical Professor

2003 to Present

University of Connecticut, Health Systems Management MBA Program, Guest Lecturer

Yale School of Epidemiology and Public Health, Master's Program, Guest Lecturer

Quinnipiac College, Undergraduate School of Business, Guest Lecturer

**Publications**

Bozzo, J. & Loftus, M. (1999). Linking mothers and babies for casemix outcomes analysis.

Proceedings of the Eleventh Casemix Conference in Australia: The Unfinished Agenda, Darwin, Australia.

## Curriculum Vitae

### ARNOLD DoROSARIO, M.D.

**PRIVATE PRACTICE:** 4699 Main Street, Bridgeport, CT 06606  
1979 - Present

#### **EDUCATION:**

- \* St. Teresa's Boys School, Nairobi, Kenya, East Africa  
(Examining Board: University of Cambridge, England)  
Graduated High School 1962
  
- \* Strathmore College, Nairobi, Kenya, East Africa  
(Examining Board: University of London, England)  
Graduated 1966 (Premed/Science)
  
- \* University of Navarra, Pamplona, Spain  
Faculty of Medicine  
Full Scholarship Student  
Graduated **Cum Laude** 1969-1975

#### **POST GRADUATE TRAINING:**

- \* **Residency in Internal Medicine**  
St. Vincent's Medical Center, Bridgeport, Connecticut  
(Yale School of Medicine Affiliated Program)  
1975-1978
  
- \* **Chief Resident**  
St. Vincent's Medical Center, Bridgeport, Connecticut  
1978

#### **CERTIFICATIONS:**

- \* Certified in Specialty of Internal Medicine  
American Board of Internal Medicine - 1978
  
- \* Certified in Geriatric Medicine  
American Board of Internal Medicine - 1988

Page 1 of 3

Curriculum Vitae

Arnold DoRosario, M.D.

Page 2 of 3

**HOSPITAL AFFILIATIONS:**

- \* Attending Physician/Teaching Facility  
Department of Medicine  
St. Vincent's Medical Center, Bridgeport, Connecticut  
(1984 - Present)
- \* Attending Physician/Teaching Facility  
Division of Aging, Department of Medicine  
St. Vincent's Medical Center, Bridgeport, Connecticut  
(1984 - Present)

**APPOINTMENTS:**

- Associate Professor, School of Medicine, Quinnipiac University**  
**2012- present**
- \* **Associate Clinical Professor**  
Columbia University  
1998 - 2008
- \* **Medical Director,**  
PriMed, LLC  
2002- Present
- Associate Clinical Professor**  
New York Medical College  
1994 - 1997
- \* **Clinical Instructor**  
Yale School of Medicine  
1982 - 1986
- \* **Medical Director**  
Maefair Health Care Center, Trumbull, Connecticut  
1994 - 2011
- \* **Assistant Medical Director**  
Northbridge Healthcare Center Bridgeport, Connecticut  
1994 - 2008
- \* **Medical Director**  
Barnett Nursing Home, Bridgeport, Connecticut  
1986 - 1994

**AWARDS:**

- \* **Resident Teaching Award**  
St. Vincent's Medical Center, Bridgeport, Connecticut - 1996 & 1999
- \* **"Teaching Attending of the Year"** (Recognition awarded by resident physicians.)  
St. Vincent's Medical Center, **Bridgeport**, Connecticut - 1991
- \* **"Teaching Attending of the Year 2004"** :St. Vincent's Medical Center, Bridgeport, Ct
- \* "New York" Magazine Best Doctors: 1999, 2000, 2001, 2005, 2006, 2007, 2008, 2009  
"Connecticut Magazine" Best Doctors: 2005, 2006, 2009  
"U.S. News & World Report: Best Doctors 2012

**Curriculum Vitae: rev 2012**  
**Arnold DoRosario, M.D.**  
**Page 2/2**

**COMMITTEE MEMBERSHIPS:**

- **Member, Executive Committee: 1996 – 2000**
- St Vincent's Medical Center, Bridgeport, Ct
- \* **Peer Review Committee**  
Fairfield County Medical Association; 1986 - 1996
- \* **Member, Committee On Geriatrics**  
Connecticut State Medical Society; 1992 - 2006
- \* **Fairfield County Medical Association-AARP**  
Addressing issues pertaining to the elderly; 1988 - 2006
- \* **Chairman, Medicare Committee**  
Connecticut State Medical Society  
1999 - current
- \* **Member: Performance Improvement Committee**  
St. Vincent's Medical Center, Bridgeport, Ct  
2007 – current
- **Chairman: Quality Council**  
St. Vincent's Medical Center, Bridgeport, Ct  
2008 – current
- **McKesson Technology Solutions Advisory Board**  
Member : 2013
- **Anthem Patient centered Primary care Program**  
**Program Advisory Council : Member 2013**

**MEMBERSHIPS:**

American College of Physicians  
 American Geriatric Society  
 American Society of Internal Medicine  
 Greater Bridgeport Medical Society  
 Fairfield County Medical Association  
 American College of Physician Executives

1992 - 1997 Board of Directors, Physicians Health Services, CT.(HealthNet)

1996 –1999: Chairman, Health Care System of Connecticut.  
 (A 45 physician Primary Care Group)

1999 - present Vice-President, PriMed, L.L.C.  
**Medical Director, PriMed LLC**

1998 - 2000 Vice-President: Medical Staff  
St. Vincent's Medical Center, Bridgeport, CT

2000 – 2002: **President: Medical Staff**  
St. Vincent's Medical Center, Bridgeport, Ct

1998 - 2004 Board of Trustees, Fairfield County Medical Association

**H. ANTHONY CARTER, MD/MBA**  
15 Perkins Farm Road  
Waterford, CT 06385  
860-912-1693  
E-mail: [acarter@lmhosp.org](mailto:acarter@lmhosp.org)

**Current Professional Address:**

*Lawrence and Memorial Medical Group  
194 Howard Street  
2<sup>nd</sup> floor East-Medical Office Building  
New London, CT 06320  
860-444-3366 (Office)*

**Current Clinical and Administrative Responsibilities:**

*Medical Director, Lawrence and Memorial Medical Group (Feb. 2014-present)*

- *Administrative duties comprise a 0.6 FTE position and involves clinical oversight of the outpatient primary care and specialty care services within the Lawrence and Memorial Medical Group. Oversight responsibilities include: participation in hiring and onboarding of all new physician and midlevel providers within the medical group; to facilitate program development in the adoption and implementation of standard, evidence-based clinical guidelines across the multiple specialties as well as clinical processes to address gaps in patient care and patient access; co-chairman of the Physician Operations Committee responsible for representing the interests of the medical group physicians in the creation of operational and strategic policies; active membership in the LMMG Quality Assurance Committee to ensure participation among all medical group providers in adherence to federally mandated quality and cost containment initiatives such as PQRS and Meaningful Use; counseling liaison in disputes between physicians and patients as well as between physicians and clinical/administrative staff; voting member of Lawrence and Memorial Medical Group Board of Directors governing body.*
- *Clinical duties comprise a 0.4 FTE position and involves participation as an internal medicine physician within the New London based outpatient primary care clinic of the Lawrence and Memorial Medical Group.*

## Past Clinical and Administrative Responsibilities:

### Assistant Clinical Professor/Staff Physician (1997-2013)

*Emory University School of Medicine, Department of Internal Medicine*

- *Clinical duties entail providing full-time outpatient medical services within a respected Internal Medicine group practice at an Emory Clinic multi-specialty facility.*

### Medical Director, Anticoagulation Management Clinic (2004-2013)

*Emory University Midtown Hospital*

- *Administrative duties entail supervision of an ambulatory medical service with a 1.1 million dollar projected revenue budget for FY 2013. The clinic is responsible for the comprehensive outpatient monitoring and medical management of all patients on oral anticoagulation therapy.*

### Emory Healthcare Clinically Integrated Network (CIN) Board of Directors

- *Elected member of board comprised of Emory Healthcare administrative and physician leaders charged with governance of the Emory Healthcare Clinically Integrated Network. The CIN is a collaborative partnership model initiated in August 2011 and formally incorporated by Emory Healthcare in March 2012 to enable Emory employed physicians and private practice community physicians across the metro-Atlanta area to jointly contract as a single comprehensive care management system. This is a physician led initiative with a focus on creating the foundation for new care delivery models and increasing overall healthcare value through: incorporation of information technology and data sharing; adherence to evidence-based clinical practice standards; enhanced clinical care coordination; and modification of individual physician performance gaps. The Board of Directors has the final authority on all CIN governance matters, including allocation of financial resources and contract negotiations with insurance payers.*

### Emory Midtown Hospital Local Clinically Integrated Network (LCIN) Committee

- *Elected member of committee addressing the specific interests of Emory employed and private practice community physicians on the medical staff at Emory University Midtown Hospital (EUHM) who are also participants in the Emory CIN network. All local issues pertaining to operational management and physician alignment within the Clinically Integrated Network at the EUHM facility, including development of specialty-specific quality metrics for network participants, are addressed by the LCIN.*

### Emory University Midtown Hospital Medical Executive Committee (MEC)

- *Ad-hoc member of administrative committee responsible for addressing hospital governance issues related to EUHM medical staff credentialing, physician peer review, patient safety, and monitoring quality standards.*

**Education History:**Medical School

Doctor of Medicine  
Mount Sinai School of Medicine  
New York, NY  
Graduated May 1994

Graduate School

Master of Business Administration (Executive MBA Program)  
Emory University Goizueta Business School  
Atlanta, GA  
Graduated May 2007

Master of Science (Biochemistry/Molecular Biology)  
New York Medical College  
Valhalla, NY  
Graduated June 1989

Undergraduate

Bachelor of Arts (Biology)  
SUNY at Purchase College  
Purchase, NY  
Graduated January 1988

**Physician Leadership Development:**Woodruff Leadership Academy Fellowship Program (2009)

-Intensive four month multi-disciplinary leadership enhancement program for a select group of identified leaders (fellows) within the Emory Woodruff Health Sciences Center.

Emory (PEP) Physician Executive Training Program (2008)

Department of Internal Medicine and Department of Pediatrics  
-Extended four month program designed to enhance the business and leadership skills of a select group of mid-career physician leaders within the Emory Healthcare system.

Emory Healthcare Leadership Quality Academy (2008)

-Quality and Process improvement instructional program developed for Emory physician and administrative leaders across all medical departments.

*Institute for Healthcare Improvement Professional Development Seminars:*

- Skills for Effective Medical Staff Leadership (2012)*
- Leading Quality Improvement: Essentials for Managers (2011)*
- Managing Hospital Operations Professional Development Seminar (2008)*
- The Role of Managers in Leading and Implementing Safety Strategies (2007)*

**Medical Certifications:**

*National Board of Medical Examiners Recertification, Internal Medicine (2008)*  
*National Board of Medical Examiners Certification, Internal Medicine (1997)*  
*ACLS Recertification, (2013)*

**Medical Residency:**

*Internal Medicine Residency Program*  
*Emory University School of Medicine*  
*July 1994 – June 1997*

**Medical Licensure:**

*State of Connecticut DPH- Medical License # 052597*  
*Rhode Island Board of Medical Licensure-Medical License # MD14500*  
*Georgia State Board of Medical Examiners-License # 41409*

**Organizational Affiliations:**

*American College of Physician Executives (ACPE)*  
*Institute for Healthcare Improvement (IHI)*  
*National Medical Association (NMA)*

## Curriculum Vitae

### Seth Van Essendelft

152 Long Wharf Road  
Mystic, Connecticut 06355  
Cell (252) 320-2032  
Email [svanessendelft@lmhosp.org](mailto:svanessendelft@lmhosp.org)

#### PRESENT POSITION

*Lawrence + Memorial Healthcare* – New London, CT & Westerly, RI  
Chief Financial Officer/ Vice President of Support Services 2014 – Present

#### PREVIOUS POSITIONS

*Vidant Health* – Greenville, NC  
Vice President of Financial Services (Financial Officer), Vidant Medical Center 2011 – 2014  
Vice President of Financial Operations (Financial Shared Services), Vidant Health 2009 – 2011

*Doctors Hospital* – Coral Gables, FL  
Financial Officer/Controller 2006 – 2009

*CIGNA Corporation* – Various Locations  
CIGNA Healthcare, Dental & Vision Subsidiary 2005 – 2006  
AVP, Director of Strategic Planning and Control, Plantation, FL  
  
Financial Leadership Program, Hartford, CT 2000 -- 2005  
CIGNA Healthcare Division  
Director of Capital Planning 2003 -- 2005  
Assistant Director, PPO Product Controller 2001 – 2003  
CIGNA Retirement and Investments Division  
Assistant Director, Consolidated Asset Financial Reporting 2000 – 2001

#### PREVIOUS MILITARY EXPERIENCE

*United States Coast Guard* – Various Locations 1991 -- 2011  
Senior Reserve Officer, Coast Guard Sector - Miami, FL 2005 – 2011  
Command Center Operations Controller, First Coast Guard District – Boston, MA 2000 – 2005  
Budget Officer, Pacific Area Command – Alameda, CA 1998 – 2000  
Commanding Officer, Cutter Point Huron – Virginia Beach, VA 1994 – 1996  
Department Head, Cutter Diligence – Wilmington, NC 1991 – 1994

#### EDUCATION

M.B.A  
The College of William and Mary, Graduate School of Business – Williamsburg, VA 1997  
  
B.S., Management  
United States Coast Guard Academy – New London, CT 1991

# Christopher M. Lehrach, MD, MBA

34 Sea View Dr., Charlestown, RI 02813 Tel: 401-315-5030 Cell: 401-749-7911 crlehrach@msn.com  
L+M Healthcare, 365 Montauk Ave., New London, CT 06320 Tel. 860-442-0711 clehrach@lmhosp.org

## Profile:

I am a seasoned, results-oriented clinical leader with a proven record of accomplishment in fast-paced environments. My medical and administrative leadership background, complemented by top-tier business training, allows me to approach complex issues with a value-driven and highly analytical orientation, in the dynamic high-stakes and high-energy health care industry. With a disciplined yet flexible style, I consistently achieve decision quality.

## Professional Experience:

- |  |              |
|--|--------------|
| <u>President, L+M Medical Group and Chief Transformation Officer</u><br>L+M Healthcare, Inc., New London, CT                                 | 7/14-Present |
| <ul style="list-style-type: none"> <li>• Goal of reducing cost while improving quality and patient experience across organization</li> </ul> |              |
| <u>VP, Division of Care Transformation, Chief Transformation Officer</u><br>L+M Healthcare, Inc., New London, CT                             | 7/13-7/14    |
| <ul style="list-style-type: none"> <li>• Goal of reducing cost while improving quality and patient experience across organization</li> </ul> |              |
| <u>Chief Transformation Officer-Interim Operations</u><br>The Westerly Hospital, Westerly, RI  | 11/12-6/13   |
| <ul style="list-style-type: none"> <li>• Chief Executive of a 125 bed community Hospital undergoing voluntary receivership</li> </ul>        |              |
| <u>CEO, The Atlantic Medical Group</u><br>Multispecialty, multisite, medical group serving SE CT and Southern RI.                            | 4/10-10/12   |
| <u>Chair, Department of Emergency Services</u><br>The Westerly Hospital, Westerly, RI  | 1/05-10/12   |
| <u>Emergency Department Physician/EMP</u><br>The Westerly Hospital, Westerly, RI   | 1998-Present |
| <u>Medical Director-P/T</u><br>Watch Hill Walk-In, Watch Hill, RI  | 2006-2012    |
| <u>Emergency Medicine Physician-P/T</u><br>Landmark Medical Center, Woonsocket, RI   | 1999-2002    |
| <u>Co-Director, Family Practice/Emergency Medicine</u><br>Block Island Medical Center, Block Island, RI                                      | 1998-2001    |
| <u>Emergency Medicine Physician-P/T</u><br>Pegasus Group, Emergency Medicine, Flemington, NJ   | 1996-1998    |
| <u>Urgent Care/Family Practice-P/T</u><br>The Doctor-is-In, Clinton, NJ  | 1996-1998    |
| <u>Financial Information Technician</u><br>Bloomberg L.P., London, England   | 1990-1991    |

## Education:

<u>Yale University, School of Management</u> New Haven, CT <i>Masters of Business Administration Degree, with distinction</i> <ul style="list-style-type: none"> <li>• Leadership in Healthcare Management</li> </ul>	2008-2010
<u>University of Medicine and Dentistry of New Jersey</u> Flemington, NJ <i>Residency Program, PGY I-III</i> Hunterdon Medical Center, Family Practice Residency <ul style="list-style-type: none"> <li>• Chief Resident</li> </ul>	1995-1998
<u>University of Connecticut, School of Medicine</u> Farmington, CT <i>Doctor of Medicine Degree</i>	1991-1995
<u>The University of Pennsylvania, College of Arts and Sciences</u> Philadelphia, PA <i>Bachelor of Arts Degree, cum laude</i> <ul style="list-style-type: none"> <li>• Biological Basis of Behavior, Neurobiology tract</li> <li>• Psychology</li> </ul>	1986-1990
<u>The Hartford Hospital</u> Hartford, CT <i>Summer Student Fellowship Program</i> <ul style="list-style-type: none"> <li>• Senior Fellow</li> </ul>	1988-1989
	Summer 1989

## Board Positions:

<u>Hospital Association of Rhode Island</u> -Vice Chairman Cranston, RI	2012-present
<u>Rhode Island Blood Center</u> Providence, RI	2012-present
<u>Board of Trustees-The Westerly Hospital</u> Westerly, RI	2007-2011
<u>Community Health of Westerly (CHOW)</u> Westerly, RI	2003-2011

## Certification:

<u>Diplomat, American Board of Family Medicine</u>	1998-2015
<u>Clinical Instructor in Emergency Medicine</u> Quinnipiac University, Physician Assistant Program, Hamden, CT	2001-Present
<u>Clinical Instructor in Family Medicine</u> Brown University, School of Medicine, Providence, RI	1998-2001
ACLS, ATLS, Neonatal Resuscitation certification	1996-Present
Rhode Island Allopathic Medical License MD9560	1997-Present
New Jersey Allopathic Medical License	1996-1998
Federal DEA Registration/CDS Certificate	1996-Present

**ATTACHMENT VII**



August 20, 2015

To whom it may concern,

Please accept this enthusiastic letter of support for the affiliation of the Yale/New Haven Health System with the L+M Healthcare organization. This potential relationship holds promise to better serve patients in Southeast CT and Southwest RI by enhancing the clinical offerings available, by improving the quality and consistency of that care, by improving the patients' experience and, not incidentally, by lowering the total cost of care.

Community hospitals have historically met the medical needs of their unique populations by paying close attention to the stated desires of their service areas tempered by what was financially feasible. This feasibility was often tied to the practicality of establishing standalone 24/7 clinical lines. Unfortunately, for many small and moderate sized community hospitals (like The Westerly Hospital in RI and the L+M Hospital in CT), the inability to support some full time service lines led to the unfortunate necessity for many patients of having to travel, often great distances, to larger medical centers. Almost without exception, these tertiary and quaternary medical facilities were also *very high cost centers* given their fixed costs of supporting academic programs, research and the burden of caring for the most medically complex patients in the region.

The result, high cost, inconvenient care with the potential for quality mishaps with regards to care coordination, care communication, redundant care or superfluous testing.

Enter into this environment the seismic shift in healthcare reimbursement that appropriately requires of providers an unrelenting focus on improving the value of care as opposed to simply extending more and more care. This new reality mandates that all healthcare organizations need to learn to treat patients in lower cost environments with similar or better quality than high cost settings. Moreover, they need to achieve proficiency in Population Health whereby the highest risk (and highest cost) patients are identified and preferentially offered more services and care to keep them, ideally, out of the high cost Emergency Department or inpatient care units.

Academic medical centers can't do this alone-they are too expensive. Community hospitals can't do it alone-they lack the organizational, analytical, clinical, human and capital resources to develop the Population Health infrastructure.

Only by locking arms (as opposed to locking horns) with each other can we meet the challenge of the IHI Triple Aim, and lower per capita cost while improving quality and the patients' experience. Combined with Yale, L+M is poised to do this successfully. As our mission is to "improve the health of this region," our patients will be the chief beneficiaries.

Many thanks for the consideration.

Christopher M. Lehrach, MD  
President, L+M Medical Group/  
Chief Transformation Officer

Kimberly R. Martone  
Director of Operations; Office of Health care Access  
410 Capital Avenue-MS#13HCA  
PO BOX 340308  
Hartford , Connecticut 06134-0308

July 31, 2015

Dear Ms. Martone,

As chair of the Lawrence and Memorial Medical Group Board of Directors and as a practicing physician in Southeastern Connecticut, I am writing to express my strong support for the proposed and critically necessary affiliation between Lawrence and Memorial Healthcare, Inc. and Yale New Haven Health system.

In this rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit community hospitals to remain independent, as Lawrence and Memorial has been for more than a century and Westerly hospital had been for 88 years before it was acquired by Lawrence and Memorial. In addition relatively small medical groups such as the Lawrence and Memorial Medical Group will have considerable difficulty providing necessary care for patients in our community unless aligned with a large healthcare system. In the past Lawrence and Memorial Hospital has partnered with the Yale Medical Group and Yale New Haven Hospital in a number of important clinical areas including radiation oncology, invasive cardiology and vascular surgery, neonatology, telestroke, and more recently pediatric emergency medicine. Patients in our community in Southeastern Connecticut have greatly benefited from the expertise of the Yale physicians. As a physician who has frequently referred patients to endocrine surgeons in the Yale Medical Group I know firsthand how important and crucial to my patients this clinical partnership has been. Clinicians from both healthcare organizations know, respect, and interact well with each other. A full affiliation will greatly improve both healthcare systems and expand the already substantial accessibility for healthcare in the region-particularly to populations that are traditionally underserved. As a physician I am convinced that the affiliation of Lawrence and Memorial Healthcare with the Yale New Haven Healthcare system will facilitate the recruitment and retention of quality physicians in all areas of care. Clearly this is critically important for continuing to provide the healthcare necessary for our patients in Southeastern Connecticut. And very importantly both healthcare systems will be financially healthier from this affiliation.

Representatives from both healthcare organizations have completed an extensive due diligence and have concluded, along with community elected Board of Directors and the physicians on the Board of Directors for the Medical Group that the affiliation with Yale New Haven Healthcare would be the best outcome for both organizations and the communities they serve. I completely agree with this assessment.

Based on the above I strongly encourage you to approve this application,

Very truly yours,

A handwritten signature in black ink, appearing to read "Preston Lambertson". The signature is fluid and cursive, with a large initial "P" and a long horizontal stroke extending across the middle of the name.

Preston Lambertson, M.D.

Chair, Lawrence and Memorial Medical Group



365 Montauk Avenue | New London, CT 06320  
860.442.0711 | lmhospital.org

August 6, 2015

Kimberly R. Martone  
Director of Operations  
Office of Health Care Access  
410 Capitol Avenue  
MS#13HCA  
PO Box 340308  
Hartford, Ct 06134-0308

Dear Ms. Martone:

As a physician and surgeon at L+M Hospital for the past 25 years and current President of its medical staff I am writing this letter in support of the proposed affiliation with the Yale New Haven Health System.

Months of hard work and due diligence by both institutions have led to a comprehensive affiliation agreement which contains the aspirational goals and rationales for the desired relationship and which I am sure you have as part of this filing. I won't repeat them here except to say that they are widely supported by the medical staff at L+M hospital.

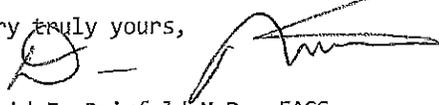
The physicians and other clinical providers at our community hospital have seen many changes in the health care system in recent years and are quite knowledgeable about those that are coming. We have been adept at negotiating these changes while still accomplishing the core mission of caring for the patients in our community. We also know that even more change is coming that will place even more demands on accomplishing the so called triple aim in medicine. This means improving patient experience, caring for populations of patients, and improving the value of care we provide. The collective wisdom of our physicians tells us that we will need to partner with a larger system to move into this future of health care and accomplish these aims which will allow not just the same care but vastly improved care.

The medical staff of L+M has considered the Yale system as its natural partner almost forever because of its deserved reputation as a worldwide leader in healthcare. We consider it a great fortune for us and our community to have them as our potential partner. Many L+M physicians historically came from the Yale system and we already have several stellar working clinical relationships.

Our medical staff is very diverse with physicians in many different configurations of practice. Employed and private practice. Hospital based and community based. Exclusive contract groups that provide our emergency room service, hospitalist care, pathology and anesthesia services. The proposed affiliation has the potential to affect all of us in as yet unknown ways. Despite this potential change to practitioners individually I can attest that the medical staff stands behind this initiative and I think this should speak volumes to the wisdom of the endeavor because it is the physicians and other clinical providers who have the expertise to understand that for L+M to continue to provide the best care to this community such an affiliation is necessary.

In addition to my confidence in the support of the medical staff for this initiative I have also been given the support of our Medical Executive Committee for the contents of this letter. If I can in any way provide you with more information regarding the physician perspective on the proposed affiliation please let me know.

Very truly yours,

  
David F. Reisfeld M.D., FACS  
Medical Staff President and  
the Medical Executive Committee of L+M Hospital



Adrian Hamburger, M.D.  
*Interventional Pain Specialist*

45 Wells Street, Suite 201  
Westerly, RI 02891  
Phone (401) 348-3865  
Fax (401) 596-6368

LETTER OF SUPPORT

To Whom It May Concern:

In my role as President of the Westerly Hospital Medical Staff, I have seen firsthand the difficulties that local community hospitals deal with on a day-to-day basis. As you know, our hospital went through receivership a few years ago, and was acquired by Lawrence & Memorial Hospital in June of 2013 after a lengthy regulatory process. L&M Hospital has made significant improvements - and even though the Westerly Hospital is finally making a slight profit the last few years - there is still a significant capital deficit to maintain the physical structure, and improve our current clinical offerings.

With further convulsions in the Healthcare industry, with unclear ACA mandates, nebulous insurance changes from year to year - and the growing focus on population health to better manage costs and care - it has become evident that as a health care system we need to be affiliated with a larger entity with further capital resources.

I support the planned merger of the L&M Healthcare system with the Yale New Haven Health system, because I believe it will improve the stability of our health industry in this region, it will allow for increased capital to improve our physical structures and increase our clinical reach, and it will bring tertiary/quarternary care to our region that is so desperately needed.

L&M Hospital already has a history of successful affiliation with the Yale New Haven Health system on several clinical endeavors, and I believe that this sets the tone for further collaborative efforts.

Thank you

Adrian Hamburger, M.D.  
President of the Westerly Hospital Medical Staff

Kimberly R. Martone  
Director of Operations  
Office of Health Care Access  
410 Capitol Avenue, MS#13HCA  
P.O. Box 340308  
Hartford, CT 06134-0308

September 1, 2015

Dear Ms. Martone:

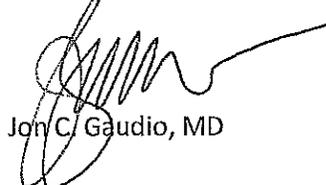
I am writing to send my unqualified endorsement of the proposed transition of the Lawrence and Memorial Medical Group to the Yale-affiliated New England Medical Group (NEMG)

I am a Cardiologist in a community hospital with professional aspirations first and foremost to provide for the health of this wonderful, diverse community of New London. I view the potential merger as a major step toward bringing needed healthcare resources into our county. By formalizing a relationship with NEMG, we are building upon and, indeed, formalizing an already existing strong bond. We already send the lion's share of our complex cardiac cases, for example, to our colleagues at Yale and its NEMG affiliate. Specifically, we rely heavily on the ability of NEMG for cardiac surgery, interventional cardiology, electrophysiology, and heart failure--areas in which we, a smaller hospital, could never realistically have the volume to support a competent cadre of physicians and staff.

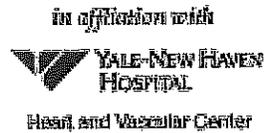
By formalizing such an arrangement, it would facilitate a more rapid spread of information, a vital key- and the one most often overlooked- aspect in the provision of care to our complex and varied patients.

Of course there are political considerations, and seemingly bigger administrative questions about which I frankly don't much bother because I know, in my heart of hearts, that the single most important issue is to be able to sit with my patient, as I did yesterday with Gillian, a 53 year old woman recently diagnosed with advanced idiopathic cardiomyopathy, and tell her that I have a solid relationship with the heart failure team, the interventional team and the electrophysiology team at Yale and that together we will communicate together and with her so that I can hopefully help her navigate through some very dangerous waters and into a safe harbor of good health. It is quite clear to me that by merging into NEMG and by having instant access to their medical records and instant access to the leading specialists in each field, I will be more easily able to deliver safely Gillian (and every other patient I see) to that safe harbor.

Sincerely,



Jon C. Gaudio, MD



September 3, 2015

To Whom it May Concern:

As medical director of the Lawrence + Memorial Heart and Vascular Center in affiliation with Yale New Haven Hospital, I have been privileged to see enormous growth in the cardiovascular services made available locally to the patient's of the greater New London region. We have been able to develop an incredibly successful interventional cardiology program providing primary and elective percutaneous coronary interventions for both emergency heart attack victims and more stable patients with coronary artery disease. We have enhanced vascular services locally providing both surgical and percutaneous treatment options. We are slated to have advanced electrophysiologic and heart failure services beginning this year.

We have not accomplished this alone, but rather over the past 8 years we have worked side-by-side with the cardiologists of the Lawrence + Memorial Medical Group. Together we provide state of the art advanced heart care locally and have developed timely and efficient mechanisms to provide tertiary and quaternary services at Yale New Haven Hospital when necessary. This has gone a long way to help streamline patient care and provide for very effective means of communication among the members of the patient's care team.

We are now poised to take a broader position and align ourselves even closer with our colleagues from Yale New Haven as we hope to transition to the Northeast Medical Group. Such a merger would allow even closer collaboration and better communication among all services including primary care and a variety of subspecialties. Sharing common resources would go a long way to improve efficiency in the overall delivery of healthcare to our region. I am certain this would go a long way to help develop other healthcare service lines in much the same way we have done with cardiology.

Sincerely,

A handwritten signature in cursive script that reads 'Brian Cambi' followed by a small flourish.

Brian Cambi, MD, FACC, FSCAI  
Medical Director

L+M Heart and Vascular Center in affiliation with Yale New Haven



September 1, 2015

To Whom It May Concern:

I am writing this letter to support the affiliation of the Yale/New Haven Health System with the L+M Health care organization. My support is based upon the potential for improved coordination of care and outcomes for our shared patients, as well as improved cost effectiveness of this care, which will lead to reduced costs for our patients.

It goes without saying that viability of our smaller community hospitals are challenged given our current healthcare environment, and these hospital systems are increasingly aligning with larger healthcare organizations. While this practical goal would clearly be served by the above-mentioned affiliation, it is important to understand the potential benefits to our patients.

Accurate and thorough information of the patient's medical history is obviously important for providing optimal care. Unfortunately, achieving this has historically proven challenging, largely due our fragmented system of care. Alignment between these systems of care would facilitate seamless communication between care providers, and thereby improve transitions of care, which would allow for better care coordination for these patients in conjunction with their medical homes.

It is also important to acknowledge that this relationship would afford the opportunity to provide services to patients at a lower cost. Community hospitals are able to provide many of the same services as tertiary or quaternary medical facilities at significantly lower cost. Additionally, Improved care coordination allows us to identify, and therefore offer superior support, for our higher-risk patients. This brings the potential of reducing emergency department visits and hospital stays for these patients.

It is clear to me that alignment with the Yale/New Haven Health System will be of benefit to our patients. Given our model of patient-centric care at L+M Medical Group, I offer my unequivocal support for this relationship.

Sincerely,  


Brian L. Williams MD  
Medical Director of Informatics  
L+M Medical Group

**ATTACHMENT VIII**

**Lawrence + Memorial  
Corporation and Subsidiaries**  
Consolidated Financial Statements and  
Supplemental Information  
September 30, 2014 and 2013

**Lawrence + Memorial Corporation and Subsidiaries**  
**Index**  
**September 30, 2014 and 2013**

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## Report of Independent Auditors

To the Board of Trustees of  
Lawrence + Memorial Corporation

We have audited the accompanying consolidated financial statements of Lawrence + Memorial Corporation (the "Corporation") and its subsidiaries, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations, of changes in net assets and of cash flows for the years then ended.

### *Management's Responsibility for the Consolidated Financial Statements*

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

### *Auditor's Responsibility*

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We did not audit the financial statements of Visiting Nurse Association of Southeastern Connecticut, Inc., a wholly owned subsidiary, which statements reflect total assets of \$20,659,633 and \$18,372,801 as of September 30, 2014 and September 30, 2013, respectively, and total revenues of \$16,156,841 and \$14,990,091 for the years then ended. Those statements were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for Visiting Nurse Association of Southeastern Connecticut, Inc., is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Corporation's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant

accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### ***Opinion***

In our opinion, based on our audits and the report of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Lawrence + Memorial Corporation (the "Corporation") and its subsidiaries at September 30, 2014 and September 30, 2013, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole.

The consolidating information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole.

The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations and cash flows of the individual organizations and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations, and changes in net assets, of the individual organizations.

PricewaterhouseCoopers LLP

January 23, 2015

**Lawrence + Memorial Corporation and Subsidiaries**  
**Consolidated Balance Sheets**  
**September 30, 2014 and 2013**

	2014	2013
<b>Assets</b>		
Current assets		
Cash and cash equivalents	\$ 16,480,529	\$ 11,532,247
Investments	184,426,039	181,339,986
Patient accounts receivable, net of allowance for doubtful accounts of \$10,334,227 and \$6,158,515, respectively	47,482,954	44,410,454
Other receivables	5,792,415	5,321,417
Inventories	8,393,007	7,501,154
Prepaid expenses and other current assets	3,748,725	3,557,507
Debt service fund	<u>1,304,562</u>	<u>1,306,255</u>
Total current assets	<u>267,628,231</u>	<u>254,969,020</u>
Assets limited as to use		
Cash	182,862	182,366
Construction fund	561,676	9,541,685
Investments held in trust	925,227	985,034
Endowment investments	36,641,428	34,155,796
Funds held in trust by others	11,348,610	10,956,429
Contributions receivable	3,520,787	2,702,993
Funds held in escrow by agreement with State of Connecticut Health and Educational Facilities Authority and trustees	<u>-</u>	<u>2,247,255</u>
Total assets limited as to use	53,180,590	60,771,558
Intangible assets, net	2,978,625	3,352,875
Other receivables	2,580,786	2,547,462
Deferred financing costs and other assets, net	2,315,752	1,776,176
Property, plant and equipment, net	<u>206,850,299</u>	<u>208,182,039</u>
	<u>\$ 535,534,283</u>	<u>\$ 531,599,130</u>
<b>Liabilities and Net Assets</b>		
Current liabilities		
Accounts payable	\$ 37,529,850	\$ 42,611,470
Accrued vacation and sick pay	14,223,728	12,580,707
Salaries, wages, payroll taxes and amounts withheld from employees	10,671,516	10,101,654
Due to third party payors	7,257,949	5,870,981
Other current liabilities	582,553	123,017
Current portion of long-term debt	<u>5,476,980</u>	<u>9,347,876</u>
Total current liabilities	75,742,576	80,635,705
Accrued pension and other postretirement benefits	43,216,010	42,309,345
Other liabilities	25,610,890	21,676,677
Long-term debt less current portion	<u>108,587,802</u>	<u>101,001,797</u>
Total liabilities	<u>253,157,278</u>	<u>245,623,524</u>
Net assets		
Unrestricted	241,902,500	246,531,146
Temporarily restricted	24,770,687	24,154,982
Permanently restricted	<u>15,703,818</u>	<u>15,289,478</u>
Total net assets	<u>282,377,005</u>	<u>285,975,606</u>
	<u>\$ 535,534,283</u>	<u>\$ 531,599,130</u>

The accompanying notes are an integral part of these consolidated financial statements.

**Lawrence + Memorial Corporation and Subsidiaries**  
**Consolidated Statements of Operations**  
**September 30, 2014 and 2013**

	2014	2013
<b>Unrestricted revenues, gains and other support</b>		
Net revenues from services to patients	\$ 453,529,100	\$ 372,745,739
Provision for bad debt	<u>(20,298,386)</u>	<u>(14,555,970)</u>
Net revenue less provision for bad debt	433,230,714	358,189,769
Other operating revenues	20,795,287	21,448,860
Net assets released from restriction used for operations	<u>876,203</u>	<u>748,784</u>
Total unrestricted revenues, gains and other support	<u>454,902,204</u>	<u>380,387,413</u>
<b>Expenses</b>		
Salaries and wages	213,467,507	193,780,844
Employee benefits	59,185,837	49,062,244
Supplies	71,998,110	49,529,083
Purchased services	54,475,011	32,278,640
Other	43,427,170	37,265,822
Interest	3,554,919	2,865,011
Depreciation and amortization	<u>27,479,122</u>	<u>23,023,433</u>
Total expenses	<u>473,587,676</u>	<u>387,805,077</u>
Loss from operations	<u>(18,685,472)</u>	<u>(7,417,664)</u>
<b>Nonoperating gains</b>		
Unrestricted investment income	180,488	122,109
Income from investments	9,832,164	7,752,127
Inherent contribution received from purchase of Westerly Hospital	<u>5,284,752</u>	<u>1,796,782</u>
Total nonoperating gains	<u>15,297,404</u>	<u>9,671,018</u>
(Deficit)/excess of revenues over expenses	(3,388,068)	2,253,354
Net unrealized gains on investments	2,028,088	12,046,855
Net assets released from restrictions used for purchase of property, plant and equipment	1,006,500	167,751
Donated equipment	6,350	-
Pension related changes other than periodic pension costs	<u>(4,281,516)</u>	<u>5,929,845</u>
(Decrease)/Increase in unrestricted net assets	<u>\$ (4,628,646)</u>	<u>\$ 20,397,805</u>

The accompanying notes are an integral part of these consolidated financial statements.

**Lawrence + Memorial Corporation and Subsidiaries**  
**Consolidated Statements of Changes in Net Assets**  
**September 30, 2014 and 2013**

	2014	2013
<b>Unrestricted net assets</b>		
Excess of revenues over expenses	\$ (3,388,068)	\$ 2,253,354
Net unrealized gains on investments	2,028,088	12,046,855
Net assets released from restrictions used for purchase of property, plant and equipment	1,006,500	167,751
Donated equipment	6,350	-
Pension related changes other than periodic pension costs	<u>(4,281,516)</u>	<u>5,929,845</u>
(Decrease)/increase in unrestricted net assets	(4,628,646)	20,397,805
Beginning of year unrestricted net assets	<u>246,531,146</u>	<u>226,133,341</u>
End of year unrestricted net assets	<u>\$ 241,902,500</u>	<u>\$ 246,531,146</u>
<b>Temporarily restricted net assets</b>		
Income from investments	\$ 677,343	\$ 668,022
Net assets released from restrictions	(1,882,704)	(916,535)
Inherent contribution received from purchase of Westerly Hospital	-	871,209
Contributions received	421,640	506,462
Change in value of funds held in trust by others	111,315	239,710
Net realized and unrealized gains on investments	<u>1,288,111</u>	<u>1,701,848</u>
Increase in temporarily restricted net assets	615,705	3,070,716
<b>Temporarily restricted net assets</b>		
Beginning of year	<u>24,154,982</u>	<u>21,084,266</u>
End of year	<u>\$ 24,770,687</u>	<u>\$ 24,154,982</u>
<b>Permanently restricted net assets</b>		
Income from investments	\$ 20,569	\$ 13,823
Inherent contribution received from purchase of Westerly Hospital	-	9,343,478
Contributions received	80,074	22,888
Change in value of funds held in trust by others	280,866	17,482
Net realized and unrealized gains on investments	<u>32,831</u>	<u>-</u>
Increase in permanently restricted net assets	414,340	9,397,671
<b>Permanently restricted net assets</b>		
Beginning of year	<u>15,289,478</u>	<u>5,891,807</u>
End of year	<u>15,703,818</u>	<u>15,289,478</u>
(Decrease)/increase in net assets	<u>\$ (3,598,601)</u>	<u>\$ 32,866,192</u>

The accompanying notes are an integral part of these consolidated financial statements.

**Lawrence + Memorial Corporation and Subsidiaries**  
**Consolidated Statements of Cash Flows**  
**Years Ended September 30, 2014 and 2013**

	2014	2013
<b>Cash flows from operating activities</b>		
Change in net assets	\$ (3,598,601)	\$ 32,866,192
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	27,479,122	23,023,433
Net unrealized and realized gains on investments	(2,963,155)	(13,495,284)
Inherent contribution received from purchase of Westerly Hospital	(4,940,302)	(12,011,469)
Provision for bad debts	20,298,386	14,555,970
Increase in funds held in trust by others	(392,181)	(257,193)
Increase in contributions receivable	(817,794)	(794,898)
Restricted contributions	(1,164,969)	(1,174,484)
Changes in other operating accounts		
Patient accounts receivable, net	(20,461,592)	(20,317,347)
Other receivables, net	(504,322)	(970,777)
Inventories	(891,853)	(1,447,315)
Prepaid expenses and other current assets	(191,218)	(137,568)
Deferred financing costs and other assets	(539,576)	81,328
Accounts payable	(3,713,678)	(2,523,188)
Accrued vacation and sick pay	1,643,021	(1,558,312)
Salaries, wages, payroll taxes and amounts withheld from employees	569,862	3,652,618
Due to third party payors	1,386,968	(1,632,875)
Pension, postretirement and other liabilities	5,674,664	(9,245,208)
Net cash provided by operating activities	<u>16,872,782</u>	<u>8,613,623</u>
<b>Cash flows from investing activities</b>		
Purchase of property, plant and equipment, net	(25,715,324)	(50,503,163)
Purchases of investments	(70,459,536)	(78,938,843)
Sales of investments	77,121,334	107,257,276
Purchase of Westerly Hospital	-	(14,535,558)
Decrease in debt service fund	1,693	855
Increase/(decrease) in funds held in escrow	2,247,255	(130)
Net cash used in investing activities	<u>(16,804,578)</u>	<u>(36,719,563)</u>
<b>Cash flows from financing activities</b>		
Restricted contributions	1,164,969	1,174,484
Principal payments of long term debt	(28,364,994)	(2,938,881)
Proceeds of long term debt	32,080,103	25,446,569
Net cash provided by financing activities	<u>4,880,078</u>	<u>23,682,172</u>
Net decrease in cash and cash equivalents	4,948,282	(4,423,768)
<b>Cash and cash equivalents</b>		
Beginning of year	<u>11,532,247</u>	<u>15,956,015</u>
End of year	<u>\$ 16,480,529</u>	<u>\$ 11,532,247</u>
<b>Supplemental disclosure of noncash activities</b>		
Construction in process included in accounts payable	<u>\$ 1,673,118</u>	<u>\$ 2,105,176</u>
Contributed securities	<u>\$ 1,164,969</u>	<u>\$ 1,174,484</u>

The accompanying notes are an integral part of these consolidated financial statements.

## Lawrence + Memorial Corporation and Subsidiaries

### Notes to Consolidated Financial Statements

#### September 30, 2014 and 2013

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#### 1. Significant Accounting Policies and Organization

##### Organization

Lawrence + Memorial Corporation (the "Corporation") is a not-for-profit organization incorporated under the Nonstock Corporation Act of the State of Connecticut. The Corporation is organized exclusively for public welfare, charitable, scientific, literary and education purposes, including the furtherance of the welfare, programs and activities of Lawrence + Memorial Hospital (the "Hospital"), a nonprofit organization incorporated under the General Statutes of the State of Connecticut.

The following entities are subsidiaries of the Corporation: Lawrence + Memorial Hospital ("L+M"), L& M Physician Association Inc., L&M Systems, Inc., VNA of Southeastern Connecticut, L&M Healthcare, L&M Indemnity Ltd, VNA of Southeastern Connecticut Inc. and LMW Healthcare Inc. (Westerly Hospital).

##### Acquisition of Westerly Hospital

On June 1, 2013, the Corporation and its subsidiary, LMW Healthcare, Inc. ("LMW") completed the acquisition of certain assets and liabilities of Westerly Hospital, a 125-bed general acute care hospital located in Westerly, Rhode Island on a 10.6 acre campus. The acquisition was the culmination of a process that included the appointment of W. Mark Russo, Esq. as the special master (the "Special Master") for Westerly Hospital and its affiliates by the Rhode Island Superior Court for the County of Washington (the "RI Court") in December 2011, due to the deteriorating financial condition of Westerly Hospital. The Special Master was granted authority by the RI Court to negotiate the sale of the assets of Westerly Hospital and its affiliates.

The Corporation formed LMW as a Rhode Island nonprofit corporation, and in June 2012, LMW entered into an Asset Purchase Agreement (the "Purchase Agreement") with the Special Master for Westerly Hospital and its affiliates, which was approved by the RI Court in September 2012. The Corporation guaranteed LMW's commitments under the Purchase Agreement. Pursuant to the Purchase Agreement and upon the successful completion of regulatory review by various Rhode Island agencies, the Corporation acquired certain assets and liabilities of Westerly Hospital and its affiliates, in order to expand its care and operations to the Westerly, Rhode Island community. The acquisition of the Westerly Hospital furthers the Corporation and Lawrence + Memorial Hospital's strategy of improving the depth and breadth of services available to all residents in the eastern Connecticut and western Rhode Island regions, without regard to ability to pay. Lawrence + Memorial Hospital expects to reduce unnecessary duplication of effort and costs with Westerly Hospital, while maintaining community access to essential services in the Westerly service area.

As part of the purchase agreement the Corporation agreed to fund \$30 million in capital costs for Westerly Hospital over five years after the closing, and agreed to provide up to \$6.5 million of working capital for Westerly Hospital over the first two years after the closing.

**Lawrence + Memorial Corporation and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**September 30, 2014 and 2013**

The fair value of assets and liabilities acquired under this transaction as of June 1, 2013 are as follows:

	2013
Cash	\$ 1,563,200
Patient accounts receivable	4,658,183
Inventories	1,550,130
Pledges	750,000
Prepaid expenses	325,650
Investments	6,870,933
Assets held in trust	4,247,816
Intangible assets	3,690,000
Property, plant & equipment	<u>30,850,000</u>
Total assets	<u>54,505,912</u>
Accrued compensation	2,488,190
Accounts payable and accrued expenses	15,052,105
Due to third parties	1,856,951
Asset retirement obligation	1,425,678
Debt	<u>5,572,761</u>
Total liabilities	<u>26,395,685</u>
Net assets acquired	<u>\$ 28,110,227</u>

The purchase price of \$16,098,758 was paid in cash. The transaction resulted in an inherent contribution of \$12,011,469 which has been appropriately allocated to the three net asset classes within the statement of changes in net assets in 2013. The inherent contribution is a result of the value of net assets being acquired exceeding the purchase price. The purchase price allocation was preliminary and has been adjusted as additional information was obtained in 2014. An additional \$5.3 million in inherent contribution was recorded in 2014, principally due to \$3.1 million better experience on accounts receivable and \$1.8 million in better experience on accounts payable.

Intangible assets acquired in conjunction with the Westerly acquisition include:

	Fair value as of June 1, 2013	Amortization Period (in years)	
Patient relationships	\$ 1,530,000	10.0	
Medical records	1,350,000	10.0	
Trademark	<u>810,000</u>	<u>8.0</u>	
	<u>\$ 3,690,000</u>	<u>9.5</u>	(weighted average)

## **Lawrence + Memorial Corporation and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **September 30, 2014 and 2013**

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L&M Healthcare has an affiliation agreement effective January 31, 1999 (the "Agreement") with the Hospice of Southeastern Connecticut, Inc. (the "Hospice"). The Agreement gives L&M Healthcare a membership of the Hospice with one other not-for-profit healthcare organization. L&M Healthcare does not have an equity investment in the Hospice because the affiliation agreement does not require L&M Healthcare to provide capital to the Hospice and L&M Healthcare is not entitled to any of the net assets of the Hospice should the relationship terminate or the Hospice dissolve. The Corporation and its subsidiaries have never given capital to the Hospice and the Hospice has never made capital distributions to the Corporation or its subsidiaries.

L & M Physician Association, Inc. ("LMPA") was formed exclusively for the charitable purpose of benefiting, supporting, and furthering the charitable activities of Lawrence + Memorial Hospital by engaging physicians to provide physician services to the Hospital, organizations affiliated with the Hospital and communities they serve for purpose of practicing medicine and health care services.

#### **Principles of Consolidation**

The consolidated financial statements include the accounts of the Corporation and its wholly-owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation.

#### **Use of Estimates**

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying footnotes. Actual results could differ from those estimates and there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Corporation's significant estimates include the collectability of patient accounts receivable, useful lives of fixed assets, settlements due to third party payors, estimated reserves for self-insurance liabilities, and benefit plan assumptions.

#### **Temporarily and Permanently Restricted Net Assets**

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation and its subsidiaries in perpetuity or in funds held in trust by others whose purpose is for the funds to be maintained in perpetuity.

#### **Donor Restricted Gifts**

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statements of operations as net assets released from restrictions. Donor restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions in the accompanying consolidated statements of operations.

#### **Cash and Cash Equivalents**

The Corporation and its subsidiaries consider all highly liquid investments with original maturities of three months or less at the date of purchase to be cash equivalents.

## Lawrence + Memorial Corporation and Subsidiaries

### Notes to Consolidated Financial Statements

#### September 30, 2014 and 2013

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#### Investments

Investments in equity and debt securities are recorded at fair value in the balance sheet. Fair value is generally determined based on quoted market prices where available or net asset values provided by investment managers. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are included in the change in net assets. Under accounting principles generally accepted in the United States of America, an "other than temporary impairment" is recognized if the Corporation does not expect the fair value of a security to recover above cost or amortized cost. Once an "other than temporary impairment" charge has been recorded, a new cost basis is established.

The Corporation continues to review its securities for appropriate valuation on an ongoing basis. The Corporation determined that none of their investments were impaired as of September 30, 2014 or 2013.

Realized and unrealized gains and losses on donor restricted endowment funds are included in temporarily restricted net assets under State law which allows the Board to appropriate as much of the net appreciation of investments as is prudent considering the Corporation's long and short-term needs, present and anticipated financial requirements, expected total return on its investments, price level trends, and general economic conditions.

Investments in limited liability companies are accounted for using the equity method in instances where the limited partner's interest is more than minor (3-5%).

#### Fair Value Measurements

Fair value guidance establishes a hierarchy of valuation inputs based on the extent to which the inputs are observable in the marketplace. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entities own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The guidance describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the Corporation for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

- Level 1 Quoted prices in active markets for identical assets.
- Level 2 Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets in active markets, quoted prices in markets that are not active, or can be corroborated by observable market data for substantially the same term of the assets.
- Level 3 Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets.

**Lawrence + Memorial Corporation and Subsidiaries**  
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**Assets Held in Trust by Others**

The Hospital has been named sole or participating beneficiary in several perpetual and charitable remainder trusts. Under the terms of these trusts, the Hospital has the irrevocable right to receive the income earned on the trust assets in perpetuity from the perpetual trusts and to receive the remainder of the trust assets for the charitable remainder trusts. For perpetual trusts, the estimated present value of the future payments to the Hospital is recorded at the fair value of the assets held in the trust. The charitable remainder trusts are recorded at the present value of the estimated future distributions expected to be received over the expected term of the trust agreement. The Hospital uses appropriate credit adjusted rates to discount amounts.

**Assets Limited as to Use**

Assets limited as to use include assets set aside by the Board of Directors, contribution receivables and for the established purpose of providing for future improvement, expansion and replacement of plant and equipment. In addition, the Corporation's interest in externally managed trusts, unexpended bond proceeds for construction purposes, and assets held by trustees under indenture agreements relating to financing activities with the State of Connecticut Health and Education Facilities Authority ("CHEFA") are also included therein.

**Property, Plant and Equipment**

Property, plant and equipment are recorded at cost, or if received as a donation, at the fair value on the date received. The Corporation provides for depreciation of property, plant and equipment using the straight-line method in amounts sufficient to amortize the cost of its assets over their estimated useful lives. American Hospital Association lives are generally used and provide for a 2-25 year life for land improvements, 5-50 year life for buildings and a 2-25 year life for equipment. Lease improvements are amortized over the life of the lease.

**Nonoperating Gains and Losses**

Activities other than in connection with providing health care services are considered to be nonoperating.

**Excess of Revenues over Expenses**

The consolidated statements of operations include excess of revenues over expenses. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, permanent transfers of assets to and from affiliates for other than goods and services, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and pension-related charges other than periodic pension costs and other postretirement benefits liabilities.

**Fair Value of Financial Instruments**

Investments and other assets and liabilities are carried at amounts that approximate fair value based on current market conditions. The fair value of long term debt is estimated based on the quoted market prices for the same or similar issues or on current rates offered to the Corporation and its Subsidiaries for debt of the same remaining maturities.

**Medical Malpractice Self-Insurance**

The Corporation purchases claims made professional and general liability insurance to cover medical malpractice claims from L&M Indemnity Ltd. The Hospital, LMPA and VNA have adopted the policy of self-insuring the tail portion of its malpractice insurance coverage. Management accrues its best estimate of losses as incidents which give rise to potential losses occur.

## **Lawrence + Memorial Corporation and Subsidiaries**

### **Notes to Consolidated Financial Statements**

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#### **Income Taxes**

The Corporation and its subsidiaries are not-for-profit organizations and are exempt from federal income taxes on related income under Section 501(c)(3) of the Internal Revenue Code, except for L&M Systems. L&M Systems provides for taxes based on current taxable income and the future tax consequences of temporary differences between financial and income tax reporting. Such amounts are not material to the consolidated financial statements.

#### **Inventories**

Inventory consists of supplies, both medical and general, pharmaceuticals and food products needed to sustain daily operation of patient care. Inventories are carried at the lower of cost or market under the first-in-first-out (FIFO) method.

#### **Impairment of Long-Lived Assets**

Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value less cost to dispose.

#### **Accrued Vacation and Sick Pay**

Accrued vacation is recorded as a liability as time is earned. As the time is used, the time is relieved from the liability. Accrued sick time is recorded as a percent for employees who have a balance greater than or equal to 800 hours. The payout is only upon termination of employment.

#### **Labor action update**

The Hospital's negotiations with two of its three unions, AFT Healthcare, AFT-CT, AFT, AFL-CIO, Local 5049 (registered nurses) and AFT Healthcare, AFT-CT, AFLCIO, Local 5051 (licensed practical nurses and technicians) for a new contract resulted in a 4-day strike that commenced on November 27, 2013. The Hospital brought in temporary replacement workers, and, in order to provide ongoing patient care given the threat of additional, intermittent strikes, had a lockout of employees through December 18, 2013. The lockout was lifted and employees returned to work without a contract being reached. A contract was reached and ratified and the workforce had a three year contract that was signed in February 2014. The Hospital monitored the negative impact of the strike and lockout on both revenues and expenses. The financial negative impact included in these financials is approximately \$14,200,000. This consisted of a reduction in net revenue of approximately \$1,900,000 and \$12,300,000 of replacement workers, security and reduced salary costs during the strike and lock out period.

#### **Subsequent Events**

The Corporation has performed an evaluation of subsequent events through January 23, 2015, which is the date the financial statements were issued.

**Lawrence + Memorial Corporation and Subsidiaries**  
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**2. Revenues From Services to Patients and Charity Care**

The following summarizes net revenues from services to patients:

	2014	2013
Gross charges from services to patients	\$ 1,078,626,933	\$ 837,486,803
Less: Charity care	<u>6,782,933</u>	<u>7,772,037</u>
Charges from services to patients, net of charity care	<u>1,071,844,000</u>	<u>829,714,766</u>
Deductions		
Allowances	615,856,880	455,921,391
State of Connecticut uncompensated care system	<u>2,458,020</u>	<u>1,047,636</u>
Total deductions	<u>618,314,900</u>	<u>456,969,027</u>
Net revenues from services to patients	<u>\$ 453,529,100</u>	<u>\$ 372,745,739</u>

Patient accounts receivable and revenues are recorded when patient services are performed. Amounts received from most payors are different from established billing rates of the Corporation, and these differences are accounted for as allowances. The State of Connecticut has reduced Uncompensated Care Payments to all hospitals beginning July 2013 for a three year period. In 2014, the Corporation paid cash into the State of Connecticut Uncompensated Care Pool that exceeded the amount was received from the State.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Adjustments related to prior year settlements decreased the Hospital's revenues by approximately \$1,584,575 in 2014 and increased the Hospital's revenue by approximately \$1,126,576 in 2013.

During 2014 and 2013, approximately 35% and 33%, respectively, of net patient service revenue was received under the Medicare program, and 11% and 12%, respectively, under the state Medicaid program. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation. Non compliance could result in significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and reductions of funding levels could have an adverse impact on the Hospital.

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. In assessing a patient's inability to pay, the Hospital utilizes the generally recognized federal poverty income guidelines.

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**3. Investments**

Investments included in current assets consist of the following:

	2014	2013
<b>Other investments</b>		
Cash and cash equivalents	6,293,794	3,618,554
Bonds	40,097,819	38,890,479
Mutual funds	72,596,528	79,030,543
Hedge funds	57,360,354	54,766,338
Private equities	4,535,516	1,884,631
Marketable equities	<u>3,542,028</u>	<u>3,149,441</u>
Total other investments	<u>184,426,039</u>	<u>181,339,986</u>
<b>Funds held in trust by others</b>		
Investments held in trust by others	<u>11,348,610</u>	<u>10,956,429</u>
Total funds held in trust by others	<u>11,348,610</u>	<u>10,956,429</u>
<b>Endowment investments</b>		
Cash and cash equivalents	\$ 4,307,512	\$ 3,785,088
Bonds	5,061,901	4,823,170
Mutual funds	14,191,010	13,492,698
Hedge funds	6,263,387	5,961,109
Private equities	209,627	112,204
Marketable equities	<u>6,607,991</u>	<u>5,981,527</u>
Total endowment investments	<u>36,641,428</u>	<u>34,155,796</u>
Total investments at fair value	<u>\$ 232,416,077</u>	<u>\$ 226,452,211</u>

**Lawrence + Memorial Corporation and Subsidiaries**  
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The Corporation's financial instrument categorization is based upon the lowest level of input that is significant to the fair value measurement within the valuation hierarchy. The following table presents the financial instruments carried at fair value using the by the fair value guidance valuation hierarchy defined above:

	2014			Total Fair Value
	Level 1	Level 2	Level 3	
<b>Other investments</b>				
Cash and cash equivalents	6,293,794	-	-	6,293,794
Bonds	33,184,269	6,913,550	-	40,097,819
Mutual funds	72,596,528	-	-	72,596,528
Hedge funds	-	-	57,360,354	57,360,354
Private equities	-	-	4,535,516	4,535,516
Marketable equities	3,542,028	-	-	3,542,028
Total other investments	115,616,619	6,913,550	61,895,870	184,426,039
<b>Funds held in trust by others</b>				
Investments held in trust by others	-	-	11,348,610	11,348,610
Total held in trust by others	-	-	11,348,610	11,348,610
<b>Endowment investments</b>				
Cash and cash equivalents	\$ 4,307,512	\$ -	\$ -	\$ 4,307,512
Bonds	3,300,408	1,449,067	312,427	5,061,902
Mutual funds	12,613,287	-	1,577,722	14,191,009
Hedge funds	-	-	6,263,387	6,263,387
Private equities	-	-	209,627	209,627
Marketable equities	6,607,991	-	-	6,607,991
Total endowment investments	26,829,198	1,449,067	8,363,163	36,641,428
Total Investments at fair value	\$ 142,445,817	\$ 8,362,617	\$ 81,607,643	\$ 232,416,077

	2013			Total Fair Value
	Level 1	Level 2	Level 3	
<b>Other investments</b>				
Cash and cash equivalents	3,618,554	-	-	3,618,554
Bonds	32,082,552	6,807,927	-	38,890,479
Mutual funds	79,030,543	-	-	79,030,543
Hedge funds	-	-	54,766,338	54,766,338
Private equities	-	-	1,884,631	1,884,631
Marketable equities	3,149,441	-	-	3,149,441
Total other investments	117,881,090	6,807,927	56,650,969	181,339,986
<b>Funds held in trust by others</b>				
Investments held in trust by others	-	-	10,956,429	10,956,429
Total held in trust by others	-	-	10,956,429	10,956,429
<b>Endowment investments</b>				
Cash and cash equivalents	\$ 3,785,088	\$ -	\$ -	\$ 3,785,088
Bonds	3,185,997	1,425,678	211,495	4,823,170
Mutual funds	12,044,760	-	1,447,938	13,492,698
Hedge funds	-	-	5,961,109	5,961,109
Private equities	-	-	112,204	112,204
Marketable equities	5,981,527	-	-	5,981,527
Total endowment investments	24,997,372	1,425,678	7,732,746	34,155,796
Total Investments at fair value	\$ 142,878,462	\$ 8,233,605	\$ 75,340,144	\$ 226,452,211

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Fair value for Level 1 is based upon quoted prices in active markets that the Corporation has the ability to access at the measurement date. Market price data is generally obtained from exchange or dealer markets. The Corporation does not adjust the quoted price for such assets.

Fair value for Level 2 is based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources including market participants, dealers and brokers.

Fair value for Level 3 is based on valuation techniques that use significant inputs that are unobservable as they trade infrequently or not at all and reflect assumptions based on the best information available in the circumstances.

Investments included in Level 3 primarily consist of the Corporation's ownership in alternative investments (principally limited partnership interests in hedge funds). The value of these alternative investments represents the ownership interest in the net asset value ("NAV") of the respective partnership. The fair values of the securities held by limited partnerships that do not have readily determinable fair values are determined by the general partner and are based on appraisals, or other estimates that require varying degrees of judgment. If no public market exists for the investment securities, the fair value is determined by the general partner taking into consideration, among other things, the cost of the securities, prices of recent significant placements of securities of the same issuer, and subsequent developments concerning the companies to which the securities relate. Also included in Level 3 investments are charitable remainder trusts held by third parties which are recorded at the present value of the future distributions expected to be received over the term of the agreement and investments in for-profit companies.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Corporation believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

The following table is a roll forward of the amounts by investment type for financial instruments classified by the Corporation within Level 3 of the fair value hierarchy defined above:

	Beginning October 1, 2013	Investment Income	Realized Gains/(losses)	Unrealized Gains	Investment Fees	Purchases	Sales	Ending September 30, 2014
<b>Investment pool</b>								
Hedge funds	\$ 62,386,880	\$ 624,650	\$ 270,868	\$ 2,316,323	\$ (158,389)	\$ 381,586	\$ (268,029)	\$ 65,555,889
Private equities	1,996,835	-	387,382	311,627	(86,266)	2,169,982	(78,416)	4,703,144
Funds held in trust	10,956,429	141,409	(38,835)	344,380	(51,515)	-	(3,258)	11,348,610
<b>Total</b>	<b>\$ 75,340,144</b>	<b>\$ 766,059</b>	<b>\$ 619,415</b>	<b>\$ 2,974,330</b>	<b>\$ (296,170)</b>	<b>\$ 2,551,568</b>	<b>\$ (347,703)</b>	<b>\$ 81,607,643</b>

	Beginning October 1, 2012	Investment Income	Realized Gains	Unrealized Gains	Investment Fees	Purchases	Sales	Ending September 30, 2013
<b>Investment pool</b>								
Hedge funds	\$ 56,124,316	\$ 354,977	\$ 1,118,631	\$ 5,509,944	\$ (131,712)	\$ 1,037,785	\$ (1,627,061)	\$ 62,386,890
Private equities	487,257	-	67,055	122,281	(63,590)	1,398,832	(15,000)	1,996,835
Funds held in trust	6,451,420	-	-	322,158	(64,965)	4,247,816	-	10,956,429
<b>Total</b>	<b>\$ 63,062,993</b>	<b>\$ 354,977</b>	<b>\$ 1,185,686</b>	<b>\$ 5,954,383</b>	<b>\$ (260,267)</b>	<b>\$ 6,684,433</b>	<b>\$ (1,642,061)</b>	<b>\$ 75,340,144</b>

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There were no significant transfers of assets between levels for the year ended September 30, 2014.

A summary of the endowment investment return is presented below:

	2014	2013
Investment income	\$ 752,014	\$ 649,876
Realized and unrealized gains	1,714,027	2,225,435
Management fees and other costs	(55,806)	(47,805)
Total return on endowment investments	<u>\$ 2,410,235</u>	<u>\$ 2,827,506</u>

Following is additional information related to funds whose fair value is not readily determinable as of September 30, 2014.

	Strategy	Fair Value	# of Investments	Remaining Life	\$ Amount of Unfunded Commitments	Timing to Draw Down Commitments	Redemption Terms	Redemption Restrictions	Restrictions in Place at Year End
Equity securities	Global developed and emerging market equity	\$ 15,362,932	1	N/A	\$ -	No remaining commitments	Monthly with 10 day's notice	None	None
Absolute return	Long/short and long-biased equity and credit hedge funds	19,653,964	2	N/A		No remaining commitments	Annual with 90 day's notice	lock up provision of 12 months from the purchase date	None
Directional hedge	Long/short and long-biased equity and credit hedge funds	25,350,100	1	N/A		No remaining commitments	Quarterly with 60 day's notice	lock up provision of 25 months from the purchase date	None
Commodities	Commodity index	6,146,893	1	N/A		No remaining commitments	Monthly with 5 day's notice	None	None
Private equity	Private equity	4,745,144	8	N/A		Illiquid long term 5 years	None	None	None
		<u>\$ 70,259,033</u>							

#### 4. Endowments

The Corporation's endowments consist of donor restricted endowment funds for a variety of purposes. The net assets associated with endowment funds including funds designated by the Board of Directors to function as endowments are classified and reported based on the existence or absence of donor imposed restrictions.

The Corporation understands net asset classification guidance to require that donor restricted endowment gifts be maintained in perpetuity. Consistent with net asset classification guidance, the Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure. The Corporation considers the following factors in making a determination to appropriate or accumulate endowment funds:

- The duration and preservation of the fund.
- The purposes of the Corporation and donor-restricted endowment fund.
- General economic conditions.
- The possible effect of inflation and deflation.
- The expected total return from income and the appreciation of investments.
- Other resources of the Corporation.

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- The investment policies of the Corporation.

Changes in endowment net assets for the year ended September 30:

	2014			Total
	Unrestricted	Temporarily Restricted	Permanently Restricted	
Endowment net assets at beginning of year	\$ 9,257,584	\$ 16,178,222	\$ 7,249,055	\$ 32,684,861
Addition of Westerly Hospital Endowment Net Assets	18,975	-	-	18,975
Investment return				
Investment income	304,778	170,106	20,569	495,453
Net realized and unrealized gain	715,724	1,288,111	32,832	2,036,667
Contributions	183,147	-	80,073	263,220
Total investment return	1,203,649	1,458,217	133,474	2,795,340
Income distribution	-	(139,360)	-	(139,360)
Endowment net assets at end of year	<u>\$ 10,480,208</u>	<u>\$ 17,497,079</u>	<u>\$ 7,382,529</u>	<u>\$ 35,359,816</u>

	2013			Total
	Unrestricted	Temporarily Restricted	Permanently Restricted	
Endowment net assets at beginning of year	\$ 6,676,924	\$ 13,633,436	\$ 2,866,683	\$ 23,177,043
Addition of Westerly Hospital Endowment Net Assets	1,714,560	810,769	4,345,662	6,870,991
Investment return				
Investment income	287,500	161,761	(748)	448,513
Net realized and unrealized gain	451,980	1,701,848	14,570	2,168,398
Contributions	126,620	-	22,888	149,508
Total investment return	866,100	1,863,609	36,710	2,766,419
Income distribution	-	(129,592)	-	(129,592)
Endowment net assets at end of year	<u>\$ 9,257,584</u>	<u>\$ 16,178,222</u>	<u>\$ 7,249,055</u>	<u>\$ 32,684,861</u>

Endowment funds classified as permanently and temporarily restricted net assets:

The portion of perpetual endowment funds retained permanently either by explicit donor stipulation or by net asset classification guidance is summarized as follows:

	2014	2013
<b>Temporarily restricted net assets</b>		
Unspent income and appreciation on permanently restricted endowments for purchase of equipment and healthcare services	<u>\$ 17,497,079</u>	<u>\$ 16,178,222</u>
Total endowment funds classified as temporarily restricted net assets	<u>\$ 17,497,079</u>	<u>\$ 16,178,222</u>
<b>Permanently restricted net assets</b>		
Corpus of permanently restricted contributions for which income is to be used for purchase of equipment and healthcare services	<u>\$ 7,382,529</u>	<u>\$ 7,249,055</u>
Total endowment funds classified as permanently restricted net assets	<u>\$ 7,382,529</u>	<u>\$ 7,249,055</u>

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**Endowment Funds With Deficits**

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the value of the initial and subsequent donor gift amounts (deficit). When donor endowment deficits exist they are classified as a reduction of unrestricted net assets. The Corporation analyzed the endowments and notes there are no deficits as of September 30, 2014 and 2013.

**Endowment Investment Return Objectives and Risk Parameters**

The Corporation has adopted endowment investment and spending policies that attempt to provide predictable stream of funding to programs supported by the endowment while seeking to maintain the permanent nature of endowment funds. Under this policy, the return objective for the endowment assets measured over a full market cycle shall be to maximize the return against a blended index, based on the endowment's target asset allocation applied to the appropriate individual benchmarks.

**Strategies Employed for Achieving Endowment Investment Objectives**

To achieve its long-term rate of return objectives, the Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). The Corporation targets a diversified asset allocation to achieve its long-term objectives within prudent Corporation risk constraints.

**Endowment Spending Allocation and Relationship of Spending Policy to Investment Objectives**

Spending is guided by several factors most important is the value of the portfolio. Generally, the Board will approve a spending policy limiting annual expenditures for grants and operating expenses up to 4.5% of the value of the Funds' assets based on a 12 quarter rolling average for the endowment, and operating funds.

Investment managers are given ample notice of the required withdrawal schedule. Appropriate liquidity is maintained to fund these withdrawals without impairing the investment process.

**5. Temporary and Permanently Restricted Net Assets**

Temporarily restricted net assets are available for the following purposes at September 30, 2014 and 2013:

	2014	2013
<b>Temporarily restricted net assets</b>		
Funds held in trust by others	\$ 3,799,127	\$ 3,687,812
Contributions receivable	20,366	20,366
Free beds and plant replacement and expansion	16,369,376	15,304,434
Specific purpose reserves	7,321,842	5,412,960
	<u>\$ 27,510,711</u>	<u>\$ 24,425,572</u>

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Permanently restricted net assets at September 30, 2014 and 2013 are restricted to:

	2014	2013
<b>Permanently restricted net assets</b>		
Funds held in trust by others	\$ 7,571,288	\$ 7,290,422
Donor restricted endowment funds	8,132,530	7,999,056
	<u>\$ 15,703,818</u>	<u>\$ 15,289,478</u>

**6. Property, Plant and Equipment**

Property, plant and equipment consists of the following:

	2014	2013
Land and land improvements	\$ 23,323,273	\$ 21,524,487
Buildings	171,045,151	138,297,388
Equipment	284,414,885	252,682,233
	<u>478,783,309</u>	<u>412,504,108</u>
Less: Accumulated depreciation	<u>(274,060,791)</u>	<u>(250,099,034)</u>
	204,722,518	162,405,074
Construction in progress		
	<u>2,127,781</u>	<u>45,776,965</u>
	<u>\$ 206,850,299</u>	<u>\$ 208,182,039</u>

**7. Long-Term Debt**

	2014	2013
CHEFA Series F Revenue Bonds		
Various rate bonds, due 2014 to 2026	\$ 30,900,000	\$ 33,625,000
5.0% Term Bonds, due 2027 to 2031	8,705,000	8,705,000
5.0% Term Bonds, due 2032 to 2036	11,100,000	11,100,000
CHEFA Series E revenue bonds		
Variable rate bonds, due 2023-2034	-	22,990,000
CHEFA Series G revenue bonds		
3.2% Term Bonds, due 2023, option to extend 2038	29,200,000	-
CHEFA Series H revenue bonds		
Variable rate bonds, due 2023-2034	21,405,000	-
Line of credit	-	18,663,400
Tax exempt lease	9,963,984	11,596,368
Capital lease obligation	246,684	1,010,148
	<u>111,520,668</u>	<u>107,689,916</u>
Total debt outstanding		
Less: Amounts classified as current	5,476,980	9,347,876
Add: Bond premium	2,544,115	2,659,757
	<u>\$ 108,587,803</u>	<u>\$ 101,001,797</u>
Total long-term portion of long-term debt		

**Lawrence + Memorial Corporation and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**September 30, 2014 and 2013**

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On September 15, 2011 the Connecticut Health and Education Facilities Authority ("CHEFA") issued \$58,940,000 of Series F Bonds (the "Series F Bonds") on behalf of the Hospital and Lawrence + Memorial Corporation (collectively referred to as the "Obligated Group" under the Series F Bond agreements). The Series F Bonds are structured with a term bond due July 1, 2036, with annual sinking fund payments due each July 1<sup>st</sup>. Interest on the Series F Bonds is payable semiannually on the first business day of January 1 and July 1 which began on January 1, 2012.

The Series E bonds were paid early with the issuance of CHEFA series H.

The tax exempt lease was obtained on June 27, 2013 in the principal amount of \$12,000,000. This is a seven year equipment lease on specific capital purchases that is administered through CHEFA and Bank of America-Merrill Lynch. This lease will be amortized monthly through June 27, 2020 at a nominal annual interest rate of 1.759%.

On October 10, 2013 Series G was issued in a private placement offering with Bank of America-Merrill Lynch and CHEFA in the amount of \$29,200,000 with an interest rate of 3.20% until October 1, 2023 with an option to extend at a negotiated rate with a maturity date of July 1, 2038.

On November 5, 2013, Series H was issued by CHEFA to refinance Series E. Series H was issued in the amount of \$21,405,000 with a variable rate and a maturity date of July 1, 2034. This bond has a letter of credit guaranteed by T.D. Bank. Interest on the Series H Bonds accrues at the weekly rate and is payable on the first business day of each month commencing January 1, 2014.

Under the terms of the trust indenture for the Series H Bonds, the Obligated Group is required to meet certain financial covenants including a debt service coverage ratio and days cash on hand ratio. Members of the Obligated Group are jointly and severally obligated to provide amounts sufficient to enable the Authority to pay principal and interest on the Series H Bonds. The Bonds and bond proceeds have been allocated to the Hospital and as such, the Hospital will make future debt service payments as required under the terms of the bonds.

The bonds may be retired at an earlier date pursuant to terms of the master indenture. Payment of the bonds is collateralized by a pledge of the gross receipts, as defined and certain real property of the Hospital.

The Series H Bonds are considered variable rate demand bonds and are remarketed on a weekly basis. The Hospital maintains a letter of credit in the amount of \$21,405,000 which expires on November 5, 2016. If the bonds are unable to be remarketed, the letter of credit could be utilized to purchase the bonds. The Obligated Group would then be subject to the payment terms of the letter of credit, which are monthly installments. The Series H Bonds have been successfully remarketed in the past and there have been no draws on the letter of credit.

The Corporation had a line of credit with Bank of America-Merrill Lynch for \$13,802,758. This was taken as a bridge loan prior to issuance of Series G private Placement. The proceeds of Series G were used to pay off this line of credit on October 10, 2013. LMW Healthcare had a line of credit with Washington Trust for \$4,860,642. This line was reissued at time of closing but was paid off in November 2013.

**Lawrence + Memorial Corporation and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**September 30, 2014 and 2013**

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The fair value of the outstanding bonds is \$106,215,296 and \$78,820,117 at September 30, 2014 and September 30, 2013, respectively.

Principal repayments, excluding capital leases and the line of credit, are as follows:

Years	Annual Principal Repayment
2015	\$ 3,660,000
2016	3,825,000
2017	4,010,000
2018	4,165,000
2019 and thereafter	<u>85,650,000</u>
	<u>\$ 101,310,000</u>

Cash interest payments of \$3,566,051 and \$2,682,472 were made in fiscal year 2014 and 2013, respectively. No interest was capitalized during 2014 and 2013.

**8. Pension and Other Postretirement Benefits**

The Hospital has a defined benefit plan covering all employees who elected to stay in the Plan. The Plan is frozen to new participants as of June 30, 1999. The benefits are based on years of service and the employee's compensation during the last five years of employment.

The Hospital provides health care and life insurance benefits to its retired employees who meet certain eligibility requirements. The Hospital's policy is to fund the cost of postretirement benefits other than pensions as incurred. This plan was frozen to include only those employees who retired prior to May 1, 1994.

**Lawrence + Memorial Corporation and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**September 30, 2014 and 2013**

The following table sets forth the Hospital's plans' funded status and amounts recognized in the consolidated balance sheet at September 30, 2014 and 2013 (measurement date of ), the significant change in the actuarial loss is predominantly related to the decrease in the discount rate used to determine the benefit obligation at the end of the year:

September 30):

	Pension Benefits		Other Postretirement Benefits	
	2014	2013	2014	2013
<b>Change in benefit obligation</b>				
Benefit obligation at beginning of year	\$ 145,789,789	\$ 147,201,452	\$ 1,000,744	\$ 1,289,208
Service cost	2,402,724	1,536,115	-	-
Interest cost	6,417,121	5,685,930	29,884	31,620
Employee contributions	69,839	90,611	-	-
Benefits paid	(7,015,362)	(6,590,842)	(95,403)	(107,793)
Actuarial (gain)/loss	9,010,698	(2,133,477)	(97,788)	(212,291)
Benefit obligation at end of year	<u>156,674,809</u>	<u>145,789,789</u>	<u>837,437</u>	<u>1,000,744</u>
<b>Change in plan assets</b>				
Fair value of plan assets at beginning of year	105,860,348	98,298,309	-	-
Actual return on plan assets	9,861,899	7,662,270	-	-
Employee contributions	69,839	90,611	-	-
Employer contributions	6,400,000	6,400,000	95,403	107,793
Benefits paid	(7,015,362)	(6,590,842)	(95,403)	(107,793)
Fair value of plan assets at end of year	<u>115,176,724</u>	<u>105,860,348</u>	<u>-</u>	<u>-</u>
Funded status of the plan	<u>(41,498,085)</u>	<u>(39,929,441)</u>	<u>(837,437)</u>	<u>(1,000,744)</u>
Unrecognized net loss/(gain) from past experience different from that assumed and effects of changes in assumptions	41,399,294	37,006,625	(488,085)	(456,751)
Unrecognized prior service cost	79,157	190,310	-	-
Accrued benefit costs recognized in the statements of operations	<u>\$ (19,634)</u>	<u>\$ (2,732,506)</u>	<u>\$ (1,325,522)</u>	<u>\$ (1,457,495)</u>
<b>Components of net periodic benefit costs</b>				
Service cost	\$ 2,402,724	\$ 1,536,115	\$ -	\$ -
Interest cost	6,417,121	5,685,930	29,884	31,620
Expected return on plan assets	(7,920,200)	(7,182,524)	-	-
Amortization of net loss/(gain)	2,676,330	3,175,983	(66,454)	(45,046)
Net amortization and deferral	111,153	140,639	-	-
Benefit cost	<u>\$ 3,687,128</u>	<u>\$ 3,356,143</u>	<u>\$ (36,570)</u>	<u>\$ (13,426)</u>

The weighted average assumptions used to determine the net benefit cost at the beginning of the year are as follows:

	2014	2013
Discount rate	4.51 %	3.95 %
Average rate of compensation increases	2.50 %	2.50 %
Expected return on assets	7.50 %	7.50 %

The weighted average assumptions used to determine the benefit obligation at the end of the year are as follows:

**Lawrence + Memorial Corporation and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**September 30, 2014 and 2013**

	2014	2013
Discount rate	4.05 %	4.51 %
Average rate of compensation increases	2.50 %	2.50 %

The Plan's asset allocations as of September 30 are as follows:

Asset Category	2014	2013
Cash	2 %	3 %
Bonds	24	23
Mutual funds	45	44
Hedge funds	29	30
Total	100 %	100 %

The expected rate of return on plan assets is calculated based on past experience.

Expected benefits to be paid under the Hospital's plans are as follows:

Fiscal Years Beginning October 1,	Expected Benefits
2014	\$ 7,399,905
2015	7,694,336
2016	8,101,708
2017	8,234,873
2018	8,658,711
Expected aggregate for 5 fiscal years beginning 2019	47,809,642

Annual contributions are determined by the Hospital based upon calculations prepared by the plan's actuary. Expected contributions to the plans for 2014 are approximately (unaudited):

Pension	\$ 6,400,000
Retiree health	94,776

The weighted-average annual assumed rate of increase in the per capita cost of covered benefits (i.e., health care cost trend rate) for participants is assumed to be 9.0% in 2014 reducing to 5.0% by the year 2021 and remaining at that level thereafter. This health care cost trend rate assumption has a significant effect on the amounts reported. To illustrate, a one percentage point increase in the assumed health care cost trend rate would increase the accumulated postretirement benefit obligation and service cost plus interest cost by approximately \$56,000 and \$71,000, respectively, at September 30, 2014 and 2013. A one percentage point decrease in the assumed health care cost trend rate would decrease the accumulated postretirement benefit obligation and service cost plus interest cost by approximately \$51,000 and \$65,000, respectively, at September 30, 2014 and 2013.

**Plan Assets**

The defined benefit plan assets are valued utilizing the same fair value hierarchy as the Hospital's investments as described in Note 1.

**Lawrence + Memorial Corporation and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**September 30, 2014 and 2013**

The following table summarizes the fair values of investments by major type held by the pension plan at September 30, 2014:

	Level 1	Level 2	Level 3	2014
<b>Investments, at fair value</b>				
Cash	\$ 2,417,830	\$ -	\$ -	\$ 2,417,830
Bonds	27,571,791	-	-	27,571,791
Mutual funds	46,557,396	5,171,869	-	51,729,265
Hedge funds	-	-	33,457,838	33,457,838
Total investments, at fair value	<u>\$ 76,547,017</u>	<u>\$ 5,171,869</u>	<u>\$ 33,457,838</u>	<u>\$ 115,176,724</u>

The following table summarizes the fair values of investments by major type held by the staff pension health plan at September 30, 2013:

	Level 1	Level 2	Level 3	2013
<b>Investments, at fair value</b>				
Cash	\$ 3,043,961	\$ -	\$ -	\$ 3,043,961
Bonds	24,488,654	-	-	24,488,654
Mutual funds	41,880,187	4,553,588	-	46,433,775
Hedge funds	-	-	31,893,958	31,893,958
Total investments, at fair value	<u>\$ 69,412,802</u>	<u>\$ 4,553,588</u>	<u>\$ 31,893,958</u>	<u>\$ 105,860,348</u>

There were no transfers between levels during 2014 or 2013.

The table below represents the change in fair value measurements for Level 3 investments held by the plans for the years ended September 30.

	2014	2013
<b>Beginning balances</b>	\$ 31,893,958	\$ 28,795,536
Realized gains	4,588,368	33,459
Fees	(79,614)	(65,081)
Unrealized gains	(2,944,874)	3,130,044
Purchases	-	-
Sales	-	-
<b>Ending balances</b>	<u>\$ 33,457,838</u>	<u>\$ 31,893,958</u>

The investment objective for the pension and post retirement plans seeks a positive long-term total return after inflation to meet the Hospital's current and future plan obligations.

Asset allocations combine tested theory and informed market judgment to balance investment risks with the need for high returns.

**Lawrence + Memorial Corporation and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**September 30, 2014 and 2013**

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The Hospital's 401(k) plan covers eligible employees who elected to participate. Eligible employees may contribute a percentage of their salary. The Hospital matches 100% of the first 4% of gross pay deferred by employees for those employees who do not participate in the defined benefit plan. Plan contributions charged to operations were approximately \$4,584,389 and \$4,618,626 for 2014 and 2013, respectively.

The VNA has a defined contribution pension plan which covers substantially all of its employees who have met specified age and length of service requirements. Contributions to the Plan are based on 5% of eligible salaries and totaled approximately \$463,475 and \$446,631 for the years ended September 30, 2014 and 2013, respectively.

**9. Functional Expenses**

The Corporation and its subsidiaries provide general health care services to residents within its geographic location including pediatric care, cardiac catheterization, and outpatient surgery. Expenses by function are as follows:

	2014	2013
Health care services	\$ 348,719,365	\$ 293,416,325
General and administrative	<u>124,868,311</u>	<u>94,388,752</u>
	<u>\$ 473,587,676</u>	<u>\$ 387,805,077</u>

**10. Commitments and Contingencies**

The Corporation and its subsidiaries are parties to various lawsuits incidental to their business. Management believes that the lawsuits will not have a material adverse effect on their financial position, results of operations, and changes in net assets or cash flows.

**Lawrence + Memorial Corporation and Subsidiaries**  
**Consolidating Balance Sheet**  
**September 30, 2014**

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
<b>Assets</b>											
Current assets											
Cash and cash equivalents	\$ 6,917,676	\$ 334,893	\$ -	\$ 7,252,569	\$ -	\$ 1,901,701	\$ 950,345	\$ 1,675,245	\$ 4,700,669	\$ -	\$ 16,480,529
Investments	128,460,331	31,541,423	-	159,991,754	-	-	16,769,765	7,523,944	140,676	-	184,426,039
Patient accounts receivable, net	36,373,089	-	-	36,373,089	-	2,378,629	-	2,740,706	5,980,550	-	47,482,954
Other receivables	4,156,260	-	-	4,156,260	24,500	289,393	1,322,262	-	-	-	5,782,415
Inventories	6,580,753	-	-	6,580,753	-	-	-	-	1,812,254	-	8,393,007
Due from affiliates	1,954,838	24,500	(1,954,838)	24,500	2,215,430	-	-	438,951	-	(2,239,930)	-
Prepaid expenses and other current assets	2,689,506	-	-	2,689,506	-	545,696	16,143	-	58,427	-	3,748,725
Debt service fund	1,304,562	-	-	1,304,562	-	-	-	-	-	-	1,304,562
<b>Total current assets</b>	<b>188,426,995</b>	<b>31,900,816</b>	<b>(1,954,838)</b>	<b>218,372,973</b>	<b>2,239,930</b>	<b>5,115,421</b>	<b>19,058,515</b>	<b>12,376,846</b>	<b>12,702,476</b>	<b>(2,239,930)</b>	<b>287,628,231</b>
Assets limited as to use											
Cash	182,862	-	-	182,862	-	-	-	-	-	-	182,862
Construction funds	561,676	-	-	561,676	-	-	-	-	-	-	561,676
Investments held in trust	925,227	-	-	925,227	-	-	-	-	-	-	925,227
Endowment investments	18,987,367	3,565,739	-	22,553,106	-	-	-	6,654,619	7,483,703	(19,281,447)	36,641,428
Investment in subsidiaries	-	19,281,447	-	19,281,447	-	-	-	-	4,362,986	-	11,348,610
Funds held in trust by others	6,985,614	-	-	6,985,614	-	-	-	-	750,000	-	3,520,787
Contributions receivable	20,366	2,750,421	-	2,770,787	-	-	-	-	-	-	-
Funds held in escrow by agreement with State of Connecticut Health and Educational Facilities Authority and trustees	-	-	-	-	-	-	-	-	-	-	-
<b>Total assets limited as to use</b>	<b>27,663,112</b>	<b>25,597,607</b>	<b>-</b>	<b>53,260,719</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>6,654,619</b>	<b>12,546,689</b>	<b>(19,281,447)</b>	<b>53,180,590</b>
Other assets											
Intangible assets, net	16,536,719	-	-	16,536,719	-	-	-	-	2,975,625	-	2,978,625
Other receivables	2,315,752	-	-	2,315,752	-	2,137,101	287,916	-	-	(16,380,950)	2,580,786
Deferred financing costs and other assets, net	-	-	-	-	-	-	-	-	-	-	2,315,752
Property, plant and equipment	8,846,232	12,330,636	-	21,176,867	-	-	-	330,275	1,816,131	-	23,323,273
Land improvements	150,810,346	-	-	150,810,346	-	1,046,733	-	2,238,496	16,849,676	-	171,046,151
Buildings/leasehold improvements	265,024,485	17,010	-	265,041,495	-	976,188	-	964,431	17,402,771	-	284,414,885
Equipment/furniture	(265,615,130)	(104,684)	-	(265,719,814)	-	(973,022)	-	(1,937,034)	(5,430,921)	-	(274,080,781)
Accumulated depreciation	1,681,663	-	-	1,681,663	-	-	-	-	455,918	-	2,127,781
Construction in progress	160,857,796	12,242,961	-	173,100,757	-	1,049,899	-	1,626,166	31,073,475	-	206,890,299
Property, plant and equipment, net	385,800,374	69,741,384	(1,954,838)	463,586,920	2,239,930	8,302,421	19,346,431	20,659,633	59,301,275	(87,902,327)	585,594,283

**Lawrence + Memorial Corporation and Subsidiaries**  
**Consolidating Balance Sheet**  
**September 30, 2014**

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
<b>Liabilities and Net Assets</b>											
Current liabilities											
Accounts payable	\$ 25,786,034	\$ 115,809	\$ -	\$ 25,901,843	\$ -	\$ 343,515	\$ 187,453	\$ 1,615,548	\$ 9,471,491	\$ -	\$ 37,529,950
Accrued vacation and sick pay	11,281,701	-	-	11,281,701	-	1,595,316	-	-	1,346,711	-	14,223,728
Salaries, wages, payroll taxes and amounts withheld from employees	5,950,567	-	-	5,950,567	-	3,536,119	-	-	1,184,830	-	10,671,516
Due to affiliates	2,215,430	1,912,595	(1,954,838)	2,173,187	56,743	-	-	-	1,868,724	(2,239,930)	7,257,949
Other current liabilities	5,185,225	-	-	5,166,225	-	-	428,096	154,457	-	-	582,853
Current portion of long-term debt	5,342,305	-	-	5,342,305	-	-	-	-	134,675	-	5,476,980
Total current liabilities	55,741,262	2,028,404	(1,954,838)	55,814,828	66,743	5,474,950	625,549	2,004,005	13,996,431	(2,239,930)	75,742,576
Accrued pension and other postretirement benefits	43,216,010	-	-	43,216,010	-	-	-	-	-	-	43,216,010
Other liabilities	20,601,530	-	-	20,601,530	-	3,744,380	17,719,580	-	1,335,389	(17,769,969)	25,610,890
Long-term debt less current portion	108,587,802	-	-	108,587,802	-	-	-	-	-	-	108,587,802
Total liabilities	228,146,604	2,028,404	(1,954,838)	228,220,170	66,743	9,219,330	18,345,109	2,004,005	15,331,820	(20,029,899)	263,157,278
Net assets											
Unrestricted	138,173,767	67,562,541	-	205,736,308	2,173,187	(916,909)	1,001,322	18,628,628	33,152,392	(17,872,428)	241,902,500
Temporarily restricted	23,432,028	150,439	-	23,582,467	-	-	-	-	1,188,220	-	24,770,687
Permanently restricted	6,047,875	-	-	6,047,875	-	-	-	27,000	9,629,843	-	15,703,918
Total net assets	167,653,770	67,712,980	-	235,366,750	2,173,187	(916,909)	1,001,322	18,655,628	43,969,455	(17,872,428)	282,377,095
	\$ 395,800,374	\$ 68,741,384	\$ (1,954,838)	\$ 463,586,920	\$ 2,239,930	\$ 8,302,421	\$ 19,346,431	\$ 20,659,633	\$ 59,301,275	\$ (37,902,327)	\$ 535,534,283

# Lawrence + Memorial Corporation and Subsidiaries

## Consolidating Balance Sheet

### September 30, 2013

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
<b>Assets</b>											
<b>Current assets</b>											
Cash and cash equivalents	\$ 418,988	\$ 129,669	\$ -	\$ 548,637	\$ -	\$ 2,024,446	\$ 82,453	\$ 783,154	\$ 8,093,557	\$ -	\$ 11,532,247
Investments	130,950,162	29,022,418	-	159,972,580	-	-	14,317,990	7,049,416	-	-	181,339,986
Patient accounts receivable, net	33,903,908	-	-	33,903,908	-	2,259,926	-	2,471,162	5,775,458	-	44,410,454
Other receivables	3,977,343	-	-	3,977,343	559,500	280,553	504,021	-	-	-	5,321,417
Inventories	5,845,470	-	-	5,845,470	-	13,280	-	-	1,942,404	-	7,501,154
Due from affiliates	1,316,775	24,500	(1,316,775)	24,500	1,867,732	-	-	420,324	291,638	(1,892,232)	3,557,507
Prepaid expenses and other current assets	2,256,087	-	-	2,256,087	-	586,555	2,893	-	-	-	1,306,255
Debt service fund	1,306,255	-	-	1,306,255	-	-	-	-	-	-	-
<b>Total current assets</b>	<b>179,974,978</b>	<b>29,176,687</b>	<b>(1,316,775)</b>	<b>207,894,790</b>	<b>2,427,232</b>	<b>5,154,760</b>	<b>14,907,357</b>	<b>10,724,056</b>	<b>15,803,057</b>	<b>(1,892,232)</b>	<b>254,969,020</b>
<b>Assets limited as to use</b>											
Cash	182,366	-	-	182,366	-	-	-	-	-	-	182,366
Construction funds	9,541,685	-	-	9,541,685	-	-	-	-	-	-	9,541,685
Investments held in trust	965,034	-	-	965,034	-	-	-	-	-	-	965,034
Endowment investments	17,922,954	3,300,079	-	21,223,033	-	-	-	5,961,912	6,970,851	-	34,155,796
Investment in subsidiaries	-	19,261,447	-	19,261,447	-	-	-	-	4,182,851	(19,261,447)	-
Funds held in trust by others	6,773,578	-	-	6,773,578	-	-	-	-	780,000	-	10,956,429
Contributions receivable	20,366	1,932,627	-	1,952,993	-	-	-	-	-	-	2,702,993
Funds held in escrow by agreement with State of Connecticut, Health and Educational Facilities Authority and trustees	2,247,255	-	-	2,247,255	-	-	-	-	-	-	2,247,255
<b>Total assets limited as to use</b>	<b>37,673,238</b>	<b>24,574,153</b>	<b>-</b>	<b>62,187,391</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>5,981,912</b>	<b>11,903,702</b>	<b>(19,261,447)</b>	<b>60,771,538</b>
<b>Other assets</b>											
Intangible assets, net	-	-	-	-	-	-	-	-	3,352,875	-	3,352,875
Other receivables	13,694,110	-	-	13,694,110	-	1,119,441	418,875	-	-	(12,664,764)	2,547,462
Deferred financing costs and other assets, net	1,776,176	-	-	1,776,176	-	-	-	-	-	-	1,776,176
<b>Property, plant and equipment</b>											
Land improvements	7,343,577	12,330,635	-	19,674,212	-	-	-	330,275	1,520,000	-	21,524,487
Buildings/leasehold improvements	120,101,634	-	-	120,101,634	-	1,339,331	-	2,238,496	14,617,927	-	138,297,388
Equipment/furniture	234,099,872	21,774	-	234,121,646	-	802,509	-	947,778	15,710,300	-	252,692,233
Accumulated depreciation	(245,331,839)	(47,756)	-	(245,379,595)	-	(1,153,698)	-	(1,829,716)	(1,736,025)	-	(250,089,034)
Construction in progress	45,776,965	-	-	45,776,965	-	-	-	-	-	-	45,776,965
Property, plant and equipment, net	161,980,209	12,304,653	-	174,284,862	-	1,088,142	-	1,686,833	31,112,202	-	206,182,039
<b>Total assets</b>	<b>\$ 395,108,711</b>	<b>\$ 65,995,393</b>	<b>\$ (1,316,775)</b>	<b>\$ 458,787,329</b>	<b>\$ 2,427,232</b>	<b>\$ 7,372,343</b>	<b>\$ 15,326,032</b>	<b>\$ 18,372,801</b>	<b>\$ 62,171,835</b>	<b>\$ (33,858,443)</b>	<b>\$ 531,899,130</b>

**Lawrence + Memorial Corporation and Subsidiaries**  
**Consolidating Balance Sheet**  
**September 30, 2013**

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
<b>Liabilities and Net Assets</b>											
<b>Current liabilities</b>											
Accounts payable	\$ 24,079,667	\$ 148,360	\$ -	\$ 24,228,047	\$ -	\$ 204,726	\$ 75,246	\$ 1,470,128	\$ 18,663,323	\$ -	\$ 42,611,470
Accrued vacation and sick pay	11,623,272	-	-	11,523,272	-	1,057,435	-	-	-	-	12,580,707
Salaries, wages, payroll taxes and amounts withheld from employees	4,495,457	-	-	4,495,457	-	2,851,853	-	-	3,254,244	-	10,101,654
Due to affiliates	1,867,732	758,960	(1,316,775)	1,309,917	582,315	-	-	251,000	1,793,887	(1,892,232)	5,670,981
Due to third party payors	3,826,094	-	-	3,826,094	-	-	-	108,411	-	-	123,017
Other current liabilities	4,497,234	-	-	4,497,234	-	-	-	-	4,360,642	-	9,347,876
Current portion of long-term debt	50,279,476	907,320	(1,316,775)	49,870,021	582,315	3,614,114	86,852	1,830,539	26,542,096	(1,892,232)	80,635,705
Total current liabilities	42,309,345	-	-	42,309,345	-	-	-	-	-	-	42,309,345
Accrued pension and other postretirement benefits	17,774,823	-	-	17,774,823	-	2,407,115	13,906,569	-	1,425,678	(13,837,528)	21,676,677
Other liabilities	86,439,477	13,802,758	-	100,242,235	-	-	-	-	759,562	-	101,001,797
Long-term debt less current portion	196,803,421	14,710,078	(1,316,775)	210,196,724	582,315	6,021,229	13,995,441	1,830,539	28,727,336	(15,729,760)	245,623,524
Total liabilities	170,160,088	50,262,836	-	220,422,924	1,844,917	1,351,114	1,330,591	16,515,262	23,195,021	(18,128,683)	246,531,146
Net assets	22,198,248	1,022,479	-	23,220,727	-	-	-	27,000	834,265	-	24,164,982
Temporarily restricted	5,947,254	-	-	5,947,254	-	-	-	-	9,315,224	-	15,269,478
Permanently restricted	198,305,590	51,285,315	-	249,590,905	1,844,917	1,351,114	1,330,591	16,542,262	33,444,500	(18,128,683)	285,975,606
Total net assets	\$ 395,106,711	\$ 65,995,393	\$ (1,316,775)	\$ 459,787,329	\$ 2,427,232	\$ 7,372,343	\$ 15,326,032	\$ 18,372,801	\$ 62,171,836	\$ (33,858,443)	\$ 531,599,130

# Lawrence + Memorial Corporation and Subsidiaries

## Consolidating Statement of Operations

### Year Ended September 30, 2014

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L & M Systems, Inc.	LMPA	L & M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Net revenues from services to patients	\$ 337,129,192	\$ -	\$ -	\$ 337,129,192	\$ -	\$ -	\$ -	\$ 12,091,733	\$ 74,874,391	\$ -	\$ 455,523,100
Provision for bad debt	(4,930,322)	-	-	(4,930,322)	-	(534,484)	-	(75,000)	(4,755,806)	-	(20,298,386)
Net revenue less provision for bad debt	322,198,870	-	-	322,198,870	-	28,769,300	-	12,016,733	70,218,791	-	483,200,774
Other operating revenues	28,151,061	2,958,303	-	31,109,364	486,265	4,787,861	5,375,804	4,140,108	2,863,590	(28,056,175)	20,952,287
Net assets released from restriction	671,797	204,406	-	876,203	-	-	-	-	-	-	876,203
	351,021,748	3,162,709	-	354,184,457	486,265	33,556,981	5,376,804	16,156,841	73,179,351	(28,056,175)	454,902,204
Operating expenses	143,838,974	-	-	143,838,974	-	37,355,344	-	10,811,798	28,074,489	(6,613,809)	213,457,507
Salaries and wages	51,044,718	-	-	51,044,718	-	6,493,091	-	2,599,219	6,464,031	(7,394,212)	59,185,937
Employee benefits	56,538,441	206,897	-	56,745,338	-	1,334,391	-	330,396	10,595,295	-	71,968,110
Supplies	38,647,787	518,743	-	39,166,530	19,330	3,482,524	334,538	480,287	15,344,077	(4,332,235)	54,475,011
Purchased services	34,490,166	42,946	-	34,533,112	122,200	7,849,748	5,486,160	837,562	4,059,583	(9,568,175)	49,427,170
Other	3,642,721	6,500	-	3,649,221	-	234,269	-	107,318	419,698	(416,000)	3,554,919
Interest	22,728,494	61,692	-	22,790,178	-	-	-	-	4,847,360	-	27,637,538
Depreciation and amortization	353,830,361	838,378	-	354,668,739	141,530	56,720,366	5,820,698	15,255,950	99,294,593	(28,324,480)	473,697,678
	(2,898,519)	2,324,331	-	(464,188)	344,785	(28,133,395)	(444,194)	880,891	3,894,816	256,255	(18,685,472)
Nonoperating gains	180,488	-	-	180,488	-	-	-	-	-	-	180,488
Unrestricted investment income	8,608,113	355,103	-	8,963,216	-	-	203,572	652,017	13,359	-	9,932,164
Interest contribution received from purchase of Westerly Hospital	-	-	-	-	-	-	-	-	5,284,732	-	5,284,732
	8,788,601	355,103	-	9,143,704	-	-	203,572	652,017	5,298,111	-	15,297,434
Net unrealized gains/(losses) over expenses	5,979,688	2,676,164	-	8,655,852	344,735	(28,133,395)	(240,622)	1,642,908	9,182,923	256,255	(9,398,069)
Transfer to L & M Affiliate	31,059	1,515,218	-	1,546,277	(16,465)	-	(88,647)	570,458	774,443	-	2,028,088
Net assets released from restrictions used for purchases of property and equipment	(83,861,262)	12,237,912	-	(71,623,350)	-	20,865,372	-	-	-	-	1,006,500
Donated equipment	139,380	687,140	-	826,520	-	-	-	-	-	-	6,350
Pension related change other than periodic pension costs	6,350	-	-	6,350	-	-	-	-	-	-	6,350
Decrease in unrestricted net assets	(4,281,516)	-	-	(4,281,516)	-	-	-	-	-	-	(4,281,516)
	\$ (31,986,321)	\$ 17,289,704	\$ -	\$ (14,696,617)	\$ 329,270	\$ (2,266,023)	\$ (329,269)	\$ 2,113,966	\$ 9,957,372	\$ 265,255	\$ (4,228,646)

# Lawrence + Memorial Corporation and Subsidiaries

## Consolidating Statement of Operations

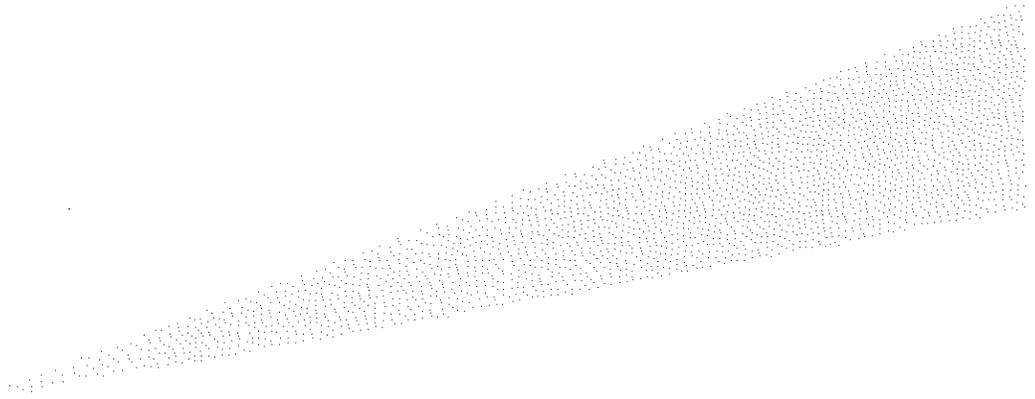
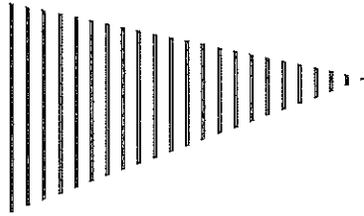
### Year Ended September 30, 2013

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMIPA	L&M Indemnity	Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Net revenues from services to patients	\$ 315,384,108	\$ -	\$ -	\$ 315,384,106	\$ -	\$ 21,002,422	\$ -	\$ 10,960,237	\$ 25,393,974	\$ -	\$ 372,747,739
Provision for bad debt	(12,127,746)	-	-	(12,127,746)	-	(315,036)	-	(75,000)	(2,035,188)	-	(14,555,970)
Net revenue less provision for bad debt	303,256,360	-	-	303,256,360	-	20,687,386	-	10,885,237	23,358,786	-	358,188,769
Other operating revenues	19,592,810	2,885,385	-	22,278,195	652,925	5,172,954	6,080,077	4,104,854	700,530	(17,440,785)	21,448,860
Net assets released from restriction	508,227	240,567	-	748,794	-	-	-	-	-	-	748,794
	323,357,397	2,925,942	-	326,283,339	552,925	25,860,350	6,080,077	14,990,091	24,051,416	(17,440,785)	386,387,413
Operating expenses	149,825,846	-	-	149,825,846	-	26,540,185	-	10,239,955	9,459,006	(2,284,188)	193,780,844
Salaries and wages	43,535,428	-	-	43,535,428	-	4,494,993	-	2,693,128	2,642,707	(4,243,989)	49,062,244
Employee benefits	45,171,409	241,132	-	45,412,541	-	870,017	-	238,625	2,977,900	-	49,529,063
Supplies	23,622,198	3,294,240	-	26,916,378	19,305	1,659,339	195,254	97,759	5,341,642	(2,152,028)	32,278,640
Purchased services	33,252,775	146,028	-	33,398,803	306,857	5,955,816	4,510,614	1,184,984	1,084,106	(8,174,806)	37,265,822
Other	2,706,025	39,577	-	2,744,902	-	243,351	-	128,767	1,200,486	-	2,865,011
Interest	20,641,159	-	-	20,679,595	-	-	-	-	1,873,530	-	22,023,433
Depreciation and amortization	318,753,780	3,759,503	-	322,513,283	326,152	39,303,165	4,706,888	14,611,202	23,599,420	(17,855,023)	387,905,077
Income from operations	4,609,617	(639,561)	-	3,770,056	226,763	(14,042,815)	1,373,209	378,899	481,936	414,238	(7,417,654)
Nonoperating gains	122,109	-	-	122,109	-	-	-	-	373	-	122,109
Unrestricted investment income	6,041,461	881,712	-	6,923,173	-	-	188,569	630,012	17,895,540	(16,098,755)	7,752,127
Income/(loss) from investments	-	-	-	-	-	-	-	-	-	-	-
Inherent contribution received from purchase of Westerly Hospital	6,163,670	881,712	-	7,045,282	-	-	-	650,012	17,895,540	(16,098,755)	21,746,792
	10,767,167	48,161	-	10,815,328	226,763	(14,042,815)	1,571,778	1,009,901	18,357,909	(15,684,520)	9,871,018
Excess of revenues over expenses	9,113,432	2,690,788	-	11,704,230	139,626	15,724,357	(141,849)	484,474	4,837,112	-	22,553,354
Net unrealized (losses)/gains on investments	1,136,545	(21,837,540)	-	(20,701,005)	-	-	-	-	-	-	12,045,865
Transfer to L & M Affiliate	-	-	-	-	-	-	-	-	-	-	-
Net assets released from restrictions used for purchases of property and equipment	167,751	-	-	167,751	-	-	-	-	-	-	167,751
Donated equipment	-	-	-	-	-	-	-	-	-	-	-
Pension related changes other than periodic pension costs	5,929,845	-	-	5,929,845	-	-	-	-	-	-	5,929,845
Decrease in unrestricted net assets	\$ 27,114,760	\$ (19,188,691)	\$ -	\$ 7,916,069	\$ 386,389	\$ 1,681,542	\$ 1,429,929	\$ 1,493,375	\$ 23,195,021	\$ (15,684,520)	\$ 20,397,605

FINANCIAL STATEMENTS

Northeast Medical Group  
Years Ended September 30, 2014 and 2013  
with Report of Independent Auditors

Ernst & Young LLP



Building a better  
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# Northeast Medical Group

## Financial Statements

Years Ended September 30, 2014 and 2013

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## Report of Independent Auditors

The Board of Directors  
Northeast Medical Group

We have audited the accompanying financial statements of Northeast Medical Group (“NEMG”), which comprise the balance sheets as of September 30, 2014 and 2013, and the related statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

### **Management’s Responsibility for the Financial Statements**

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

### **Auditor’s Responsibility**

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor’s judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity’s preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.



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## Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Northeast Medical Group at September 30, 2014 and 2013, and the results of its operations and changes in its net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

*Ernst + Young LLP*

December 23, 2014

## Northeast Medical Group

## Balance Sheets

	September 30	
	2014	2013
<b>Assets</b>		
Current assets:		
Cash and cash equivalents	\$ 2,973,459	\$ 11,005,495
Accounts receivable for services to patients, less allowance for uncollectible accounts of approximately \$4,599,000 and \$5,587,000 at September 30, 2014 and 2013, respectively	13,324,451	7,360,118
Due from affiliates, net	3,786,174	—
Prepaid expenses and other current assets	2,913,294	2,760,653
Total current assets	<u>22,997,378</u>	<u>21,126,266</u>
Goodwill	266,975	266,975
Property, plant, and equipment:		
Furniture and equipment	4,241,332	2,365,740
Leasehold improvements	1,217,073	1,348,933
	<u>5,458,405</u>	<u>3,714,673</u>
Less accumulated depreciation and amortization	2,417,456	2,347,494
	<u>3,040,949</u>	<u>1,367,179</u>
Construction in Progress	203,394	—
	<u>3,244,343</u>	<u>1,367,179</u>
Other long-term assets	2,012,669	3,324,772
Total assets	<u>\$ 28,521,365</u>	<u>\$ 26,085,192</u>
<b>Liabilities and unrestricted net assets</b>		
Current liabilities:		
Accounts payable and accrued expenses	\$ 6,699,037	\$ 4,443,853
Accrued salaries, wages, and payroll taxes	14,528,530	12,645,364
Third-party payor liabilities	3,162,744	1,322,818
Due to affiliates, net	—	5,104,242
Total current liabilities	<u>24,390,311</u>	<u>23,516,277</u>
Unrestricted net assets	4,131,054	2,568,915
Total liabilities and unrestricted net assets	<u>\$ 28,521,365</u>	<u>\$ 26,085,192</u>

*See accompanying notes.*

## Northeast Medical Group

## Statements of Operations and Changes in Unrestricted Net Assets

	Year Ended September 30	
	2014	2013
Operating revenue:		
Net patient service revenue	\$ 128,511,845	\$ 100,083,369
Less: Provision for bad debts	5,357,134	3,353,671
Net patient service revenue, less provision for bad debts	123,154,711	96,729,698
Contract and other revenue	81,519,629	67,190,525
Total operating revenue	204,674,340	163,920,223
Operating expenses:		
Salaries and wages	125,799,688	104,904,493
Employee benefits	22,402,600	21,466,568
Professional fees, supplies, and other	99,858,399	72,706,602
Depreciation	640,319	596,711
Amortization	1,594,390	1,817,319
Total operating expenses	250,295,396	201,491,693
Deficiency of revenue over expenses	(45,621,056)	(37,571,470)
Net asset transfer from Yale-New Haven Health Services Corporation	47,183,195	37,571,470
Increase in unrestricted net assets	1,562,139	-
Unrestricted net assets, beginning of period	2,568,915	2,568,915
Unrestricted net assets, end of period	<u>\$ 4,131,054</u>	<u>\$ 2,568,915</u>

*See accompanying notes.*

## Northeast Medical Group

## Statements of Cash Flows

	Year Ended September 30	
	2014	2013
<b>Cash flows from operating activities</b>		
Increase in unrestricted net assets	\$ 1,562,139	\$ —
Adjustments to reconcile increase in unrestricted net assets to net cash used in operating activities:		
Depreciation	640,319	596,711
Amortization	1,594,390	1,817,319
Bad debt expense	5,357,134	3,353,671
Net asset transfer from Yale-New Haven Health Services Corporation for operations	(45,621,056)	(37,571,470)
Changes in operating assets and liabilities:		
Accounts receivable, net	(11,321,467)	(5,787,720)
Due (to) from affiliates, net	(8,890,416)	6,469,426
Prepaid expenses and other current assets	(152,641)	(436,082)
Other long term assets	(282,287)	(844,070)
Accounts payable and accrued expenses	2,255,184	1,909,791
Accrued salaries, wages, and payroll taxes	1,883,166	1,399,054
Third-party payor liabilities	1,839,926	663,682
Net cash used in operating activities	<u>(51,135,609)</u>	<u>(28,429,688)</u>
<b>Cash flows from investing activities</b>		
Acquisitions of property, plant, and equipment	(955,344)	(970,226)
Net asset transfer from Yale-New Haven Health Services Corporation for acquisition of PriMed	(1,562,139)	—
Net cash used in investing activities	<u>(2,517,483)</u>	<u>(970,226)</u>
<b>Cash flows from financing activities</b>		
Net asset transfer from Yale-New Haven Health Services Corporation for operations	45,621,056	37,571,470
Net cash provided by financing activities	<u>45,621,056</u>	<u>37,571,470</u>
Net change in cash and cash equivalents	(8,032,036)	8,171,556
Cash and cash equivalents, beginning of year	11,005,495	2,833,939
Cash and cash equivalents, end of year	<u>\$ 2,973,459</u>	<u>\$ 11,005,495</u>

*See accompanying notes.*

Northeast Medical Group  
Notes to Financial Statements

September 30, 2014

**1. Organization and Significant Accounting Policies**

Northeast Medical Group (NEMG) is a tax-exempt medical foundation that provides physician-related services to Bridgeport, Greenwich and Yale-New Haven Hospitals (the Hospitals) and their surrounding communities. NEMG commenced operations on April 1, 2010, using the existing legal infrastructure of its predecessor, Mill Hill Medical Consultants, Inc.

Yale-New Haven Health Services Corporation (YNHHSC) is the sole member of NEMG, Bridgeport Hospital (BH), Yale-New Haven Hospital (YNHH), Greenwich Health Care Services, Inc. (GHCS) and Y-NHH-MSO, Inc. (MSO). YNHH, BH and GHCS are tax-exempt organizations and serve as the sole member/parent for their respective group of regional healthcare providers and related entities. Pursuant to its corporate bylaws, NEMG operates autonomously with a separate Board of Directors, management staff and medical staff; however, as the sole member, YNHHSC retains certain reserve powers such as approving NEMG's strategic plans, operating and capital budgets and Board of Directors appointments. YNHHSC has both the intent and ability to provide financial support relative to operations and strategic acquisitions to NEMG for the foreseeable future.

Concurrent with the issuance of the Connecticut Health and Educational Facilities Authority (CHEFA) Revenue Bonds, Yale-New Haven Health Obligated Group Issue, Series A, B, C, D and E dated May 20, 2014, six members of the Yale-New Haven Health System and subsidiaries were combined to form an Obligated Group. The Obligated Group comprises YNHHSC, YNHH, Yale-New Haven Continuum Corporation, BH, the Bridgeport Foundation, and NEMG (the "Obligated Group"). YNHHSC serves as agent of the Obligated Group. The members of the Obligated Group have adopted certain governance provisions in their certificates of incorporation and by-laws pursuant to which YNHHSC retains the authority to directly take certain actions on behalf of each Obligated Group member without the approval of the board of trustees of the applicable Obligated Group member, including the incurrence of indebtedness on behalf of each Obligated Group member, the management and control of the liquid assets of each, and the appointment of the president and chief executive officer of each Obligated Group member.

On June 1, 2014, NEMG and YNHHSC acquired certain assets of PriMed, LLC ("PriMed"), a physician practice for approximately \$54.2 million. NEMG received \$1.6 million in assets. YNHHSC contributed the entire purchase price, of which \$25 million was transferred each from YNHH and BH to YNHHSC. PriMed is a multi-specialty group of approximately 120 providers in 36 locations across Fairfield County and New Haven County, Connecticut. PriMed also is the sole member of a gastroenterology surgery center, the Fairfield County Endoscopy Center, and

## Northeast Medical Group

### Notes to Financial Statements (continued)

#### **1. Organization and Significant Accounting Policies (continued)**

offers a number of ancillary services such as a sleep laboratory, cardiac diagnostic testing, physical therapy and nutritional counseling. Under the terms of the transaction, NEMG and YNHHSAC acquired substantially all the assets of PriMed and a 40% interest in the gastroenterology surgery center. YNHHSAC deposited \$5.5 million into escrow to fund the purchase of the remaining 60% membership interest in the gastroenterology surgery center. Also at acquisition, YNHHSAC recorded a liability of \$5 million for the amounts to be paid to PriMed physicians contingent on their continued service in the three years following the acquisition closing date as per the agreement.

#### **Use of Estimates**

The preparation of the financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets, including estimated uncollectibles for accounts receivable for services to patients, and liabilities, including estimated payables to third-party payers and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the amounts of revenue and expenses during the reporting period. There is at least reasonable possibility that certain estimates will change by material amounts in the near term. Actual results could differ from these estimates.

#### **Cash Equivalents**

Cash and cash equivalents include investments in highly liquid financial instruments with original maturities of three months or less when purchased, which are not classified as assets limited as to use or held in short-term investments.

Cash and cash equivalents are maintained with domestic financial institutions with deposits which exceed federally insured limits. It is NEMG's policy to monitor the financial strength of these institutions.

#### **Goodwill**

At least annually, NEMG is required to perform a review of its goodwill for impairment. Based on NEMG's review at September 30, 2014, goodwill, which is related to the acquisition of the Huntington practice, was determined not to be impaired based on the practice's positive financial results.

## Northeast Medical Group

### Notes to Financial Statements (continued)

#### **1. Organization and Significant Accounting Policies (continued)**

##### **Accounts Receivable**

Patient accounts receivable result from the health care services provided by NEMG. Additions to the allowance for doubtful accounts result from the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts.

The amount of the allowance for doubtful accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage, and other collection indicators.

##### **Investments**

NEMG has designated all investments reported in the accompanying balance sheets as trading securities. As such, unrealized gains and losses are included in deficiency of revenue over expenses. Investments in cash and cash equivalents with readily determinable fair values and investments in debt securities are measured at fair value in the accompanying balance sheets.

Realized gains and losses on investments, interest and dividends are included in gain or loss from operations unless the income or loss is restricted by donor or law.

##### **Property, Plant, and Equipment**

Property, plant, and equipment purchased are recorded at cost and those acquired by gifts and bequests are recorded at appraised or fair value established at the date of contribution. The recorded assets and the related accumulated depreciation are removed from the accounts when such assets are disposed of and any resulting gain or loss is included in operations. Depreciation of property, plant, and equipment is computed on the straight-line method in amounts sufficient to depreciate the cost of the assets over their estimated useful lives. Depreciation expense was \$640,319 and \$596,711 for the years ended September 30, 2014 and 2013, respectively.

##### **Uncompensated Care and Community Benefit Expense**

NEMG's commitment to community service is evidenced by services provided to the poor and benefits provided to the broader community. Services provided to the poor include services provided to persons who cannot afford healthcare because of inadequate resources and/or who are uninsured or underinsured.

## Northeast Medical Group

### Notes to Financial Statements (continued)

#### **1. Organization and Significant Accounting Policies (continued)**

NEMG makes available free care programs for qualifying patients. In accordance with the established policies of NEMG, during the registration, billing and collection process a patient's eligibility for free care funds is determined. For patients who were determined by NEMG to have the ability to pay but did not, the uncollected amounts are bad debt expense. For patients who do not avail themselves of any free care program and whose ability to pay cannot be determined by NEMG, care given but not paid for, is classified as charity care.

Together, charity care and bad debt expense represent uncompensated care. The estimated cost of total uncompensated care is approximately \$4,286,911 and \$2,811,246 for the years ended September 30, 2014 and 2013, respectively. The estimated cost of uncompensated care is based on the ratio of cost to charges associated with providing charity care.

The estimated cost of charity care provided was \$903,089 and \$790,638 for the years ended September 30, 2014 and 2013, respectively. The estimated cost of charity care is based on the ratio of cost to charges, as determined by company-specific data.

For the years ended September 30, 2014 and 2013, bad debt expense at charges was \$5,357,134 and \$3,353,671, respectively. For the years ended September 30, 2014 and 2013, bad debt expense at cost was \$3,383,822 and \$2,020,608. The bad debt expense is multiplied by the ratio of cost to charges for purposes of inclusion in the total uncompensated care amount identified above.

#### **Medical Malpractice Insurance**

The physicians of NEMG are covered by the Hospital's malpractice insurance policy. This charge is a component of other expenses.

#### **Deficiency of Revenue over Expenses**

In the accompanying statement of operations and changes in unrestricted net assets, deficiency of revenue over expenses is the performance indicator.

Contributions of, or restricted to, property, plant, and equipment, transfers of assets to and from affiliates for other than goods and services, and pension and other post-retirement liability adjustments are excluded from the performance indicator but are included in the change in net assets.

## Northeast Medical Group

### Notes to Financial Statements (continued)

#### 1. Organization and Significant Accounting Policies (continued)

##### Net Patient Service Revenue

Accounts receivable for services to patients and net patient service revenue are recorded when patient services are performed. NEMG records net patient service revenue for various payers based on a fee-for-service arrangement. Amounts received from certain payers are different from established billing rates of NEMG, and the difference is accounted for as contractual allowances.

Revenue from Medicare and Medicaid programs accounted for approximately 38% and 34% of NEMG net patient service revenue for the years ended September 30, 2014 and 2013, respectively. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by material amounts in the near term. NEMG believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on NEMG.

Patient service revenue for the year ended September 30, 2014, net of contractual allowances and discounts (but before the provision for bad debts), recognized from these major payor sources based on primary insurance designation, is as follows:

	2014	2013
Third-party	\$ 125,882,388	\$ 95,391,944
Self-pay	\$2,629,457	4,691,425
Total all payors	\$ 128,511,845	\$ 100,083,369

Deductibles and copayments under third-party payment programs within the third-party payor amount above are the patient's responsibility and NEMG considers these amounts in its determination of the provision for bad debts based on collection experience. Accounts receivable are also reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, NEMG analyzes its past history and identifies trends for each of its major

## Northeast Medical Group

### Notes to Financial Statements (continued)

#### 1. Organization and Significant Accounting Policies (continued)

payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts.

NEMG's allowance for doubtful accounts totaled approximately \$4,599,000 and \$5,587,000 at September 30, 2014 and 2013, respectively. The allowance for doubtful accounts for self-pay patients was approximately 83% of self-pay accounts receivable as of September 30, 2014 and 2013. Overall, the total of self-pay discounts and write-offs did not change significantly in 2013. NEMG did not experience significant changes in write-off trends and did not change its charity care policy in 2014.

#### Income Taxes

NEMG is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and is exempt from federal or state income taxes on related income pursuant to Section 501(a) of the Code.

#### 2. Transactions with Hospitals

##### Contract Revenue

NEMG has a contract with the Hospitals to provide the following types of physician-related services: patient care, medical education, research and administration. In return for these services, the Hospitals pay NEMG a contract fee based upon the portion of each physician's time that is spent performing these services for the Hospitals. The fee was \$81,519,629 and \$67,190,525 for the years ended September 30, 2014 and 2013, respectively.

##### Cost Sharing

Certain overhead expenses incurred by the Hospitals that directly or indirectly benefit NEMG are charged to NEMG. Those expenses relate to the following services: financial management, data processing, human resources, legal services, secretarial and administrative support, certain employee benefits, and insurance coverage.

## Northeast Medical Group

### Notes to Financial Statements (continued)

#### 3. Retirement Benefit Plans

NEMG is part of the Yale-New Haven Hospital's defined benefit pension plan (the Defined Benefit Plan) covering substantially all employees. The benefits are based on years of service and employees' average compensation as defined by the plan documents. NEMG and certain other affiliates of Yale-New Haven Hospital make contributions in amounts sufficient to meet the required benefits to be paid to plan participants as they become due as required under the Employee Retirement Income Security Act of 1974. NEMG recorded expense of \$3,516,178 and \$3,348,007 for the years ended September 30, 2014 and 2013, respectively.

#### 4. Commitments and Contingencies

Various lawsuits and claims arising in the normal course of operations are pending or are in progress against NEMG. Such lawsuits and claims are either specifically covered by insurance as explained in Note 1 or are not deemed material. While the outcome of these lawsuits cannot be determined at this time, management believes that any loss, which may arise from these actions, will not have a material adverse effect on the financial position or results of operations and changes in unrestricted net assets of NEMG.

NEMG leases certain office space and equipment from both related and unrelated parties. Rent expense was approximately \$6,295,931 and \$4,867,876 for the years ended September 30, 2014 and 2013, respectively. The total rent for related parties was approximately \$1,508,286 and \$1,286,385 for the years ended September 30, 2014 and 2013, respectively.

At September 30, 2014, the future minimum rental commitments under these noncancellable operating leases were:

	<u>Total Future Minimum Rental Commitments</u>
Fiscal year:	
2015	\$ 9,435,168
2016	8,946,441
2017	8,167,760
2018	7,333,344
2019	7,006,221
Thereafter	7,711,168
	<u>\$ 48,600,102</u>

## Northeast Medical Group

## Notes to Financial Statements (continued)

**4. Commitments and Contingencies (continued)**

During 2014 and 2013, NEMG recorded decreases in net patient service revenue of approximately \$1,839,927 and \$302,861, respectively, related to changes in previously estimated third-party payor settlements.

**5. Functional Expenses**

NEMG provides general physician-related services to residents within its geographic location. Expenses related to these services are as follows:

	Year Ended September 30	
	2014	2013
Health care services	\$ 228,560,350	\$ 186,865,034
General and administrative	21,735,046	14,626,659
	<u>\$ 250,295,396</u>	<u>\$ 201,491,693</u>

**6. Related-Party Transactions**

NEMG provides physician-related services to the Hospitals and is billed for certain overhead expenses incurred by the YNHHS that directly or indirectly benefit NEMG, as described in Note 2. In addition, NEMG purchases certain management services from the delivery networks. The related amounts are as follows:

	Year Ended September 30	
	2014	2013
Services to affiliates:		
YNHHS	<u>\$ 81,519,629</u>	<u>\$ 67,190,525</u>
Due (to) from affiliate:		
Y-NH Medical Service Organization	\$ (134,517)	\$ (143,196)
Bridgeport Hospital	1,796,967	1,381,761
YNHHS	(1,127,449)	(6,653,943)
Greenwich Hospital	641,262	859,765
Yale-New Haven Hospital	2,609,911	(548,629)
	<u>\$ 3,786,174</u>	<u>\$ (5,104,242)</u>

## Northeast Medical Group

### Notes to Financial Statements (continued)

#### 7. Fair Values Measurements

In determining fair value, NEMG utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. NEMG also considers nonperformance risk in the overall assessment of fair value.

ASC No. 820-10 establishes a three tier valuation hierarchy for fair value disclosure purposes. This hierarchy is based on the transparency of the inputs utilized for the valuation. The three levels are defined as follows:

*Level 1:* Quoted prices in active markets that are accessible at the measurement date for identical assets or liabilities. This established hierarchy assigns the highest priority to Level 1 assets.

*Level 2:* Observable inputs that are based on data not quoted in active markets, but corroborated by market data.

*Level 3:* Unobservable inputs that are used when little or no market data is available. The Level 3 inputs are assigned the lowest priority.

Financial assets carried at fair value for the years ended September 30, 2014 and 2013 consisted of cash and cash equivalents and were \$2,973,459 and \$11,005,495, respectively, both classified as Level 1 assets.

#### 8. Grant Revenue

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payment program beginning in 2011 for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are available to providers that adopt, implement, or upgrade certified EHR technology. In subsequent years, providers must demonstrate meaningful use of such technology to qualify for additional Medicaid incentive payments. Providers that do not successfully demonstrate meaningful use of EHR technology are subject to payment penalties or downward adjustments to their Medicare payments beginning in federal fiscal year 2015.

## Northeast Medical Group

## Notes to Financial Statements (continued)

**8. Grant Revenue (continued)**

NEMG uses a grant accounting model to recognize revenue for the Medicare and Medicaid EHR incentive payments. Under this accounting policy, EHR incentive payment revenue is recognized when NEMG is reasonably assured that the EHR meaningful use criteria for the required period of time were met and that the grant revenue will be received. EHR incentive payment revenue totaling approximately \$2,023,531 and \$1,130,000 for Medicare for the year ended September 30, 2014 and 2013, respectively, is included in contract and other revenue in the accompanying statement of operations and changes in unrestricted net assets. Income from incentive payments is subject to retrospective adjustment upon final settlement of the applicable cost report from which payments were calculated. Additionally, NEMG's attestation of compliance with the meaningful use criteria is subject to audit by the federal government.

**9. Subsequent Events**

Subsequent events have been evaluated through December 23, 2014, which is the date the financial statements were available to be issued. No events have occurred that require disclosure or adjustment of the financial statements.

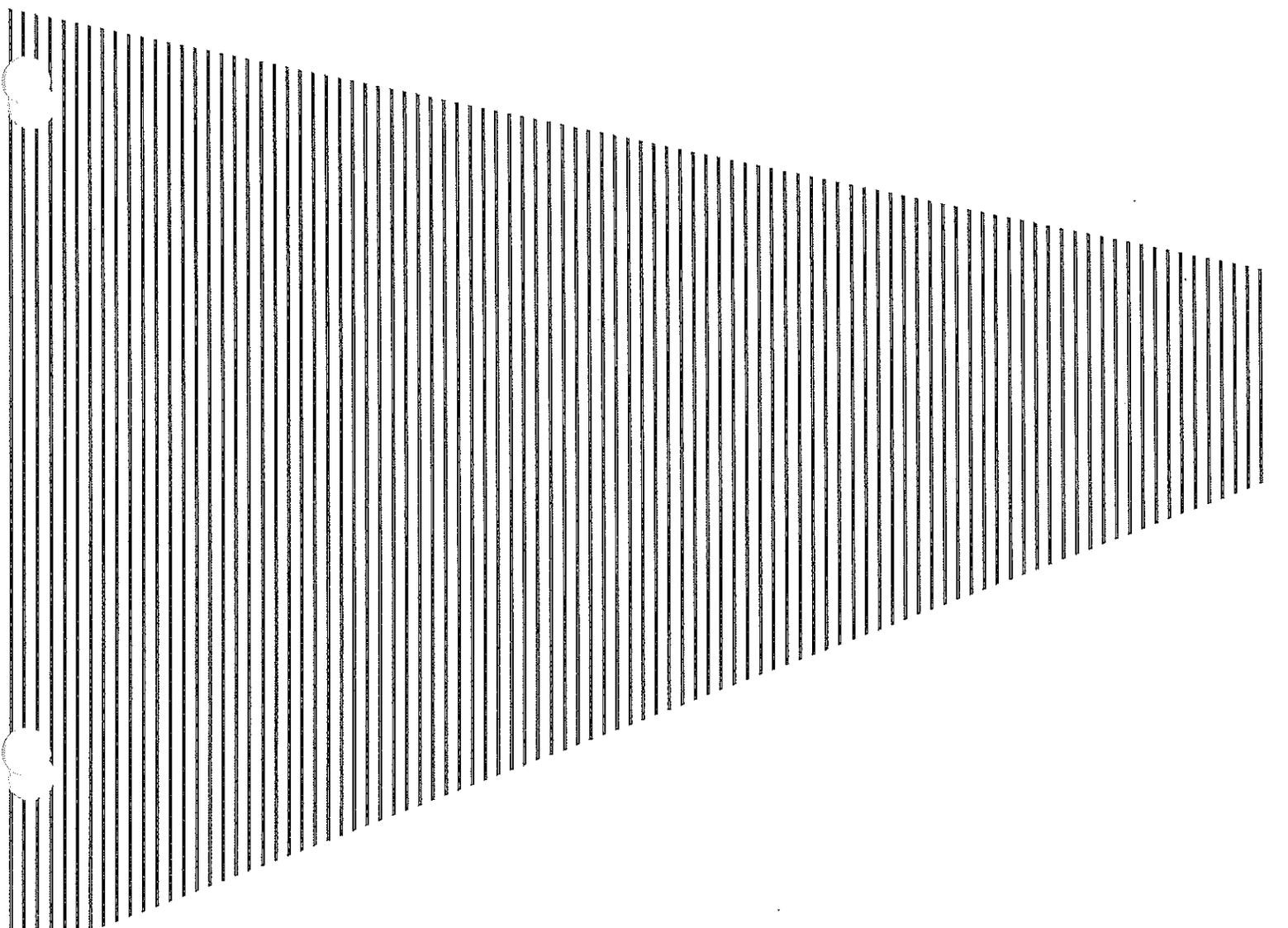
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**ATTACHMENT IX**

**NON-PROFIT**

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the COA proposal in the following recasting format:

Entity	FY 2014		FY 2016		FY 2017		FY 2018		FY 2019		FY 2020	
	Actual Results	Projected	Projected	Incremental								
<b>OPERATING REVENUE</b>												
Total Gross Patient Revenue	\$376,215,000	\$464,453,000	\$31,578,000	\$63,156,000	\$57,295,000	\$63,156,000	\$63,156,000	\$63,156,000	\$63,156,000	\$63,156,000	\$63,156,000	\$63,156,000
Less: Allowances	\$248,273,000	\$308,810,000	\$15,728,000	\$30,563,000	\$34,248,000	\$30,563,000	\$30,563,000	\$30,563,000	\$30,563,000	\$30,563,000	\$30,563,000	\$30,563,000
Less: Charity Care	\$1,430,000	\$1,430,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Less: Other Deductions	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Net Patient Service Revenue	\$126,512,000	\$177,086,000	\$15,776,000	\$32,448,000	\$23,047,000	\$32,448,000	\$32,448,000	\$32,448,000	\$32,448,000	\$32,448,000	\$32,448,000	\$32,448,000
Medicare	\$31,827,000	\$43,638,000	\$6,224,000	\$10,449,000	\$54,107,000	\$10,449,000	\$10,449,000	\$10,449,000	\$10,449,000	\$10,449,000	\$10,449,000	\$10,449,000
Medicaid	\$17,737,000	\$18,488,000	\$2,069,000	\$4,137,000	\$22,625,000	\$4,137,000	\$4,137,000	\$4,137,000	\$4,137,000	\$4,137,000	\$4,137,000	\$4,137,000
CHAMPUS & Tricare	\$630,000	\$671,000	\$461,000	\$921,000	\$1,592,000	\$921,000	\$921,000	\$921,000	\$921,000	\$921,000	\$921,000	\$921,000
Other	\$52,000	\$67,000	\$47,000	\$47,000	\$47,000	\$47,000	\$47,000	\$47,000	\$47,000	\$47,000	\$47,000	\$47,000
Total Government	\$50,245,000	\$62,864,000	\$7,754,000	\$15,507,000	\$78,371,000	\$15,507,000	\$15,507,000	\$15,507,000	\$15,507,000	\$15,507,000	\$15,507,000	\$15,507,000
Commercial Insurers	\$58,998,000	\$98,877,000	\$1,465,000	\$1,419,000	\$117,091,000	\$1,419,000	\$1,419,000	\$1,419,000	\$1,419,000	\$1,419,000	\$1,419,000	\$1,419,000
Uninsured	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Self Pay	\$9,417,000	\$15,003,000	\$116,000	\$232,000	\$15,538,000	\$232,000	\$232,000	\$232,000	\$232,000	\$232,000	\$232,000	\$232,000
Workers Compensation	\$469,000	\$353,000	\$248,000	\$492,000	\$552,000	\$492,000	\$492,000	\$492,000	\$492,000	\$492,000	\$492,000	\$492,000
Other	\$0	\$0	\$207,000	\$1,295,000	\$1,295,000	\$1,295,000	\$1,295,000	\$1,295,000	\$1,295,000	\$1,295,000	\$1,295,000	\$1,295,000
Total Non-Government	\$78,266,000	\$114,233,000	\$8,023,000	\$16,938,000	\$134,714,000	\$16,938,000	\$16,938,000	\$16,938,000	\$16,938,000	\$16,938,000	\$16,938,000	\$16,938,000
<b>Net Patient Service Revenue<sup>a</sup></b>												
(Government+Non-Government)	\$126,512,000	\$177,097,000	\$15,777,000	\$32,445,000	\$213,085,000	\$32,445,000	\$32,445,000	\$32,445,000	\$32,445,000	\$32,445,000	\$32,445,000	\$32,445,000
Less: Provision for Bad Debts	\$5,537,000	\$2,011,000	\$226,000	\$451,000	\$2,602,000	\$451,000	\$451,000	\$451,000	\$451,000	\$451,000	\$451,000	\$451,000
Net Patient Service Revenue less provision for bad debts	\$123,465,000	\$175,086,000	\$15,550,000	\$31,994,000	\$210,583,000	\$31,994,000	\$31,994,000	\$31,994,000	\$31,994,000	\$31,994,000	\$31,994,000	\$31,994,000
Other Operating Revenue	\$81,820,000	\$111,850,000	\$4,522,000	\$9,243,000	\$124,448,000	\$9,243,000	\$9,243,000	\$9,243,000	\$9,243,000	\$9,243,000	\$9,243,000	\$9,243,000
Net Assets Released from Restrictions	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL OPERATING REVENUE</b>	\$204,875,000	\$286,936,000	\$20,172,000	\$41,237,000	\$335,031,000	\$41,237,000	\$41,237,000	\$41,237,000	\$41,237,000	\$41,237,000	\$41,237,000	\$41,237,000
<b>OPERATING EXPENSES</b>												
Salaries and Wages	\$125,800,000	\$156,091,000	\$17,410,000	\$33,914,000	\$193,127,000	\$33,914,000	\$33,914,000	\$33,914,000	\$33,914,000	\$33,914,000	\$33,914,000	\$33,914,000
Fringe Benefits	\$22,403,000	\$33,996,000	\$4,210,000	\$8,042,000	\$42,708,000	\$8,042,000	\$8,042,000	\$8,042,000	\$8,042,000	\$8,042,000	\$8,042,000	\$8,042,000
Physicians Fees	\$44,540,000	\$67,508,000	\$2,402,000	\$5,793,000	\$7,464,000	\$5,793,000	\$5,793,000	\$5,793,000	\$5,793,000	\$5,793,000	\$5,793,000	\$5,793,000
Supplies and Drugs	\$4,525,000	\$10,823,000	\$1,191,000	\$2,939,000	\$3,454,000	\$2,939,000	\$2,939,000	\$2,939,000	\$2,939,000	\$2,939,000	\$2,939,000	\$2,939,000
Depreciation and Amortization	\$2,235,000	\$3,037,000	\$121,000	\$256,000	\$3,298,000	\$256,000	\$256,000	\$256,000	\$256,000	\$256,000	\$256,000	\$256,000
Provision for Bad Debts-Other <sup>b</sup>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Interest Expense	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mainpact Insurance Cost	\$8,287,000	\$7,028,000	\$1,285,000	\$2,592,000	\$9,760,000	\$2,592,000	\$2,592,000	\$2,592,000	\$2,592,000	\$2,592,000	\$2,592,000	\$2,592,000
Lease Expense	\$6,887,000	\$10,938,000	\$1,068,000	\$1,577,000	\$13,293,000	\$1,577,000	\$1,577,000	\$1,577,000	\$1,577,000	\$1,577,000	\$1,577,000	\$1,577,000
Other Operating Expenses	\$55,420,000	\$52,287,000	\$2,441,000	\$4,885,000	\$58,218,000	\$4,885,000	\$4,885,000	\$4,885,000	\$4,885,000	\$4,885,000	\$4,885,000	\$4,885,000
<b>TOTAL OPERATING EXPENSES</b>	\$230,297,000	\$341,705,000	\$30,139,000	\$50,003,000	\$408,481,000	\$50,003,000	\$50,003,000	\$50,003,000	\$50,003,000	\$50,003,000	\$50,003,000	\$50,003,000
<b>INCOME/(LOSS) FROM OPERATIONS</b>	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000
<b>NON-OPERATING REVENUE</b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES</b>	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000	\$845,622,000
<b>Principal Payments</b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>PROFITABILITY SUMMARY</b>												
Hospital Operating Margin	-22.3%	-18.1%	-49.4%	-45.5%	-21.9%	-45.5%	-45.5%	-45.5%	-45.5%	-45.5%	-45.5%	-45.5%
Hospital Non-Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Hospital Total Margin	-22.3%	-18.1%	-49.4%	-45.5%	-21.9%	-45.5%	-45.5%	-45.5%	-45.5%	-45.5%	-45.5%	-45.5%
<b>FTEs</b>	1,447	1,175	181	1,175	326	1,175	326	1,175	326	1,175	326	1,175
<b>VOLUME STATISTICS<sup>c</sup></b>												
Inpatient Discharges	283,000	320,000	19,700	39,500	350,500	39,500	39,500	39,500	39,500	39,500	39,500	39,500
Outpatient Visits	696,000	980,000	116,700	233,900	1,218,900	233,900	233,900	233,900	233,900	233,900	233,900	233,900
<b>TOTAL VOLUME</b>	\$79,000	\$1,300,000	\$136,400	\$273,400	\$1,579,400	\$273,400	\$273,400	\$273,400	\$273,400	\$273,400	\$273,400	\$273,400

<sup>a</sup> Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.  
<sup>b</sup> Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No. 2011-07, July 2011.  
<sup>c</sup> Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.



**ATTACHMENT X**

## Northeast Medical Group Assumptions

<u>Net Revenue Rate Increases</u>	FY 2016	FY 2017	FY 2018	FY 2019
1) Government	0.0%	0.0%	0.0%	0.0%
2) Non-Government	3.2%	3.2%	3.2%	3.2%
3) Inpatient Volume	0.3%	0.3%	0.3%	0.3%
4) Outpatient Volume	0.5%	0.5%	0.5%	0.5%
	FY 2016	FY 2017	FY 2018	FY 2019
<b><u>EXPENSES</u></b>				
A. Salaries and Fringe Benefits	2.0%	2.0%	2.0%	2.0%
<b>B. Non-Salary</b>				
1) Supplies and Drugs	2.0%	2.0%	2.0%	2.0%
2) Professional and Contracted Services	2.0%	2.0%	2.0%	2.0%
3) Malpractice Insurance and Lease Expense	2.0%	2.0%	2.0%	2.0%
4) All Other Expenses	2.0%	2.0%	2.0%	2.0%
	FY 2016	FY 2017	FY 2018	FY 2019
<b><u>FTEs</u></b>				
1) Total estimated FTEs	1,175	1,175	1,175	1,175

## Lawrence + Memorial Physician Associates Merger with and into NEMG Assumptions

<u>Net Revenue Rate Increases</u>	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
1) Government	0 - 1.4%	0 - 1.4%	0 - 1.2%	0 - 1.2%
2) Non-Government	0 - 2.5%	0 - 2.0%	0 - 2.0%	0 - 2.0%
3) Inpatient Volume	0.0%	0.0%	0.0%	0.0%
4) Outpatient Volume	0.0%	0.0%	0.0%	0.0%
	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
<b><u>EXPENSES</u></b>				
A. Salaries and Fringe Benefits	1.5%	1.5%	1.5%	1.5%
B. Non-Salary				
1) Supplies and Drugs	2.0%	1.5%	1.5%	1.5%
2) Professional and Contracted Services	2.0%	1.5%	1.5%	1.5%
3) Malpractice Insurance and Lease Expense	0.0%	0.0%	0.0%	0.0%
4) All Other Expenses	1.0%	1.0%	1.0%	1.0%
5) All Other Expenses				
	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
<b><u>FTEs</u></b>				
1) Total estimated FTEs	<u>181</u>	<u>0</u>	<u>0</u>	<u>0</u>

Note - The above increase projections reflect all changes relating to Medicare and Medicaid reimbursement regulations.

**ATTACHMENT XI**

LMPA Practice Locations in Connecticut

Last Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
Elsamra	Shady	M	MD	L+MMG Behavioral Health	365 Montauk Ave	New Londn CT		06320	1144458785	Psychiatry	Psychiatry	
Mendelovicz	Naomi	M	MD	L+MMG Behavioral Health	365 Montauk Ave	New Londn CT		06320	14877710141	Psychiatry	Psychiatry	
Miano	Alexander	P	MD	L+MMG Behavioral Health	194 Howard St	New Londn CT		06320	19322211612	Psychiatry	Psychiatry	
Talavera-Briggs	Amarilis	M	MD	L+MMG Behavioral Health	194 Howard St	New Londn CT		06320	1924498783	Psychiatry	Psychiatry	
Bagheri	Roshanak		MD	L+MMG Cardiology New London	194 Howard St	New Londn CT		06320	1023222650	Medicine	Cardiology	
Gaudio	Jon	C	MD	L+MMG Cardiology New London	194 Howard St	New Londn CT		06320	1205865263	Medicine	Cardiology	
Ehrlich	Brian	S	MD	L+MMG Cardiology Waterford	196 Parkway S Site 103	Waterford CT		06395	1659329688	Medicine	Cardiology	
Flango	Mark	N	DO	L+MMG Cardiology Waterford	196 Parkway S Site 103	Waterford CT		06395	1245214220	Medicine	Cardiology	
Minecki	Peter	S	MD	L+MMG Cardiology Waterford	196 Parkway S Site 103	Waterford CT		06395	1366482566	Medicine	Cardiology	
Popkin	Francis	J	MD	L+MMG Cardiology Waterford	196 Parkway S Site 103	Waterford CT		06395	1089697285	Medicine	Cardiology	
Somers	Valerie	B	MD	L+MMG Cardiology Waterford	196 Parkway S Site 103	Waterford CT		06395	1275875409	Medicine	Cardiology	
Raisfeld	Mark	J	MD	L+MMG Cardiology Waterford	196 Parkway S Site 103	Waterford CT		06395	1256374864	Medicine	Cardiology	
Willis	Robert	M	MD	L+MMG General Surgery	194 Howard St	New Londn CT		06320	1851359681	Surgery	General Surgery	
Hypollite	David	F	MD	L+MMG General Surgery	194 Howard St	New Londn CT		06320	1368593626	Surgery	General Surgery	
Patel	Christy	A	MD	L+MMG General Surgery	194 Howard St	New Londn CT		06320	1942467382	Surgery	General Surgery	
Seljad	Dean	N	MD	L+MMG General Surgery	194 Howard St	New Londn CT		06320	1598859746	Surgery	General Surgery	
Krasner	Jenny	K	DO	L+MMG Groton	404 Thames St	Groton CT		06340	1003873332	Medicine	Internal Medicine	
Quevedo	Nimesh	K	MD	L+MMG Hand Center	404 Thames St	Groton CT		06340	1902947693	Medicine	Internal Medicine	
Colulescu	Sezahr		MD	L+MMG Hand Center	404 Thames St	Groton CT		06340	1927272556	Surgery	Plastic-Hand Surgery	
Doherty	Alan	S	MD	L+MMG Joslin Diabetes Center	194 Howard Ave	New Londn CT		06320	1832211562	Medicine	Endocrinology	
Calderon	R	P	MD	L+MMG Joslin Diabetes Center	194 Howard Ave	New Londn CT		06320	1205949688	Medicine	Endocrinology	
Leare	Stephen	F	MD	L+MMG Joslin Diabetes Center	194 Howard St	New Londn CT		06320	1942313481	Medicine	Internal Medicine	
Walcott	Olivia	E	MD	L+MMG Neurology	194 Howard St	New Londn CT		06320	1639398868	Medicine	Neurology	
Williams	Patrick	F	MD	L+MMG Neurology	194 Howard St	New Londn CT		06320	1578620282	Surgery	Neurosurgery	
Vachhani	Wilton	C	DO	L+MMG New London	194 Howard St	New Londn CT		06320	1134392046	Medicine	Family Medicine	
Palker	Lisa		MD	L+MMG Niantic	184 Howard Street	New Londn CT		06320		Medicine	Ob-gyn	
Barczak	Charles	L	MD	L+MMG Niantic	248 Flinders Road	Niantic CT		06357	1518945351	Medicine	Family Medicine	
Andur	Brian	K	MD	L+MMG Niantic	248 Flinders Rd	Niantic CT		06357	1205815487	Medicine	Family Medicine	
Brown	Jish	A	MD	L+MMG Niantic	248 Flinders Rd	Niantic CT		06357	1336280007	Medicine	Hospitalist	
Watson	Neil	M	MD	L+MMG Obstetrics & Gynecology	194 Howard St	New Londn CT		06320	1427032200	OB-GYN	Internal Medicine	
D'Mello	Timothy	M	MD	L+MMG Obstetrics & Gynecology	194 Howard St	New Londn CT		06320	1706920022	OB-GYN	Gynecology	
Graves	Henry	S	MD	L+MMG Obstetrics & Gynecology	194 Howard St	New Londn CT		06320	1760628600	OB-GYN	OB-GYN	
Nelligan	Sherene	J	MD	L+MMG Obstetrics & Gynecology	194 Howard St	New Londn CT		06320	1528031804	OB-GYN	OB-GYN	
Sutherland	Edward	J	MD	L+MMG Old Lyme	19 Halls Rd PO Box 250	New Londn CT		06371	1144387838	Medicine	Family Medicine	
Cicola	Suresh	C	MD	L+MMG Old Lyme	19 Halls Rd PO Box 250	Old Lyme CT		06371	1083771745	Medicine	Family Medicine	
Parad	Jay	A	MD	L+MMG Old Lyme	19 Halls Ave PO Box 250	Old Lyme CT		06371	1174683884	Medicine	Family Medicine	
Perry	Elizabeth	K	MD	L+MMG Old Lyme	19 Halls Ave PO Box 250	Old Lyme CT		06371	1063621829	Medicine	Family Medicine	
DeBaets	Jennifer	L	MD	L+MMG Primary Care Mystic	23 Clara Dr	Mystic CT		06355	1285791046	Medicine	Family Medicine	
Carter	Robert	T	MD	L+MMG Primary Care Mystic	23 Clara Dr	Mystic CT		06355	1467659227	Medicine	Family Medicine	
Shute	Adrienne	L	MD	L+MMG Primary Care New London	194 Howard St	New Londn CT		06320	1861404402	Medicine	Family Medicine	
Applegate	Robert	J	MD	L+MMG Primary Care New London	194 Howard St	New Londn CT		06320	1649331919	Medicine	Family Medicine	
O'Keefe	Myriam	I	MD	L+MMG Primary Care New London	194 Howard St	New Londn CT		06320	1487750733	Medicine	Hospitalist & Internal Medicine	
Peters	H.Anthony		MD	L+MMG Primary Care New London	194 Howard St	New Londn CT		06320	1245552305	Medicine	Internal Medicine	
Khanna	Manene		MD	L+MMG Rehabilitation Medicine	194 Howard St	New Londn CT		06320	1871728972	Rehab	Rehabilitation	
Whelan	Anupama	L	MD	L+MMG Rehabilitation Medicine	194 Howard St	New Londn CT		06320	1638104583	Rehab	Rehabilitation	
Whelan	Joseph	F	MD	L+MMG Rehabilitation Medicine	194 Howard St	New Londn CT		06320	1992746325	Rehab	Rehabilitation	
Khalid	Joseph	W	MD	L+MMG Sleep Medicine	194 Howard St	New Londn CT		06320	1018012723	Medicine	Sleep Medicine	
Kober	Anik		MD	L+MMG Stonington	91 Voluntown Rd	Pawcatuck CT		06379	1619273042	Medicine	Dermatology	
lovinh	Tara		DO	L+MMG Stonington	91 Voluntown Rd	Pawcatuck CT		06379	1265437752	Medicine	Endocrinology	
lovinh	Mae	L	MD	L+MMG Stonington	91 Voluntown Rd	Pawcatuck CT		06379	1396724134	Medicine	Family Medicine	
Prehan	Brenda		MD	L+MMG Stonington	91 Voluntown Rd	Pawcatuck CT		06379	1693033324	Medicine	Family Medicine	
Torres	Saima	H	MD	L+MMG Stonington	91 Voluntown Rd	Pawcatuck CT		06379	139825097	Medicine	Family Medicine	
	William		DO	L+MMG Stonington	91 Voluntown Rd	Pawcatuck CT		06379	1326142332	Medicine	Internal Medicine	
	Kober		DO	L+MMG Stonington	91 Voluntown Rd	Pawcatuck CT		06379	1023063849	Emergency Medicine	Emergency Medicine	
	Brandi		DO	L+MMG Stonington	91 Voluntown Rd	Pawcatuck CT		06379				
	Louis		DO	L+MMG Stonington	91 Voluntown Rd	Pawcatuck CT		06379				
	Stephan		MD	L+MMG Stonington	91 Voluntown Rd	Pawcatuck CT		06379				
	Kevin	J	DO	L+MMG Primary Care	196 Parkway S Site 103	Waterford CT		06395				

(1) Physician to start 10/1/15.

**ATTACHMENT XII**

Physician Practices in L&MIPA Service Areas (Table 9)

Last Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
Geatano	John	M	DPM	Allergy Foot & Ankle Ctr	914 Hartford Tpke Rte 85	Waterford	CT	06385	1457831357	Surgery	Podiatry	
Shraace	George	A	MD	Allergy Assoc of NL	400 Bayonet St Ste LL-2	New London	CT	06320	1891792529	Medicine	Allergy & Immunology	
Baich	Eric	A	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1033164975	Anesthesia	Anesthesia	
Carreron	Allison	G	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1407627255	Anesthesia	Anesthesia	
Caceare	Joseph	A	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1528016088	Anesthesia	Anesthesia	
Daley	Krislin	A	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1811943208	Anesthesia	Anesthesia	
DeSantis	Christopher	J	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1306572831	Anesthesia	Anesthesia	
Feng	Honghui	J	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1649224876	Anesthesia	Anesthesia	
Oramlich	Curt	W	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1063463908	Anesthesia	Anesthesia	
Kadlin	Sudhir	K	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1366467182	Anesthesia	Anesthesia	
Lodato	Nicholas	M	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1226290496	Anesthesia	Anesthesia	
Milet	Thomas	O	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1879520184	Anesthesia	Anesthesia	
Palput	Kanishka	G	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1813173782	Anesthesia	Anesthesia	
Slater	Alexander	R	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1871332306	Anesthesia	Anesthesia	
Bart	Anthony	R	MD	Barri Eye Care Ctr	469 Rte 184 Ste 100	Groton	CT	06340	1245348796	Surgery	Ophthalmology	
Anonelli	Vincent	J	DOS	Bridgeworks Family Dental Ctr	115 Bridge St	Groton	CT	06340	1497959992	Surgery	Dental	
Haronian	Howard	L	MD	Cardiology Specialists Ltd	45 Wells St Ste 102	Westley	RI	02891	1548258635	Medicine	Cardiology	(1)
Hwang	Anita	M	MD	Cataract & Cornea Eye Spec	914 Hartford Tpke	Waterford	CT	06385	1497959992	Surgery	Ophthalmology	
Beason	William	L	MD	Charter Oak Walk-In Med Ctr	324 Flanders Road	East Lyme	CT	06333	1407056659	Surgery	Family Practice	
Walsch	Robert	C	MD	Charter Oak Walk-In Med Ctr	324 Flanders Road	East Lyme	CT	06333	1407056659	Surgery	Family Practice	
Albrecht	Richard	C	MD	Charter Oak Walk-In Med Ctr	324 Flanders Road	East Lyme	CT	06333	1407056659	Surgery	Family Practice	
Klief	Timothy	A	DMD	Childrens Dentistry of CT	1627 Rte 12 PO Box 398	Gales Ferry	CT	06335	1124213517	Surgery	Pediatric Dentistry	
Clouffer	Josee	D	MD	Clouffer Family Practice LLC	1527 Rte 12 PO Box 398	Gales Ferry	CT	06335	1790950419	Medicine	Family Medicine w/Pediatrics & Hospitalist	
Duke	Daniella	M	MD	Coastal Dermatology PC	55 Willow St	Niantic	CT	06357	1124213517	Surgery	Dermatology	
Campbell	Mical	S	MD	Coastal Digestive Diseases	234A Bank St	New London	CT	06320	1093328770	Medicine	Gastroenterology	
Frese	John	K	MD	Coastal Digestive Diseases	234A Bank St	New London	CT	06320	1457316392	Medicine	Gastroenterology	
Khan	Arzad	M	MD	Coastal Digestive Diseases	234A Bank St	New London	CT	06320	1790945995	Medicine	Gastroenterology	
Ouellette	George	S	MD	Coastal Digestive Diseases	234A Bank St	New London	CT	06320	1285680693	Medicine	Gastroenterology	
Sapozhnikov	Eugene	M	MD	Coastal Digestive Diseases	234A Bank St	New London	CT	06320	1154488094	Medicine	Gastroenterology	
Monroe	John	J	MD	Community Health Ctr	1 Shaws Cove	New London	CT	06320	1508663226	Medicine	Family Medicine	
Baiswarsen	Aranthi	S	MD	Community Health Ctr	481 Gold Star Hwy Ste 100	Groton	CT	06340	1626464444	Medicine	Hospitalist & Internal Medicine	
Duerwaldt	Harmut	E	MD	Community Health Ctr	1 Shaws Cove	New London	CT	06320	1852446272	Pediatrics	Pediatrics	
McKnight	Craig	W	MD	Crossroads Orthopaedics	425 Montauk Ave	New London	CT	06320	1936113703	Surgery	Orthopaedic	
Malaz	Frank	E	MD	Crossroads Orthopaedics	186 Parkway S Ste 201	Waterford	CT	06385	1871687862	Surgery	Orthopaedic	
Nooran	Joseph	A	MD	Crossroads Orthopaedics	195 Parkway S Ste 201	Waterford	CT	06385	144391921	Surgery	Orthopaedic	
Saikh	Jeffrey	A	MD	Crossroads Orthopaedics	195 Parkway S Ste 201	Waterford	CT	06385	1871687862	Surgery	Orthopaedic	
Burrows	Warren	B	MD	Crossroads Orthopaedics	195 Parkway S Ste 201	Waterford	CT	06385	1487628590	Surgery	Orthopaedic	
Awwa	Bassam	M	MD	CT Behavioral Health Associates	41 Faire Harbour Place	New London	CT	06320	1891729876	Surgery	Podiatry	
Lawrence	David	C	DPM	David & Dabra Lawrence DPM	131 Boston Post Rd	East Lyme	CT	06333	1079547162	Surgery	Podiatry	
Bentz	Debra	C	DPM	Dermatology Assoc of SE CT	425 Montauk Ave	New London	CT	06320	1295720910	Medicine	Dermatology	
Greenwald	Mary Ann	D	MD	Digestive Disease Assoc PC	268 Montauk Ave	New London	CT	06320	1174617419	Medicine	Gastroenterology	
Blum	Thomas	M	MD	Die Blum & Boncampi	200 Sandy Hollow Rd	Westley	CT	06355	194710210	Medicine	Internal Medicine	
Bontempi	Rosemary	C	MD	Die Blum & Boncampi	200 Sandy Hollow Rd	Westley	CT	06355	1348235462	Medicine	Internal Medicine	
Fantl	Eugene	M	MD	East Lyme Pediatric Clinic	170 Flanders Rd	Niantic	CT	06357	1255937495	Pediatrics	Pediatrics	
Malik	Selma	P	MD	East Lyme Pediatric Clinic	170 Flanders Rd	Niantic	CT	06357	1443144651	Pediatrics	Pediatrics	
Adams	Theresa	M	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1457676188	Emergency Medicine	Emergency Medicine	
Armstrong	Benjamin	P	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1346467220	Emergency Medicine	Emergency Medicine	
Berolozzi	Peter	D	DO	Emp of New London County	365 Montauk Ave	New London	CT	06320	1568941066	Emergency Medicine	Emergency Medicine	
Bryant	Craig	A	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1871565194	Emergency Medicine	Emergency Medicine	
Chillo	Louis	A	MD	Emp of New London County	52 Hazenut Hill Rd	Groton	CT	06340	1780728063	Emergency Medicine	Emergency Medicine	
Cronin Vorh	Deirdre	Sir	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1396943767	Emergency Medicine	Emergency Medicine	
Daulaire	Sir	L	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1144481805	Emergency Medicine	Emergency Medicine	
Deindorfer	Bernard	A	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1225087797	Emergency Medicine	Emergency Medicine	
Ferguson	Bernard	J	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1568336604	Emergency Medicine	Emergency Medicine	
Firman	Russell	J	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1124191465	Emergency Medicine	Emergency Medicine	
Garber	Suzanne	M	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1104110428	Emergency Medicine	Emergency Medicine	
Gianfranco	Robert	F	DO	Emp of New London County	52 Hazenut Hill Rd	Groton	CT	06340	1942370234	Emergency Medicine	Emergency Medicine	
Hartman	Daniel	G	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1609977784	Emergency Medicine	Emergency Medicine	
Kesha	Joshua	M	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1690366545	Emergency Medicine	Emergency Medicine	
Lebach	Christopher	M	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1206875440	Emergency Medicine	Emergency Medicine	
Lin Montie	Melissa	M	DO	Emp of New London County	365 Montauk Ave	New London	CT	06320	1376793125	Emergency Medicine	Emergency Medicine	
Maheshwar	Ashok	K	MD	Emp of New London County	52 Hazenut Hill Rd	Groton	CT	06340	1760543813	Emergency Medicine	Emergency Medicine	
Maitte	Angela	F	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1038672766	Emergency Medicine	Emergency Medicine	
Moyyga	Oliver	M	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	17200594661	Emergency Medicine	Emergency Medicine	
O'Donnell	Sophia	G	MD	Emp of New London County	365 Montauk Ave	New London	CT	06320	1256592268	Emergency Medicine	Emergency Medicine	

Physician Practices in L.M.P.A. Service Area (Table 9)

Last Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
Rau	Laura	D	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1621218784	Emergency Medicine	Emergency Medicine	
Sala	Deepika	J	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1215258686	Emergency Medicine	Emergency Medicine	
Singh	Deepika	J	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1114123863	Emergency Medicine	Emergency Medicine	
Smedley	Daniel	G	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1982534267	Emergency Medicine	Emergency Medicine	
Sokolowski	John	R	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1417159765	Emergency Medicine	Emergency Medicine	
Stallard	John	R	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1184543090	Emergency Medicine	Emergency Medicine	
Stevens	Anna	L	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1593926991	Emergency Medicine	Emergency Medicine	
Taranova	George	J	MD	EMIP of New London County	52 Hazelnut Hill Rd	Groton	CT	06340	1972830010	Emergency Medicine	Emergency Medicine	
Teale	Wendy	J	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1437174936	Emergency Medicine	Emergency Medicine	
Tucker	Cynthia	J	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1558571205	Emergency Medicine	Emergency Medicine	
Will	Wendy	A	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1851365738	Emergency Medicine	Emergency Medicine	
Alfonzo	Michael	J	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1932337326	Emergency Medicine	Emergency Medicine	
Cleore	Mark	X	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1548918823	Emergency Medicine	Emergency Medicine	
Dodgdon	James	M	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1629380985	Emergency Medicine	Emergency Medicine	
Hesse	Katherine	S	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1548226098	Emergency Medicine	Emergency Medicine	
Mackenzie	Bonnie	S	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1275730956	Emergency Medicine	Emergency Medicine	
Siew	Lorraine	T	MD	EMIP of New London County	365 Montauk Ave	New London	CT	06320	1891933727	Emergency Medicine	Emergency Medicine	
Gautam	Victoria	G	MD	Endocrin & Osteoporosis Ctr	383 Ocean Ave	New London	CT	06320	1316042644	Emergency Medicine	Endocrinology	
Bosoneau	David	S	MD	ENT Assoc of SE CT	201 Boston Post Rd	Waterford	CT	06385	1467429597	Surgery	Otolaryngology	
Dellacono	Frank	R	MD	ENT Assoc of SE CT	201 Boston Post Rd	Waterford	CT	06385	1073890648	Surgery	Otolaryngology	
Gaio	Raymond	A	MD	ENT Assoc of SE CT	201 Boston Post Rd	Waterford	CT	06385	1235157838	Surgery	Otolaryngology	
Mynarski	Frank	G	MD	ENT Assoc of SE CT	201 Boston Post Rd	Waterford	CT	06385	1255569199	Surgery	Otolaryngology	
Falk	Francis	Y	MD	Falk Eye Ctr LLC	35 Washington St	Myrtle	CT	06355	1255335113	Surgery	Ophthalmology	
Cambri	Kathryn	M	MD	Flanders Pediatrics LLC	305 Flanders Rd	East Lyme	CT	06333	1720047285	Pediatrics	Pediatrics	
Lopez	Maria	A	MD	Flanders Pediatrics LLC	305 Flanders Rd	East Lyme	CT	06333	1558402005	Pediatrics	Pediatrics	
Greenhouse	Samford	J	MD	GF Med Group	1527 Rte 12 PO Box 355	Gales Ferry	CT	06335	1659457894	Medicine	Internal Medicine	
Hennessy	John	A	MD	GF Med Group	1527 Rte 12 PO Box 355	Gales Ferry	CT	06335	1215916564	Medicine	Internal Medicine	
Murphy-Fiango	Mary	P	DO	GF Med Group	1527 Rte 12 PO Box 355	Gales Ferry	CT	06335	1030887001	Medicine	Internal Medicine	
Arcona	John	S	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1548359060	Pediatrics	Pediatrics	(2)
Eposho	Charles	R	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1548359076	Pediatrics	Pediatrics	(2)
Fosstein	Steven	H	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1922197482	Pediatrics	Pediatrics	(2)
Holzman	Phyllis	A	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1931783949	Pediatrics	Pediatrics	(2)
Lin	Phyllis	A	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1427184897	Pediatrics	Pediatrics	(2)
Lowin	Joan	R	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1992684001	Pediatrics	Pediatrics	(2)
Ritzer	David	M	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1225127616	Pediatrics	Pediatrics	(2)
Rosenthal	Mark	A	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1144319890	Pediatrics	Pediatrics	(2)
Watson	Michelle	N	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1487745928	Pediatrics	Pediatrics	(2)
Caruso-Uy	Cynthia	A	MD	Gold Coast Pulmonary & Sleep	125 Shaw St	New London	CT	06320	1790783264	Medicine	Pulmonary	
Leata	Paul	J	DO	Gold Coast Pulmonary & Sleep	125 Shaw St	New London	CT	06320	1225036981	Medicine	Pulmonary	
Biefeld	Michael	E	MD	Gold Star Pediatrics	495 Rte 194 Ste 120	Groton	CT	06340	1104897923	Pediatrics	Pediatrics	
Fifell	Carol	J	MD	Gold Star Pediatrics	495 Rte 194 Ste 120	Groton	CT	06340	1548331374	Pediatrics	Pediatrics	
Glenn	Mary	A	MD	Gold Star Pediatrics	495 Rte 194 Ste 120	Groton	CT	06340	1790345949	Pediatrics	Pediatrics	
Melchert	Anna-Maria	L	MD	Gold Star Pediatrics	495 Rte 194 Ste 120	Groton	CT	06340	1225103051	Pediatrics	Pediatrics	
Bertran	Gary	M	MD	GP Family Care LLC	157 Montauk Ave	New London	CT	06320	1689569309	Pediatrics	Family Medicine w/Pediatrics	
Gales	Peter	J	MD	GP Family Care LLC	157 Montauk Ave	New London	CT	06320	1154416782	Pediatrics	Family Medicine	
Campes	Helar	E	MD	Helar Campos MD & Assoc	491 Gold Star Hwy Ste 310	New London	CT	06320	1556437289	Medicine	Endocrinology & Hospitalist	
Esker	Ronco	B	MD	Integrated Dermatology of Groton LLC	365 Montauk Ave	Groton	CT	06320	1811950074	Medicine	Dermatology	
Cooper	Bruce	J	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1043203037	Medicine	Family Medicine	
Feltes	Michael	J	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1686890216	Medicine	Hospitalist	
Williams	Gada	L	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1023094158	Medicine	Hospitalist	
Accardi	Gada	M	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1467649558	Medicine	Hospitalist	
Crispino	Carmine	R	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1861487367	Medicine	Hospitalist	
Doherty	Lauren	M	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1905997255	Medicine	Hospitalist	
Donovan	Kenneth	W	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1689447207	Medicine	Hospitalist	
Feder	Ingrid	M	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1609872645	Medicine	Hospitalist	
Fredetis	David	J	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1225048168	Medicine	Hospitalist	
Gerontimo	Mark Dennis	V	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1215132949	Medicine	Hospitalist	
Giffault	George	K	DO	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1750357593	Medicine	Hospitalist	
Lu	Steven	L	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1568460186	Medicine	Hospitalist	
Malhotra	Sanjay	M	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1487946339	Medicine	Hospitalist	
Martin	Victor	M	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1831705572	Medicine	Hospitalist	
McComick	Rachel	R	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1154331031	Medicine	Hospitalist	
Miller	Adriene	R	DO	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1003897737	Medicine	Hospitalist	
Nelson	John	J	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1376540005	Medicine	Hospitalist	
Obtelata	Chinemya	A	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1962868780	Medicine	Hospitalist	
Phillips	Hairod	E	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1124025569	Medicine	Hospitalist	

Physician Practices in L&MPA Service Area (Table 9)

Physician Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NP	Department	Specialty	Notes
Reardon	Claire	L	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320		Medicine	Hospitalist	
Villegas	Monica	DO	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1257343688	Medicine	Hospitalist	
Wolf	Mirela	MD	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1256337817	Medicine	Hospitalist	
Main	Roy	MD	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	12058595216	Medicine	Hospitalist & Internal Medicine	
Perahio	Robert	A	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1283653800	Medicine	Hospitalist & Pulmonary	
Manthous	Constantine	A	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1760643759	Medicine	Hospitalist, Internal Medicine & Pulmonary	
Felitto	Donald	J	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1631164977	Medicine	Nephrology	
Alessi	Anthony	G	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1174573812	Medicine	Neuro-Hospitalist	
Tong	Tao	MD	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1942401815	Medicine	Neuro-Hospitalist	
Winer	Andrew	N	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1808804357	Medicine	Neuro-Hospitalist	
Zeevi	Neer	G	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1810066509	Medicine	Thyroid	
Crawford	William	A	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1114071909	Surgery	Endocrinology	
Galland	Robert	G	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1952381947	Medicine	Podiatry	
Kierstein	Jeffrey	M	DFM	Kleinlein & DiFrancesca DPM PC	196 Parkway S Ste 302	Waterford	CT	06385	1841250446	Surgery	Medical Oncology & Hematology	
Holdes	Jason	R	MD	L-HM Cancer Center	230 Waterford Parkway S	Waterford	CT	06385	1276532544	Medicine	Medical Oncology & Hematology	
Heltman	Richard	M	MD	L-HM Cancer Center	230 Waterford Parkway S	Waterford	CT	06385	1821097801	Medicine	Medical Oncology & Hematology	
Johnson	Vanessa	M	MD	L-HM Cancer Center	230 Waterford Parkway S	Waterford	CT	06385	1326047549	Medicine	Medical Oncology & Hematology	
Newton	Benjamin	R	MD	L-HM Cancer Center	230 Waterford Parkway S	Waterford	CT	06385	1265520191	Medicine	Medical Oncology & Hematology	
Rebin	Michael	S	MD	L-HM Hospital/Wound Care Clinic	40 Boston Post Rd	Waterford	CT	06385	1862449801	Medicine	Wound Care	
Nevin	Terence	J	MD	L-HM Hospital/Neurology Dept	365 Montauk Ave	New London	CT	06320	1487637203	Pediatrics	Neonatology	(3)
Bizzarro	Matthew	V	MD	L-HM Hospital/Neurology Dept	365 Montauk Ave	New London	CT	06320	1194022148	Pediatrics	Neonatology	(4)
Ciarella	Bret	K	MD	L-HM Hospital/Neurology Dept	365 Montauk Ave	New London	CT	06320	1346256811	Pediatrics	Neonatology	(4)
James	Edward	A	MD	L-HM Hospital/Neurology Dept	365 Montauk Ave	New London	CT	06320	1942240478	Pediatrics	Neonatology	(4)
Kelly	Barbara	K	MD	L-HM Hospital/Neurology Dept	365 Montauk Ave	New London	CT	06320	1588914446	Pediatrics	Neonatology	(4)
Saikooli	Santita	A	MD	L-HM Hospital/Neurology Dept	365 Montauk Ave	New London	CT	06320	1154545754	Medicine	Infectious Disease	
Borjan	Alin	O	MD	L-HM Infectious Disease Dept	365 Montauk Ave	New London	CT	06320	1306989282	Medicine	Infectious Disease	
Purtaguina	Sallaja	E	MD	L-HM Neurodiagnostic Lab	365 Montauk Ave Unit 4.1	New London	CT	06320	1427063958	Medicine	Neurodiagnostic	
Moallil	Dani	E	MD	L-HM Neurodiagnostic Lab	365 Montauk Ave Unit 4.1	New London	CT	06320	1427063958	Medicine	Neurodiagnostic	
Nerdness	Robert	J	MD	L-HM Occupational Health @ PHC	62 Hazelnut Hill Rd	Groton	CT	06340	1154360198	Emergency Medicine, Medicine & Rehab Medicine	Emergency Medicine, Occupational Med & Rehab Medicine	
Desbanda	Shrikant	R	MD	L-HM Occupational Health @ PHC	62 Hazelnut Hill Rd	Groton	CT	06340	1891927496	Medicine	Emergency Medicine	
Pallock	Dennis	C	MD	L-HM Occupational Health @ PHC	52 Hazelnut Hill Rd	Groton	CT	06340	1609959383	Medicine	Occupational Medicine	
Ruffa	Gerardine	S	MD	L-HM Occupational Health @ PHC	52 Hazelnut Hill Rd	Groton	CT	06340	1578576781	Medicine	Occupational Medicine	
Elsarna	Shady	M	MD	L-HM Behavioral Health	365 Montauk Ave	New London	CT	06320	11444569785	Psychiatry	Psychiatry	
Manolevitz	Naomi	M	MD	L-HM Behavioral Health	365 Montauk Ave	New London	CT	06320	1487710141	Psychiatry	Psychiatry	
Miano	Alexander	P	MD	L-HM Behavioral Health	184 Howard St	New London	CT	06320	1932211812	Psychiatry	Psychiatry	
Talavera-Briggs	Amariis	M	MD	L-HM Behavioral Health	194 Howard St	New London	CT	06320	1852469733	Psychiatry	Psychiatry	(5)
Bagheri	Rochanak	M	MD	L-HM Cardiology New London	194 Howard St	New London	CT	06320	1023222850	Medicine	Cardiology	
Gaulib	Brian	C	MD	L-HM Cardiology New London	194 Howard St	New London	CT	06320	1003033390	Medicine	Cardiology	
Jon	Brian	C	MD	L-HM Cardiology Waterford	194 Howard St	New London	CT	06320	1206885258	Medicine	Cardiology	
Flengo	Mark	N	DO	L-HM Cardiology Waterford	195 Parkway S Ste 103	Waterford	CT	06385	1698296888	Medicine	Cardiology	
Mansu-Huraco	Carlos	S	MD	L-HM Cardiology Waterford	195 Parkway S Ste 103	Waterford	CT	06385	1245214220	Medicine	Cardiology	
Mirecki	Peter	I	MD	L-HM Cardiology Waterford	195 Parkway S Ste 103	Waterford	CT	06385	1205800273	Medicine	Cardiology	
Popkin	Francis	J	MD	L-HM Cardiology Waterford	195 Parkway S Ste 103	Waterford	CT	06385	1386482656	Medicine	Cardiology	
Lincer	Valerie	B	MD	L-HM Cardiology Waterford	195 Parkway S Ste 103	Waterford	CT	06385	1035867285	Medicine	Cardiology	
Somers	Mark	J	MD	L-HM Cardiology Waterford	195 Parkway S Ste 103	Waterford	CT	06385	1276573409	Medicine	Cardiology	
Ralsfeld	Robert	M	MD	L-HM General Surgery	194 Howard St	New London	CT	06320	1861359681	Surgery	General Surgery	
Stanak	David	F	MD	L-HM General Surgery	194 Howard St	New London	CT	06320	1366536526	Surgery	General Surgery	
Willis	Dean	A	MD	L-HM General Surgery	194 Howard St	New London	CT	06320	1942497352	Surgery	General Surgery	
Hypollite	Jenny	N	MD	L-HM General Surgery	194 Howard St	New London	CT	06320	1598958746	Surgery	General Surgery	
Patal	Nirmesh	K	DO	L-HM Groton	404 Thames St	Groton	CT	06340-3989	1003673332	Medicine	Internal Medicine	
Sajjad	Sapahr	P	MD	L-HM Hand Center	194 Howard St	New London	CT	06320	1902847568	Medicine	Plastic-Hand Surgery	
Krasner	Alan	S	MD	L-HM Insulin Diabetes Center	194 Howard St	New London	CT	06320	1972772556	Surgery	Endocrinology	
Lamberton	Pat	E	MD	L-HM Insulin Diabetes Center	194 Howard St	New London	CT	06320	1932211562	Medicine	Endocrinology	
Cuevascu	Stephen	F	MD	L-HM Insulin Diabetes Center	184 Howard Ave	New London	CT	06320	1205849658	Medicine	Internal Medicine	
Conter	Olivia	E	MD	L-HM Neurology	184 Howard St	New London	CT	06320	1639338858	Medicine	Neurology	
Doherty	Patrick	F	MD	L-HM Neurosurgery	184 Howard St	New London	CT	06320	1576620282	Surgery	Neurosurgery	
Calderon	Wilton	C	DO	L-HM Neurosurgery	184 Howard St	New London	CT	06320	11343802046	Medicine	Family Medicine	
Licare	Lisa	L	MD	L-HM Niantic	194 Howard Street	New London	CT	06320	11343802046	Medicine	Ob-gyn	
Walcott	Charles	L	MD	L-HM Niantic	248 Flanders Road	Niantic	CT	06367	1518948351	Medicine	Family Medicine	
Williams	Brian	K	MD	L-HM Niantic	248 Flanders Rd	Niantic	CT	06367	1206915487	Medicine	Family Medicine	
Vachhani	Jitesh	L	MD	L-HM Niantic	248 Flanders Rd	Niantic	CT	06367	1336280007	Medicine	Hospitalist	
Pelker	Neil	A	MD	L-HM Niantic	248 Flanders Rd	Niantic	CT	06367	1336280007	Medicine	Internal Medicine	
Barczak	Timothy	M	MD	L-HM Obstetrics & Gynecology	184 Howard St	New London	CT	06320	1427032200	OB-GYN	Gynecology	

Physician Name	First Name	Middle Initial	Last Name	Centric	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
Amur	Henry	S	Amur	MD	L-HMMG Obstetrics & Gynecology	194 Howard St	New London	CT	06320	1700920022	OB-GYN	OB-GYN	
Shereene	J	C	Amur	MD	L-HMMG Obstetrics & Gynecology	194 Howard St	New London	CT	06320	1700920022	OB-GYN	OB-GYN	
Mason	Edward	J	Amur	MD	L-HMMG Obstetrics & Gynecology	194 Howard St	New London	CT	06320	1700920022	OB-GYN	OB-GYN	
Niello	Suresh	C	Amur	MD	L-HMMG Obstetrics & Gynecology	194 Howard St	New London	CT	06320	1700920022	OB-GYN	OB-GYN	
Araves	Jay	K	Amur	MD	L-HMMG Old Lyme	19 Halls Rd PO Box 250	Old Lyme	CT	06371	1144387833	Medicine	Family Medicine	
Walgan	Elizabeth	A	Amur	MD	L-HMMG Old Lyme	19 Halls Ave PO Box 250	Old Lyme	CT	06371	1083771745	Medicine	Family Medicine	
Sutherland	Jennifer	L	Amur	MD	L-HMMG Old Lyme	19 Halls Ave PO Box 250	Old Lyme	CT	06371	1083621829	Medicine	Family Medicine	
Diobla	Robert	T	Amur	MD	L-HMMG Old Lyme	19 Halls Ave PO Box 250	Old Lyme	CT	06371	1083621829	Medicine	Family Medicine	
Arad	Adrienne	L	Amur	MD	L-HMMG Primary Care Mystic	23 Clara Dr	Mystic	CT	06355	1487659227	Medicine	Family Medicine	
erry	Robert	J	Amur	MD	L-HMMG Primary Care Mystic	23 Clara Dr Ste 203	Mystic	CT	06355	1487659227	Medicine	Family Medicine	
DeBels	Myrian	I	Amur	MD	L-HMMG Primary Care New London	194 Howard St	New London	CT	06320	1851494402	Medicine	Hospitalist & Internal Medicine	
Carter	H Anthony		Amur	MD	L-HMMG Primary Care New London	194 Howard St	New London	CT	06320	1487750733	Medicine	Internal Medicine	
Shule	Marlene		Amur	MD	L-HMMG Primary Care New London	194 Howard St	New London	CT	06320	1245952306	Medicine	Internal Medicine	
Korra	Anupama		Amur	MD	L-HMMG Primary Care New London	194 Howard St	New London	CT	06320	181728972	Medicine	Rehabilitation	
Peters	Joseph	F	Amur	MD	L-HMMG Rehabilitation Medicine	194 Howard St	New London	CT	06320	4538104683	Rehab Medicine	Rehab Medicine	
Khanna	Anit	W	Amur	MD	L-HMMG Rehabilitation Medicine	194 Howard St	New London	CT	06320	1992746325	Medicine	Rehab Medicine	
Whelan	Tara		Amur	DO	L-HMMG Sleep Medicine	91 Voluntown Rd	Pawcatuck	CT	06379	1619273042	Medicine	Sleep Medicine	
Whelan	Mae		Amur	DO	L-HMMG Stomlition	91 Voluntown Rd	Pawcatuck	CT	06379	1619273042	Medicine	Sleep Medicine	
Appligate	Brenda	L	Amur	MD	L-HMMG Stomlition	91 Voluntown Rd	Pawcatuck	CT	06379	1255437752	Medicine	Endocrinology	
Khalid	Saima	H	Amur	MD	L-HMMG Stomlition	91 Voluntown Rd	Pawcatuck	CT	06379	1396724154	Medicine	Family Medicine	
Kobor	William		Amur	MD	L-HMMG Stomlition	91 Voluntown Rd	Pawcatuck	CT	06379	1639203324	Medicine	Family Medicine	
Avino	Brandi		Amur	DO	L-HMMG Stomlition	91 Voluntown Rd	Pawcatuck	CT	06379	1388825087	Medicine	Internal Medicine	
Phelan	Louis		Amur	DO	L-HMMG Stomlition	91 Voluntown Rd	Pawcatuck	CT	06379	1328142332	Medicine	Internal Medicine	
Torres	Kevin	J	Amur	DO	L-HMMG Stomlition	91 Voluntown Rd	Pawcatuck	CT	06379	1023058949	Emergency Medicine	Emergency Medicine	
Spitz	Robert	M	Amur	MD	Montauk GYN	342 Montauk Ave	New London	CT	06320	1871575085	Medicine	OB-GYN	
Fields	Warren	L	Amur	MD	Mystic Med Group	200 Sandy Hollow Rd	Mystic	CT	06355	1821059999	Medicine	Hospitalist & Internal Medicine	
Sullivan	James	F	Amur	MD	Mystic Med Group	200 Sandy Hollow Rd	Mystic	CT	06355	1780079472	Medicine	Hospitalist & Rheumatology	
Scarles	James		Amur	MD	Mystic Med Group	200 Sandy Hollow Rd	Mystic	CT	06355	1194710269	Medicine	Internal Medicine	
Radin	Laurence	I	Amur	MD	Neurological Group PC	350 Montauk Ave	New London	CT	06320	1509860158	Medicine	Neurology	
Lee	John	C	Amur	MD	New England Plastic Surgery	8 Vista Dr	Old Lyme	CT	06371	1566625176	Surgery	Plastic-Hand Surgery	
Gordon	Jeffrey	A	Amur	MD	New London Cancer Ctr	196 Parkway S Ste 303	Waterford	CT	06385	1609857119	Medicine	Medical Oncology & Hematology	
Govil	Mithlesh	L	Amur	MD	New London Cancer Ctr	196 Parkway S Ste 303	Waterford	CT	06385	1235135094	Medicine	Medical Oncology & Hematology	
Katwar	Thila	C	Amur	MD	New London Cancer Ctr	196 Parkway S Ste 303	Waterford	CT	06385	1802852190	Medicine	Medical Oncology & Hematology	
Laharzi	Stephen	K	Amur	MD	New London Family Practice	4 Shaws Cove Ste 103	Waterford	CT	06385	1801854555	Medicine	Family Medicine w/Pediatrics	
Allard	Elizabeth	J	Amur	DO	New London Family Practice	4 Shaws Cove Ste 103	New London	CT	06320	3295155367	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Flislar	Elio	P	Amur	DO	New London Family Practice	4 Shaws Cove Ste 103	New London	CT	06320	1730190034	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Johnson	Steven	K	Amur	MD	New London Family Practice	4 Shaws Cove Ste 103	New London	CT	06320	1902801434	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Stockl	Margaret		Amur	MD	North Stomlition Med. Walk-In Ctr	82 Norwich-Westerly Road	New London	CT	06320	1154332427	Medicine & Pediatrics	Internal Medicine	
Rydzal	Jerzy	V	Amur	MD	Northeast Plastic Surgery	5 DeVe Rd East	Old Lyme	CT	06371	1822298098	Surgery	Plastic-Hand Surgery	
Parry	Vinod	M	Amur	MD	Northwest Pediatric Pulmonary Svcs	6 Business Park Dr Ste 202	Old Lyme	CT	06371	1822298098	Pediatrics	Pediatric Pulmonology	
Patazzo	Regina	M	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1801862802	Radiology	Diagnostic Radiology	
Basu	Arun	M	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1861227835	Radiology	Diagnostic Radiology	
Blue	Todd	M	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1693895933	Radiology	Diagnostic Radiology	
Colby	Jay	M	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1770513301	Radiology	Diagnostic Radiology	
Cross	Robert	R	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1649240821	Radiology	Diagnostic Radiology	
Diffin	Deniel	C	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1104897695	Radiology	Diagnostic Radiology	
Keresli	Tibor		Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1332136629	Radiology	Diagnostic Radiology	
Thomas	Brenda	M	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1316894059	Radiology	Diagnostic Radiology	
Manning	Thomas	J	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1114978194	Radiology	Diagnostic Radiology	
Marzearali	Louis	C	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1598745996	Radiology	Diagnostic Radiology	
Niles	Michael	M	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1285513593	Radiology	Diagnostic Radiology	
Robbins	Michael	C	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1821055502	Radiology	Diagnostic Radiology	
Shtok	Sheldon	R	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1407893183	Radiology	Diagnostic Radiology	
Sorrentino	John	R	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1457678641	Radiology	Diagnostic Radiology	
Anic	Joseph	C	Amur	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1851424905	Radiology	Diagnostic Radiology	
Benedict	Anita		Amur	MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1346403852	Pathology	Pathology	
Eljz	Ashim	B	Amur	MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1356307534	Pathology	Pathology	
Green	Kevin	L	Amur	MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1700940285	Pathology	Pathology	
Kragl	Elise	E	Amur	MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1164878041	Pathology	Pathology	
Muscato	Nicole	G	Amur	MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1998787517	Pathology	Pathology	
Reyes	Nicole	A	Amur	MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1587359182	Pathology	Pathology	
Philips	Kimberly	M	Amur	MD	Philips Integrative Health	801 Poquonnock Rd Ste 6	Groton	CT	06340	1497359182	Medicine	Family Medicine	
McLean	Christina	M	Amur	MD	Primary Care for Women	8 Vista Dr	Old Lyme	CT	06371	1812072455	Medicine	Family Medicine	
Parakh	Anisha	R	Amur	MD	Primary Care for Women	8 Vista Dr	Old Lyme	CT	06371	1538116348	Medicine	Family Medicine	

Physician Practices in L&MHA Services Area (Table 9)

Last Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
Sattl	Mary	C	MD	Primary Care for Women	8 Viala Dr	Old Lyme	CT	06371	12786540949	Medicine	Internal Medicine	
Enrich	Owen	R	MD	Pro-Health Ped Assoc of NL	53C Granite St	New London	CT	06320	12958595999	Medicine	Pediatrics	
Giesman	Bernard	A	MD	Pro-Health Ped Assoc of NL	53C Granite St	New London	CT	06320	1467652166	Medicine	Pediatrics	
Khanna	Erika	M	MD	Pro-Health Ped Assoc of NL	53C Granite St	New London	CT	06320	11546686891	Medicine	Pediatrics	
Lebovitz	Ruth	M	MD	Pro-Health Ped Assoc of NL	53C Granite St	New London	CT	06320	1497943007	Medicine	Pediatrics	
Salek	Allyson	A	MD	Pro-Health Ped Assoc of NL	53C Granite St	New London	CT	06320	1942474739	Medicine	Pediatrics	
Donahue	Jennifer	A	MD	Pro-Health Phys Womens Care	85 Poheganut Dr	Groton	CT	06340	1275647448	Medicine	Family Medicine	
Molitor	Laura	F	MD	Pro-Health Phys Womens Care	85 Poheganut Drive	Groton	CT	06340			Family Practice	
Watts	Henry	A	MD	Pro-Health Phys Womens Care	Five Shaw's Cove	New London	CT	06340			Psychiatry	
Creshe	Anthony	J	MD	Psychiatric Medicine Clinic	82 Plaza Ct	Groton	CT	06340	1407653163	Surgery	Ophthalmology	
Romania	Eric	J	MD	SE CT Maternal Fetal Med Assoc	4 Shaws Cove Ste 201	Groton	CT	06340	1689891673	OB-GYN	Maternal Fetal Medicine	
Hodgson	Saul	D	MD	SE CT Med Assoc	127 Elm St Ste 500/600	New London	CT	06320	1318041801	Medicine	Endocrinology	
Neuman	Terrance	G	MD	SE CT Med Assoc	447 Montauk Ave	Old Saybrook	CT	06475	12554035555	Medicine	Family Medicine	
Doherty	Stephen	A	MD	SE CT Med Assoc	447 Montauk Ave	New London	CT	06320	1841394137	Medicine	Hospitalist & Internal Medicine	
Colon	William	A	MD	SE CT Med Assoc	447 Montauk Ave	New London	CT	06320	15540686848	Medicine	Internal Medicine	
Ginsberg	Jay	M	MD	SE CT Neph Assoc	88 Norwich Nl Tpke 2E	Ureahsville	CT	06382	18412859509	Medicine	Nephrology	
Haus	Mikheil	J	MD	SE CT Neph Assoc	88 Norwich Nl Tpke 2E	Ureahsville	CT	06382	18412859599	Medicine	Nephrology	
Negulescu	Mihale	O	MD	SE CT Neph Assoc	88 Norwich Nl Tpke 2E	Ureahsville	CT	06382	1858473501	Medicine	Nephrology	
Peter	Thomas	C	MD	SE CT Neph Assoc	88 Norwich Nl Tpke 2E	Ureahsville	CT	06382	1892297549	Medicine	Nephrology	
Raeool	Altat	J	MD	SE CT Neph Assoc	88 Norwich Nl Tpke 2E	Ureahsville	CT	06382	1013016357	Medicine	Nephrology	
Klakotka	Suzanne	J	MD	SE Pulmonary Assoc	155 Montauk Ave	New London	CT	06320	11644364433	Medicine	Internal Medicine	
Kelner	Robert	M	MD	SE Pulmonary Assoc	155 Montauk Ave	New London	CT	06320	1093733675	Medicine	Internal Medicine	
Urbanetti	John	B	MD	SE Pulmonary Assoc	155 Montauk Ave	New London	CT	06320	1720181209	Medicine	Internal Medicine	
Carlow	Steven	S	MD	Seacoast Ortho/Sports Med	485 Rte 184 Ste 300	Groton	CT	06340	1013835692	Surgery	Pulmonary	
Thoms	R Justin	B	MD	Seacoast Ortho/Sports Med	485 Rte 184 Ste 300	Groton	CT	06340	11944957863	Surgery	Orthopaedic	
Wei	Steven	Y	MD	Seacoast Ortho/Sports Med	485 Rte 184 Ste 300	Groton	CT	06340	1225057895	Surgery	Orthopaedic	
West	John	R	MD	Seacoast Ortho/Sports Med	485 Rte 184 Ste 300	Groton	CT	06340	1487606117	Medicine	Orthopaedic	
Miller	Jeffrey	A	DO	Seacoast Ortho/Sports Med	34 Waler St Ste 2	Mystic	CT	06355	11846924162	Surgery	Orthopaedic	
Bar	Dorion	A	MD	Shoreline Allergy & Asthma	23 Clara Dr Ste 204	Mystic	CT	06355	1318924749	Medicine & Pediatrics	Allergy & Immunology & Pediatric Allergy	
Nelraveli	Manesh	J	MD	Shoreline Allergy & Asthma	23 Clara Dr Ste 204	Mystic	CT	06355	1942424551	Medicine & Pediatrics	Allergy & Immunology & Pediatric Allergy	
Waggoner	Daniel	L	MD	Shoreline Allergy & Asthma	23 Clara Dr Ste 204	Mystic	CT	06355	1559406655	Medicine & Pediatrics	Allergy & Immunology & Pediatric Allergy	
Waggoner	Lor	J	MD	Shoreline Eye Group PC	741 Broad St Ext	Waterford	CT	06385	1318013358	Surgery	Ophthalmology	
Ryan	John	J	MD	Shoreline Eye Group PC	741 Broad St Ext	Waterford	CT	06385	1184192354	Surgery	Ophthalmology	
Feldman	Barry	S	MD	Shoreline Family Practice	36 Clark Ln	Waterford	CT	06385	1386858397	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Golden	David	J	MD	Shoreline Family Practice	36 Clark Ln	Waterford	CT	06385	1386858397	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Parad	Andrew	M	MD	Shoreline Family Practice	36 Clark Ln	Waterford	CT	06385	1053405505	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Courtright	Darren	J	MD	Shoreline Foot & Ankle Ctr	85 Poheganut Dr	Groton	CT	06340	1417957475	Surgery	Podiatry	
Marshall	Sonya	L	MD	Shoreline OB/GYN PC	4 Shaws Cove Ste 204-205	New London	CT	06320	1809055286	OB-GYN	OB-GYN	
LeVine	Michael	A	MD	Shoreline OB/GYN PC	4 Shaws Cove Ste 204-205	New London	CT	06320	1447488741	OB-GYN	OB-GYN	
Lavallee	Jonathan	L	MD	Shoreline OB/GYN PC	4 Shaws Cove Ste 204-205	New London	CT	06320	1083631055	OB-GYN	OB-GYN	
Mayeda	Francis	J	MD	Shoreline OB/GYN PC	4 Shaws Cove Ste 204-205	New London	CT	06320	1730405535	OB-GYN	OB-GYN	
Szulowska	Margdalena	J	MD	Shoreline Pulmonary Assoc LLC	415 Ocean Ave	New London	CT	06320	1578503987	Medicine	Pulmonary	
Dunig	Niall	J	MD	Shoreline Pulmonary Assoc LLC	4 Shaws Cove Site 203	New London	CT	06320	1033125323	Surgery	Dental	
Dyer	James	A	DMD	Sourthview Oral & Maxillofacial	4 Shaws Cove Site 203	New London	CT	06320	1154344293	Surgery	Dental	
Sarfilippo	Ross	J	DMD	Sourthview Oral & Maxillofacial	4 Shaws Cove Site 203	New London	CT	06320	1538188117	Surgery	Dental	
Geaciere	Daniel	R	MD	Sourthview Orthopaedic Assoc	480 Route 184 Ste 110	New London	CT	06340	1902805591	Surgery	Orthopaedic	
Hutchins	Christopher	M	MD	Teleradiology Solutions	488 Rte 184 Ste 110	Groton	CT	06340	1902805591	Surgery	Orthopaedic	
Aschkenasi	Menohar	J	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1427034016	Radiology	Teleradiology	
Chinta	Carl	J	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1720032655	Radiology	Teleradiology	
Bharath Kumar	Stephen	B	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1378612739	Radiology	Teleradiology	
Egias	Matthew	A	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1033184422	Radiology	Teleradiology	
Fox	Margaret	A	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1619970787	Radiology	Teleradiology	
Goodman	Arjun	M	MD	Teleradiology Solutions	205 Church St 3rd Fl	New Haven	CT	06510	1538370889	Radiology	Teleradiology	
Kalyanpur	Sanjay	V	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1376528315	Radiology	Teleradiology	
Kamath	Pandit	E	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	17006971537	Radiology	Teleradiology	
Pennington	Norman	E	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1295728251	Radiology	Teleradiology	
Wabla	Sumathi	F	MD	Teleradiology Solutions	205 Church St 3rd Fl	New Haven	CT	06510	1447345635	Radiology	Teleradiology	
Lezillo	Charles	F	MD	Thames Eye Group	200 Sandy Hollow Rd	Mystic	CT	06355	1013945344	Surgery	Ophthalmology	
Prifer	Prior	L	MD	Thames Eye Group	200 Sandy Hollow Rd	Mystic	CT	06355	1328076795	Surgery	Ophthalmology	
Fraser	Richard	A	MD	Thames Urology Ctr	3 Shaws Cove Ste 206	New London	CT	06320	1164504247	Surgery	Urology	
Quinn	Anthony	D	MD	Thames Urology Ctr	3 Shaws Cove Ste 206	New London	CT	06320	1053319624	Surgery	Urology	
Schoenberger	Steven	M	MD	Thames Urology Ctr	491 Rte 184 Ste 100	New London	CT	06320	1477551034	Surgery	Urology	
Auerbach	Peter	T	MD	Thameside OB/GYN Ctr	491 Rte 184 Ste 100	Groton	CT	06340	1164472674	OB-GYN	OB-GYN	

Physician Practices in L&MMPA Service Area (Table 9)

Last Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
Alulio	Anthony		MD	Thameside OB/GYN Cr	491 Rte 184 Ste 100	Groton	CT	06340	1477657932	OB-GYN	OB-GYN	(6)
Alulio	Elija	M	MD	Thameside OB/GYN Cr	491 Rte 184 Ste 100	Groton	CT	06340	1700881688	OB-GYN	OB-GYN	(6)
Alulio	Tricia	A	MD	Thameside OB/GYN Cr	491 Rte 184 Ste 100	Groton	CT	06340	1154478915	OB-GYN	OB-GYN	(6)
Alulio	Schrempf	A	MD	Thameside OB/GYN Cr	491 Rte 184 Ste 100	Groton	CT	06340	1972694495	OB-GYN	OB-GYN	(6)
Alulio	Abel	A	MD	Thompson Goldberg & Donika	22 W Main St	Niantic	CT	06357	1649322686	Medicine	Internal Medicine	(6)
Alulio	Goldberg	P	MD	Thompson Goldberg & Donika	22 W Main St	Niantic	CT	06357	1013903066	Medicine	Internal Medicine	(6)
Alulio	Thompson	D	MD	Thompson Goldberg & Donika	22 W Main St	Niantic	CT	06357	4477548465	Medicine	Internal Medicine	(6)
Alulio	David	D	MD	Thompson Goldberg & Donika	22 W Main St	Niantic	CT	06357	4326856114	Surgery	Dental	(6)
Alulio	Bruce	H	DMD	Waterford Dental Health	177 Boston Post Rd PO Box 254	Waterford	CT	06388	1174539603	OB-GYN	OB-GYN	(6)
Alulio	Paul	A	MD	Women & Infants Hospital	101 Dudley St	Providence	RI	02908	4877660296	OB-GYN	OB-GYN	(6)
Alulio	Comeluis	O	MD	Women & Infants Hospital	101 Dudley St	Providence	RI	02908	4877660296	OB-GYN	OB-GYN	(6)
Alulio	Carra	A	MD	Women & Infants Hospital	101 Dudley St	Providence	RI	02908	4877660296	OB-GYN	OB-GYN	(6)
Alulio	Stucky	R	MD	Women & Infants Hospital	101 Dudley St	Providence	RI	02908	4877660296	OB-GYN	OB-GYN	(6)
Alulio	Abbeck	M	MD	Yale Medical Group	333 Cedar St TMP4	New Haven	CT	06510	1457444321	OB-GYN	OB-GYN	(6)
Alulio	Maxwell	S	MD	Yale Medical Group	333 Cedar St TMP4	New Haven	CT	06510	1366612026	Surgery	Neurosurgery	(6)
Alulio	Cherill	C	MD	Yale Medical Group	333 Cedar St TMP4	New Haven	CT	06510	1881874434	Surgery	Neurosurgery	(6)
Alulio	Jeffrey	E	MD	Yale Medical Group	333 Cedar St TMP4	New Haven	CT	06510	1063996187	Surgery	Neurosurgery	(6)
Alulio	Cassius	I	MD	Yale Medical Group	333 Cedar St BB204	New Haven	CT	06510	10839884100	Surgery	Vascular	(6)
Alulio	Bauer	E	MD	Yale Medical Group	333 Cedar St BB 204	New Haven	CT	06510	1669600688	Surgery	Vascular	(6)
Alulio	Bruckner	M	MD	Yale Medical Group	333 Cedar St BB204	New Haven	CT	06510	1750498671	Surgery	Vascular	(6)
Alulio	Fathey	T	MD	Yale Pediatric Cardiology	333 Cedar St Box 208064	New Haven	CT	06520	1124003975	Pediatrics	Pediatric Cardiology	(6)
Alulio	Friedman	A	MD	Yale Pediatric Cardiology	333 Cedar St LCI 302	New Haven	CT	06520	1851974098	Pediatrics	Pediatric Cardiology	(6)
Alulio	Greenstein	E	MD	Yale Pediatric Cardiology	333 Cedar St Box 208064	New Haven	CT	06520	1386929848	Pediatrics	Pediatric Cardiology	(6)
Alulio	Ellen	E	MD	Yale Pediatric Cardiology	333 Cedar St PO Box 208064	New Haven	CT	06520	1053560763	Pediatrics	Pediatric Cardiology	(6)
Alulio	Weeks	P	MD	Yale Pediatric Cardiology	333 Cedar St Box 208064	New Haven	CT	06520	1346432820	Pediatrics	Pediatric Cardiology	(6)
Alulio	Waters	P	MD	Yale Pediatric Cardiology	333 Cedar St Box 208064	New Haven	CT	06520	1124003988	Pediatrics	Pediatric Cardiology	(6)
Alulio	Waldmann	G	MD	Yale Pediatric Cardiology	333 Cedar St Box 208064	New Haven	CT	06520	1851852487	Pediatrics	Pediatric Cardiology	(6)
Alulio	Atkhan	R	MD	Yale Univ Cardiovascular Med	PO Box 208017	New Haven	CT	06520	1628270510	Medicine	Cardiology	(6)
Alulio	Brennan	J	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06510	1528057304	Medicine	Cardiology	(6)
Alulio	Cadin	H	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06510	1881684116	Medicine	Cardiology	(6)
Alulio	Clemm	W	MD	Yale Univ Cardiovascular Med	333 Cedar St PO Box 208017	New Haven	CT	06520	1023006269	Medicine	Cardiology	(6)
Alulio	Curtis	J	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06510	1700876273	Medicine	Cardiology	(6)
Alulio	Forrest	J	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06510	1386827491	Medicine	Cardiology	(6)
Alulio	Giordano	K	MD	Yale Univ Cardiovascular Med	111 College Ln Ste 2400	Gulford	CT	06437	1386430458	Medicine	Cardiology	(6)
Alulio	Henry	G	MD	Yale Univ Cardiovascular Med	1591 Boston Post Rd	Gulford	CT	06437	172007324	Medicine	Cardiology	(6)
Alulio	Frau	S	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06520	1114015162	Medicine	Cardiology	(6)
Alulio	Renetz	M	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06520	1566450841	Medicine	Cardiology	(6)
Alulio	Selato	F	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06510	1932189494	Medicine	Cardiology	(6)
Alulio	Abdel-Razek	J	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1265415350	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Bakhtyar	O	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1822167352	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Bukowski	R	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	192167352	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Campbell	K	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	197274784	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Conat	A	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1295112392	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Galembeau	A	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1649254475	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Kolhart	S	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06510	1358508996	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Lipkind	S	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1033149311	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Magriples	U	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1740293973	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Paides	J	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1821071994	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Christian	M	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	145734842	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Anna	K	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06510	1184405239	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Slaknaki	M	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1316122475	OB-GYN	Maternal Fetal Medicine	(6)
Alulio	Silasi	M	MD	Yale Univ Maternal Fetal Med	PO Box 208040	New Haven	CT	06520	1328206855	Medicine	Radiation Oncology	(6)
Alulio	Bindra	H	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1477673584	Medicine	Radiation Oncology	(6)
Alulio	Decker	R	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1750400544	Medicine	Radiation Oncology	(6)
Alulio	Evans	B	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1396734168	Medicine	Radiation Oncology	(6)
Alulio	Glazer	P	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1356601589	Medicine	Radiation Oncology	(6)
Alulio	Hansen	E	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1862465987	Medicine	Radiation Oncology	(6)
Alulio	Higgins	A	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1356601589	Medicine	Radiation Oncology	(6)
Alulio	Husain	Z	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1862465987	Medicine	Radiation Oncology	(6)
Alulio	Johann	L	MD	Yale Univ Therapeutic Rad Dept	35 Park St Willow LL 515	New Haven	CT	06520	1265605768	Medicine	Radiation Oncology	(6)
Alulio	Knott	L	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1673733422	Medicine	Radiation Oncology	(6)
Alulio	Knowlton	A	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1841280385	Medicine	Radiation Oncology	(6)
Alulio	Moran	A	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1942278076	Medicine	Radiation Oncology	(6)
Alulio	Abeloff	A	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1275552247	Medicine	Radiation Oncology	(6)
Alulio	Roberts	B	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1770571770	Medicine	Radiation Oncology	(6)
Alulio	Lynn	D	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1306020474	Medicine	Radiation Oncology	(6)
Alulio	Wilson	P	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1306020474	Medicine	Radiation Oncology	(6)
Alulio	Yan	B	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06510	1679716195	Medicine	Neurology-Telestroke	(6)
Alulio	Amir	Y	MD	Yale-New Haven Telestroke	16 York St LCI 710 PO Box 208018	New Haven	CT	06520	1992686622	Medicine	Neurology-Telestroke	(6)
Alulio	Hardik	M	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1992686622	Medicine	Neurology-Telestroke	(6)
Alulio	Joachim	M	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	11444457755	Medicine	Neurology-Telestroke	(6)
Alulio	Deatbom	L	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	11444457755	Medicine	Neurology-Telestroke	(6)

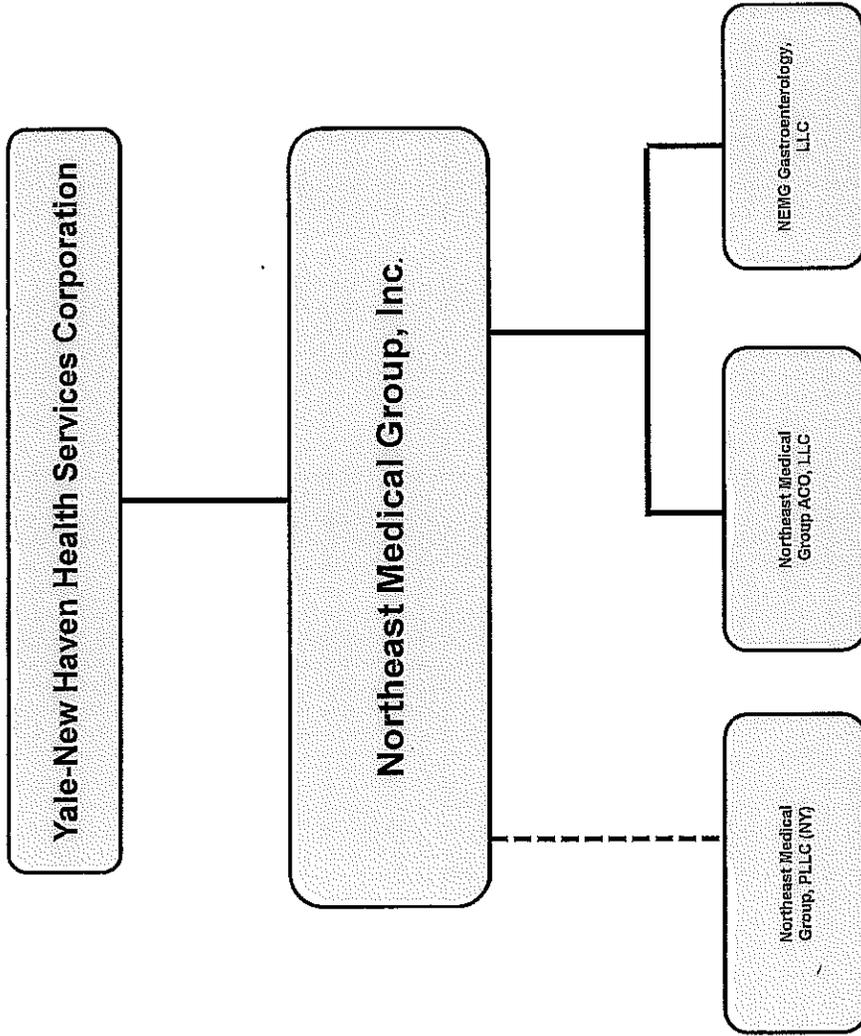
Physician Practices in LAMPA Service Area (Table 3)

Last Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
Arner	David	W	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	103807215	Medicine	Neurology-Telestroke	(9)
Hwang	David	Y	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	140799389	Medicine	Neurology-Telestroke	(9)
Joomis	Caitlin		MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	116486909	Medicine	Neurology-Telestroke	(9)
Javaretnam	Dhaakumar	S	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	152904738	Medicine	Neurology-Telestroke	(9)
Perkins	Nils	H	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	186284472	Medicine	Neurology-Telestroke	(9)
Sansing	Lauren	H	MD	Yale-New Haven Telestroke	15 York St LCI 1005	New Haven	CT	06510	1912052820	Medicine	Neurology-Telestroke	(9)
Schindler	Joseph	L	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1609857044	Medicine	Neurology-Telestroke	(9)
Sheth	Kevin	N	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1629184585	Medicine	Neurology-Telestroke	(9)
Allen	John	E	DMD	464 Montauk Ave	New London	CT	06320	1891871273		Surgery	Dental	
Laris	Rendall	D	DDS	1527 Rte 12 PO Box 396	Gales Ferry	CT	06335	1063977811		Surgery	Dental	
Leadley	Annette	L	MD	56 Whitehall Ave	Mystic	CT	06355	1285841682		Medicine	Dermatology	
Viller	Debra	R	MD	53 Granite St Ste D	New London	CT	06320	1568369215		Medicine	Dermatology	
Wolf	Eric	K	MD	495 Rte 184 Site 108	Groton	CT	06340	1043309885		Medicine	Dermatology	
Sikand	Vijay	K	MD	41 Heritage Rd	East Lyme	CT	06333	1013914187		Medicine	Family Medicine	
Verma	Shir	K	MD	381 Ocean Ave	New London	CT	06320	1790879248		Medicine	Gastroenterology Gen Surgery, Gastroenterology Pulmonary &	
Azia	Gregory	S	MD	389 Ocean Ave	New London	CT	06320	1437297785		Medicine & Surgery	Vascular & Thoracic Surgery	
Deren	Michael	M	MD	125 Shaw St	New London	CT	06320	1972696534		Surgery	General & Thoracic Surgery	
Kuhn	Kris		MD	3 Heron Road	Mystic	CT	06355			Medicine	Geriatric Medicine	
Giordano	Joan		MD	183 Boston Post Rd	East Lyme	CT	06333	1144897887		Medicine	Internal Medicine	
McDermott	Edward	J	MD	28 Church St	Groton	CT	06340	1356924008		Medicine	Internal Medicine	
Yoselevsky	Melvin	A	MD	354 Montauk Ave	New London	CT	06520	1710076924		Medicine	Internal Medicine	
Simpson	Jeffrey	A	MD	345 Montauk Ave	New London	CT	06520	1275625168		Medicine	OB-GYN	
Fannigleit	Petar	J	MD	339 Flanders Rd Ste 109	East Lyme	CT	06333	1811894510		Surgery	Ophthalmology	
Samboro	Fred	E	MD	Flanders Plaza Ste 214 PO Box 159	East Lyme	CT	06333	1639269970		Pediatrics	Pediatrics	
Sena	Thomas		MD	196 Parkway S Ste 101	Waterford	CT	06395	1972689073		Surgery	Plastic-Hand Surgery	
Coleen	Steven	R	MD	18 Lincoln Avenue	Waterford	CT	06379			Surgery	Podiatry	
Coss	Edward	W	MD	196 Parkway S Ste 201	Waterford	CT	06395	1276666564		Psychiatry	Psychiatry	
Maloney	Madlin	J	MD	400 Bayonal Street	New London	CT	06380			Psychiatry	Psychiatry	
Ogland	Cliff	J	MD	19 Halls Road	Old Lyme	CT	06371			Psychiatry	Psychiatry	
Levit	Robert	E	MD	131 Boston Post Rd Ste 6	East Lyme	CT	06333	1568457168		Medicine	Rheumatology	
Deghn	Kathleen		MD	165 State Street	New London	CT	06320			Medicine		

(1) Physician part of YMG; supports LMH's angioplasty program, thus clinically active part-time in CT.  
 (2) Physician part of MEMG.  
 (3) Physician leaving service area on 9/30/15.  
 (4) Physician part of YMG; coverage of LMH's NICU service provided through services agreement among LMH, YNHCH, and YSM.  
 (5) Physician part of YMG; provides clinical services within service area on a part-time basis through services agreements among (as applicable) LMH, LMPH, YNHCH, and YSM.  
 (6) Physician to start 10/1/15.  
 (7) Physician provides telestroke services to patient's residing within service area.  
 (8) Physician affiliated with W&J Hospital in Providence, RI; provides clinical services within service area on a part-time basis.  
 (9) Physician affiliated with YNHCH; provides telestroke services to patients residing within service area.

**ATTACHMENT A**

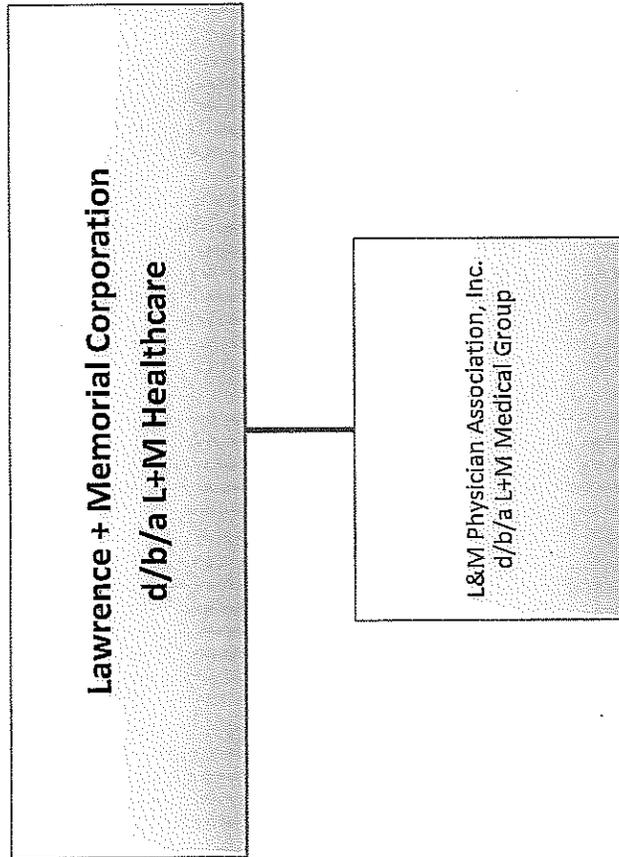
CURRENT



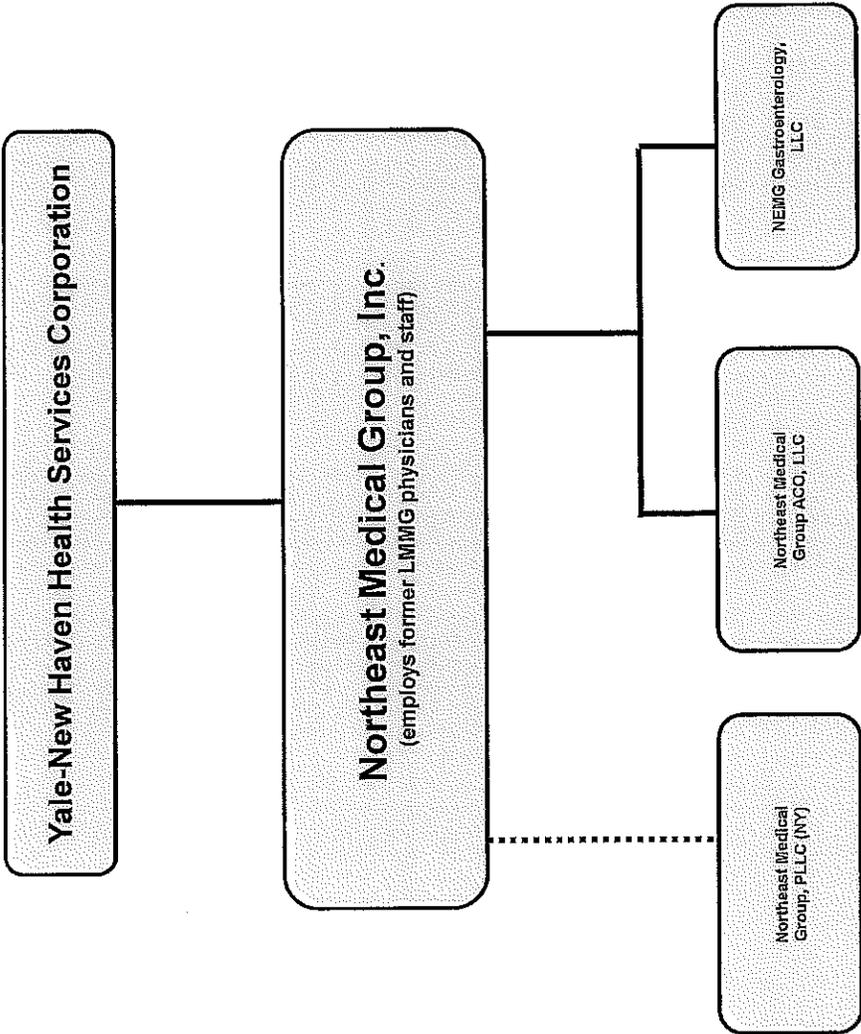
-----  
 indicates authority to elect directors or  
 other indirect relationships

**L+M Healthcare**

**L+M**



**PROPOSED**



..... indicates authority to elect directors or other indirect relationships



365 Montauk Avenue  
New London, CT 06320



July 24, 2015

Ms. Kimberly R. Martone  
Director of Operations  
Department of Public Health  
Office of Health Care Access  
410 Capitol Avenue, MS # 13HCA  
Hartford, CT 06134-0308

Re: L & M Physician Association, Inc.

Dear Ms. Martone,

Pursuant to Section 33-182bb(d) of the Connecticut General Statutes, this shall serve as notice that, at a meeting duly called and held on July 13, 2015, that the Board of Directors of L & M Physician Association, Inc. ("LMPA") voted to approve the merger of LMPA with and into Northeast Medical Group, Inc. ("NEMG"), with NEMG as the surviving entity (the "Merger"). The Merger is contemplated in connection with Yale-New Haven Services Corporation becoming the sole corporate member of Lawrence + Memorial Corporation. Enclosed is a copy of the Agreement and Plan of Merger between LMPA and NEMG to be executed immediately prior to the effective date of the Merger. Such Merger shall not take effect until all necessary regulatory approvals have been obtained, including but not limited to OHCA's approval relating to such Merger.

If you need any additional information about the proposed Merger, please feel free to contact me.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Maureen J. Anderson'.

Maureen J. Anderson  
Vice President/General Counsel

MA/PBC  
Enclosure

## AGREEMENT AND PLAN OF MERGER

of

**L&M PHYSICIAN ASSOCIATION, INC.**  
a Connecticut medical foundation

with and into

**NORTHEAST MEDICAL GROUP, INC.,**  
a Connecticut medical foundation

### ARTICLE I PARTIES

The parties to the merger (the "Merger") are L&M Physician Association, Inc., a Connecticut medical foundation (the "Merging Corporation"), and Northeast Medical Group, Inc., a Connecticut medical foundation (the "Surviving Corporation" and, together with the Merging Corporation, the "Constituent Corporations"). The Merging Corporation shall merge with and into the Surviving Corporation in accordance with the Connecticut Medical Foundations Law and the Connecticut Revised Nonstock Corporation Act (together, the "Act").

### ARTICLE II SURVIVING CORPORATION, NAME

Northeast Medical Group, Inc. shall be the surviving corporation of the Merger. The Constituent Corporations shall cause an appropriate Certificate of Merger (the "Certificate of Merger") reflecting the Merger to be filed with the Secretary of the State of the State of Connecticut. Upon the Effective Time (as defined below) of the Merger, the name of the Surviving Corporation shall continue to be Northeast Medical Group, Inc.

### ARTICLE III EFFECTIVE TIME AND DATE

The Constituent Corporations shall do all acts and things as shall be necessary or desirable to effect the Merger. The effective time and date of the Merger provided for herein shall be the time and date on which the Certificate of Merger is filed with the Secretary of the State of the State of Connecticut (the "Effective Time").

**ARTICLE IV**  
**PURPOSES OF THE PLAN OF MERGER**

(a) L&M Physician Association, Inc. is a corporation without capital stock organized and existing under the Act. Northeast Medical Group, Inc. is a corporation without capital stock organized and existing under the Act.

(b) This Agreement and Plan of Merger (the "Plan") is intended to accomplish the merger of L&M Physician Association, Inc. with and into Northeast Medical Group, Inc., with Northeast Medical Group, Inc. as the surviving corporation, in the manner stated in this Plan and in accordance with the provisions of the Act.

**ARTICLE V**  
**MEMBERSHIP, CERTIFICATE OF INCORPORATION, BYLAWS, OFFICERS AND TRUSTEES**

At the Effective Time, the following shall happen automatically and immediately, without the need for any other action by the board of directors of the Merging Corporation, the board of trustees of the Surviving Corporation, or the respective members of either of the Constituent Corporations, and without any filing other than the filing of the Certificate of Merger:

(a) As of the Effective Time, the separate existence of the Merging Corporation shall cease, and the membership of the Merging Corporation shall not convert into membership of the Surviving Corporation.

(b) The Certificate of Incorporation and the Bylaws of Northeast Medical Group, Inc. shall each be amended and restated at the Effective Time as a result of the Merger. The Amended and Restated Certificate of Incorporation and the Amended and Restated Bylaws of the Surviving Corporation, are set forth as Exhibit A and Exhibit B, respectively, to this Plan, and shall be effective from and after the Effective Time, until further amended pursuant to the Act and in the manner prescribed therein.

(c) The officers and trustees of Northeast Medical Group, Inc. in office immediately prior to the Effective Time shall be the officers and trustees of the Surviving Corporation until such time as they may be changed in accordance with the Bylaws of the Surviving Corporation and other applicable law.

**ARTICLE VI**  
**EFFECT OF MERGER**

Upon the Effective Time of the Merger, the separate existence of L&M Physician Association, Inc. shall cease. The effect of the Merger shall be as set forth in §33-1158 of the Act.

**ARTICLE VII**  
**OTHER TERMS AND CONDITIONS**

If, at any time after the Effective Time, the Surviving Corporation or its successor or assigns determines that any documentation, action or other things are necessary or desirable to further carry out the purposes of this Plan or to vest the Surviving Corporation with all right, title and interest in to and under all of the assets, properties, rights, claims, privileges, immunities, powers, franchises and authority of each of the Constituent Corporations, the officers and directors of the Surviving Corporation shall be authorized to execute and deliver, in the name of and on behalf of any Constituent Corporation or otherwise, all such documentation, and to take and do, in the name and on behalf of any Constituent Corporation or otherwise, all such other actions and things.

**END OF PLAN OF MERGER**

\* \* \* \* \*

*[Signature page follows.]*

IN WITNESS WHEREOF, each of the Constituent Entities has caused this Agreement and Plan of Merger to be executed on its behalf by its duly authorized officers on this \_\_\_\_ day of \_\_\_\_\_.

L&M PHYSICIAN ASSOCIATION, INC.

By: \_\_\_\_\_  
Name: Christopher M. Lehrach, M.D.  
Title: President

NORTHEAST MEDICAL GROUP, INC.

By: \_\_\_\_\_  
Name: Amit Rastogi, M.D.  
Title: Interim President

EXHIBIT A  
to  
AGREEMENT AND PLAN OF MERGER

Amended and Restated Certificate of Incorporation  
of  
Northeast Medical Group, Inc.

**AMENDED AND RESTATED  
CERTIFICATE OF INCORPORATION**

**NORTHEAST MEDICAL GROUP, INC.**

§1. Name. The name of the Corporation shall hereafter be: NORTHEAST MEDICAL GROUP, INC. (the "Corporation").

§2. Purposes. The nature of the activities to be conducted and the purposes to be promoted or carried out by the Corporation shall be exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and shall include the following:

(a) to operate and maintain one or more offices or facilities for the study, diagnosis and treatment of human ailments and injuries by licensed persons;

(b) to render medical and surgical treatment, consultation or advice by duly licensed employees or agents of the Corporation to patients without regard to race, color, creed, sex, age or ability to pay for such care and services;

(c) to promote, enhance, improve, and develop medical, surgical and scientific research at providers affiliated with Yale-New Haven Health Services Corporation, including, for so long as such providers are affiliated with Yale-New Haven Health Services Corporation, Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Corporation, Yale-New Haven Hospital and such other providers that may affiliate with Yale-New Haven Health Services Corporation in the future (the "Affiliated Delivery Networks") and throughout the communities they serve;

(d) to promote, enhance, improve and augment the quality of medical and clinical education and patient care at Affiliated Delivery Networks and at any other sites determined by the Corporation;

(e) to promote and enhance a high quality of medical care and other human services for the benefit of all persons in the communities it serves;

(f) to augment the planning process for the promotion of the general well-being and human health needs of the communities it serves;

(g) to solicit, accept, hold, invest, reinvest, and administer any contributions, grants, donations, gifts, bequests, devises, benefits of trusts (but not to act as trustee of any trust), and property of any sort, without limitation as to amount or value, and to use, disperse or donate the income or principal thereof for exclusively charitable and educational purposes in such manner as, in the judgment of the Board of Trustees and the member of the Corporation, will best promote the purposes of the Corporation;

(h) to contract for, purchase, receive, own, manage, operate or lease property, real, personal and mixed, wheresoever situated, as may be necessary to promote and further the purposes and objectives of the Corporation; and

(i) to engage in any lawful act or activity for which a medical foundation may be organized under Chapter 594b of the General Statutes of Connecticut or for which a nonstock corporation may be organized under Chapter 602 of the General Statutes of Connecticut.

The member of the Corporation has elected to bring the Corporation within the provisions of Chapter 594b of the General Statutes of Connecticut.

In furtherance of the purposes set forth herein, the Corporation shall (i) participate as an integral part of the integrated health care delivery system known as the Yale New Haven Health System (the "System"), which System provides, through the corporation and its affiliates, comprehensive, cost effective, advanced patient care characterized by safety and clinical and service quality; and (ii) fund and promote activities and programs of the System, including activities and programs of its affiliates, consistent with and in furtherance of the corporation's charitable purposes and the charitable purposes of all System affiliates.

§3. Nonprofit. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions.

§4. Member. The Corporation shall have but one voting member. The member shall be Yale-New Haven Health Services Corporation, a "Health System" as defined in Section 33-182aa of the Connecticut General Statutes. The member shall have the rights, powers and privileges provided in the Corporation's Bylaws and by Connecticut law, including certain expressly reserved powers and retained rights described in the Bylaws.

§5. Duration. The duration of the Corporation shall be perpetual.

§6. Board of Trustees. Subject to the rights, powers and privileges of the member, the Corporation shall operate under the management of its Board of Trustees. The Bylaws may provide that certain persons occupying certain positions within or without the Corporation shall be ex-officio trustees, who may be counted in determining a quorum and may have the right to vote as may be provided in the Bylaws. As may be further provided in the Bylaws, the terms of elected trustees may be staggered by dividing the elected trustees into up to three groups so that approximately an equal number of such trustees have terms that expire each year. Trustees may be removed by the member for cause as set forth in the Bylaws.

§7. Restrictions. No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, the Corporation's trustees, officers or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Section 2 hereof. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of "statements")

any political campaign on behalf of any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

§8. Dissolution. Upon the dissolution or termination of the existence of the Corporation, all of its property and assets, after payment of the lawful debts of the Corporation and the expenses of its dissolution or termination, shall be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to Yale-New Haven Health Services Corporation, or, if at the time of the dissolution or termination of the existence of the Corporation, Yale-New Haven Health Services Corporation is not in existence or does not qualify as exempt under Section 501(c)(3) of the Code, to any organization (or organizations) that qualifies as an organization exempt under Section 501(c)(3) of the Code, in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Trustees may determine.

§9. Limitation of Liability of Trustees. In addition to and not in derogation of any other rights conferred by law, a Trustee shall not be personally liable for monetary damages for breach of duty as a Trustee in an amount greater than the amount of compensation received by the Trustee for serving the Corporation during the year of the violation, provided that such breach did not (a) involve a knowing and culpable violation of law by the Trustee, (b) enable the Trustee or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain, (c) show a lack of good faith and a conscious disregard for the duty of the Trustee to the Corporation under circumstances in which the Trustee was aware that his/her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (d) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the Trustee's duty to the Corporation. Any lawful repeal or modification of this Section 9 or the adoption of any provision inconsistent herewith by the Board of Trustees or member of the Corporation shall not, with respect to a person who is or was a Trustee, adversely affect any limitation of liability, right or protection of such person existing at or prior to the effective date of such repeal, modification or adoption of a provision inconsistent herewith. The limitation of liability of any person who is or was a Trustee provided for in this Section 9 shall not be exclusive of any other limitation or elimination of liability contained in, or which may be provided to any person under, Connecticut law.

§10. Indemnification. The Corporation shall provide its Trustees with the full amount of indemnification that the Corporation is permitted to provide pursuant to the Connecticut Revised Nonstock Corporation Act. In furtherance of the foregoing, the Corporation shall indemnify its Trustees against liability as defined in Section 33-1116(4) of the Connecticut General Statutes to any person for any action taken, or any failure to take any action, as a Trustee, except liability that (1) involved a knowing and culpable violation of law by the Trustee, (2) enabled the Trustee or an associate to receive an improper personal economic gain, (3) showed a lack of good faith and a conscious disregard for the duty of the Trustee to the Corporation under circumstances in which the Trustee was aware that his or her conduct or omission created an

unjustifiable risk of serious injury to the Corporation, or (4) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Trustee's duty to the Corporation.

The Corporation may indemnify and advance expenses to each officer, employee or agent of the Corporation who is not a Trustee, or who is a Trustee but is made a party to a proceeding in his or her capacity solely as an officer, employee or agent, to the same extent as the Corporation is permitted to provide the same to a Trustee, and may indemnify and advance expenses to such persons to the extent permitted by Section 33-1122 of the Connecticut General Statutes.

Notwithstanding any provision hereof to the contrary, the Corporation shall not indemnify any Trustee, officer, employee or agent against any penalty excise taxes assessed against such person under Section 4958 of the Internal Revenue Code.

§11. Amendment of Bylaws. The Bylaws of the Corporation may be amended or repealed, and new Bylaws may be adopted, only with the approval of the Board of Trustees and the member.

EXHIBIT B  
to  
AGREEMENT AND PLAN OF MERGER

Amended and Restated Bylaws  
of  
Northeast Medical Group, Inc.

**NORTHEAST MEDICAL GROUP, INC.**  
**AMENDED AND RESTATED BYLAWS**

Amended and Restated as of \_\_\_\_\_, 201\_\_

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**NORTHEAST MEDICAL GROUP, INC.  
AMENDED AND RESTATED BYLAWS**

**ARTICLE I. NAME AND GENERAL PURPOSES**

**Section 1.1 Name.** The name of the corporation is **Northeast Medical Group, Inc.** (the "Corporation").

**Section 1.2 General Purposes.** The purposes of the Corporation shall be as set forth in the Corporation's Certificate of Incorporation as in effect from time to time. These Bylaws, the powers of the Corporation, its member, trustees and officers, and all matters concerning the conduct and regulation of the affairs of the Corporation shall be subject to the Certificate of Incorporation.

**ARTICLE II. MEMBERSHIP**

**Section 2.1 Member.** The Corporation shall have a single member, Yale-New Haven Health Services Corporation (the "Member"), a "Health System" as defined in Section 33-182aa of the Connecticut General Statutes.

**Section 2.2 Rights, Powers and Privileges.** The Member shall have all the rights, powers and privileges usually or by law accorded to the member of a medical foundation under the Chapter 594b of the Connecticut General Statutes (as it may be amended from time to time, the "Foundation Act") and of a Connecticut nonstock, nonprofit corporation under the Connecticut Revised Nonstock Corporation Act (as it may be amended from time to time, the "Nonstock Act") and not conferred thereby or by the Certificate of Incorporation or these Bylaws upon the Board of Trustees of the Corporation (the "Board"), including the right to elect the members of the Board in accordance with these Bylaws.

Notwithstanding anything in these Bylaws to the contrary:

(a) Neither the Board, nor any officer or employee of the Corporation, may take any of the actions set forth in Exhibit A of these Bylaws, nor may the Board or any officer or employee of the Corporation approve the taking of any such action by an Affiliate (as hereafter defined), without the prior approval of the Member. For purposes hereof, an "Affiliate" of the Corporation shall mean, unless otherwise determined by the Member, any entity which at the time Affiliate status is being determined is directly or indirectly controlling or controlled by or under the direct or indirect common control with the Corporation. "Control" shall mean the legal power to (a) elect or cause the election of a majority of the governing body of the subject entity, or (b) direct or cause the direction of the subject entity's operations or management, whether the foregoing power(s) exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means.

(b) In addition to the approval rights reserved to the Member set forth in Exhibit A, the Member expressly retains the rights to take the actions set forth in Exhibit B on

behalf of and in the name of the Corporation, directly and without the approval of the Board of this Corporation.

(c) The Board shall have the authority, from time to time, to delegate to the Member any rights, powers and privileges that would otherwise be exercised by the Board to the fullest extent permitted by applicable law.

**Section 2.3 Liability and Reimbursement of Expenses.** Unless the Member expressly agrees otherwise in writing, the Member shall not be liable for the debts or obligations of the Corporation. The Member may be reimbursed for expenses reasonably incurred on behalf of the Corporation.

### ARTICLE III. BOARD OF TRUSTEES

**Section 3.1 Powers and Duties.** Subject to the powers retained by, conferred upon, or reserved to the Member by law or under these Bylaws, the Board shall have charge, control and management of the affairs, property and funds of the Corporation in the manner and subject to the limitations set forth in these Bylaws. Each Trustee shall discharge his or her duties in good faith with the care an ordinarily prudent person in like position would exercise under similar circumstances, and in a manner he or she reasonably believes to be in the best interests of the Corporation.

**Section 3.2 Composition.** The Board shall consist of two classes of voting Trustees, the Elected Trustees and the Ex Officio Trustees (collectively, the "Trustees").

(a) **Elected Trustees.** Elected Trustees shall be the persons elected by the Member for terms as set forth in these Bylaws, following nomination and approval pursuant to Section 3.4 of this Article III. Elected Trustees will represent a cross section of major segments of the community served by the Corporation and shall be selected, on the basis of demonstrated skill and ability, for their potential contribution to the governance of the affairs of the Corporation.

(b) **Ex Officio Trustees.** In addition to the Elected Trustees, there shall be the following Ex Officio Trustees, each of whom shall serve automatically by virtue of and while holding the designated office:

- (i) the President of the Corporation; and
- (ii) the President of each Affiliated Delivery Network, or his or her designee.

For purposes hereof, "Affiliated Delivery Network" shall mean Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Corporation, Yale-New Haven Hospital and such other providers that may affiliate with the Yale New Haven System in the future, as designated by the Member.

**Section 3.3 Number.** The Board shall consist of no fewer than thirteen (13) nor more

than twenty-four (24) Trustees, inclusive of Ex Officio Trustees. The number of Trustees within the range set forth in the preceding sentence shall be determined from time to time by the Member.

**Section 3.4 Election of Trustees.** At the annual meeting of the Member, the Member shall elect successors to the Elected Trustees whose terms are then expiring. The Member shall elect such successors consistent with the following Board composition:

(a) two (2) representatives of senior management of the Member (each, a "YNHIISC Board Member");

(b) one (1) representative from each Affiliated Delivery Network other than Lawrence + Memorial Corporation (in addition to the President, or his or her designee, who shall serve Ex Officio as set forth in Section 3.2(b));

(c) two (2) physicians employed by the Corporation, each of whom is a member in good standing on the medical staff of Lawrence + Memorial Hospital or Westerly Hospital;

(d) up to eight (8) individuals, each of whom is either (1) nominated by a majority vote of the Board and approved by the Member; or (2) self-nominated and appointed by the Member; provided, however, that each such individual, whether nominated by a majority vote of the Board or self-nominated, shall be a Provider (as defined in the Foundation Act) employed or engaged by the Corporation and a member in good standing on the medical staff of one or more Affiliated Delivery Network;

(e) two (2) representatives of Yale School of Medicine;

(f) such other individuals nominated Yale School of Medicine and approved by the Member; provided, however, that each such other individual shall be a Provider employed or engaged by the Corporation and a member in good standing on the medical staff of one or more Affiliated Deliver Network.

Notwithstanding anything herein to the contrary: (x) in accordance with the Foundation Act, the number of Trustees on the Board who are Providers shall equal or exceed the number of Trustees on the Board who are nonprovider employees of the Member; and (y) the number of Trustees appointed to the Board as representatives of, or on the nomination of, Yale School of Medicine shall constitute twenty-five percent (25%) of the total number of Trustees on the Board.

**Section 3.5 Term and Term Limits.** There shall be three (3) classes of Elected Trustees, with approximately one-third of the Elected Trustees in each class, and the terms of all Trustees in the same class shall expire at the adjournment of the same annual meeting of the Member at which Trustees are elected. Elected Trustees shall take office at the close of the meeting of the Member at which they were elected or at such later date as may be established by the Member and, subject to Section 3.6 of this Article III, shall hold office for a term of three (3) years and until a successor is duly elected and qualified.

Notwithstanding anything herein to the contrary:

(a) No person shall be elected a Trustee for a term beginning after the date of his or her seventy-sixth birthday, provided that an Elected Trustee who is seventy-six (76) years of age or older may be re-elected for another term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(b) An Elected Trustee who has served three (3) consecutive full terms (provided that for the purposes of this Section 3.5 a term of service of more than one-half of a full term shall be considered a full term) shall not be eligible for re-election for a period of one year, provided that a Trustee may be re-elected for an additional consecutive term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such additional term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board, which such determination shall be made only in limited circumstances and shall be made prior to each proposed re-election after the Trustee's completion of three (3) consecutive full terms. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(c) The provisions of paragraphs (a) and (b) of this Section shall not apply to an Elected Trustee in the event such Trustee also serves as a trustee of Yale-New Haven Health Services Corporation at the time such person is elected to serve as an Elected Trustee for a term otherwise prohibited by such paragraphs (a) and (b). In the instance of re-election as a Trustee for an additional term as provided in this paragraph (c), Board membership shall be coterminous with said Trustee's service as a trustee of Yale-New Haven Health Services Corporation.

**Section 3.6 Resignation.** Any Elected Trustee may resign at any time by giving written notice of such resignation to the Secretary of this Corporation. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective. Any Ex Officio Trustee who for any reason ceases to hold the office or position from which his or status as an Ex Officio Trustee derives shall automatically be deemed to have resigned as a Trustee of the Corporation and from any position held by virtue of such office with any Affiliate.

**Section 3.7 Removal.** One or more Elected Trustees may be removed from the Board with cause by action of the Member, which action may be taken upon its own initiative or upon the recommendation of the Board.

**Section 3.8 Vacancies.** In the event of the death, resignation or removal of an Elected Trustee, the vacancy resulting therefrom may be filled only by the Member in accordance with Section 3.4 of these Bylaws. An individual elected to fill a vacancy shall serve the remainder of the term of the Trustee replaced.

**Section 3.9 Meetings.**

(a) **Annual Meetings.** The annual meeting of the Board shall be held on such date and time as the Board or the President shall designate.

(b) **Regular Meetings.** Regular meetings of the Board shall be held on such dates and at such times and places as the Board or President shall designate.

(c) **Special Meetings.** Special meetings of the Board may be called at any time by the President and shall be called by the President upon the written request of the Member or any Trustee.

**Section 3.10 Notice of Meetings.** Notice of the date, time and place of any meeting of the Board shall be given to each Trustee and to the Member at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule established at the beginning of the fiscal year and provided to the Board and the Member in writing. Any notice of a meeting required under these Bylaws may be communicated to a Trustee in person, by mail or other delivery service, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic email address at which a Trustee has consented to receive notice. Notice to the Member shall be directed to the President/Chief Executive Officer of the Member and may be provided in person, by mail, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic mail address at which the President/Chief Executive Officer of the Member has consented to receive notice.

**Section 3.11 Waiver of Notice.** Notice of any meeting of the Board may be waived in writing by all the Trustees and, if any Trustee present at a meeting of the Board does not protest prior to or at the commencement of the meeting the lack of proper notice, he or she shall be deemed to have waived notice of such meeting.

**Section 3.12 Action by Unanimous Written Consent.** Any action required or permitted to be taken by the Board may be taken without a meeting if all the Trustees unanimously consent to such action in writing. Such written consent(s) shall be filed with the minutes of the Corporation and shall have the same force and effect as a vote of Trustees at a duly convened meeting. For purposes of this section, a Trustee may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an email communication from the Trustee to the Corporation from an email address provided by the Trustee to the Corporation.

**Section 3.13 Participation by Conference Call.** The members of the Board may participate in a meeting of the Board by means of conference telephone or similar communications equipment (including, without limitation, video conferencing equipment) affording all persons participating in the meeting the ability to hear one another, and such participation in the meeting by means of such equipment shall constitute presence in person at such meeting.

**Section 3.14 Quorum and Voting.** A majority of the number of Trustees in office at the time shall constitute a quorum for the transaction of business at all meetings of the Board, provided

that if less than a majority of the Trustees is present at said meeting, a majority of the Trustees present may adjourn the meeting from time to time without further notice. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the act of a greater number is required by these Bylaws, by the Certificate of Incorporation or by law. Notwithstanding the foregoing, in the event that any Trustee has a conflict of interest with respect to any transaction to be undertaken by the Corporation, such transaction shall require the approval of the Board or the Member consistent with Article VII.

#### ARTICLE IV. OFFICERS

**Section 4.1 Officers.** The officers of the Corporation shall consist of a Chair, a President, a Secretary, a Treasurer and such other officers, including Vice Chairs, as may be appointed from time to time consistent with Section 4.6. The Chair and any Vice Chair shall be members of the Board.

**Section 4.2 Election and Term of Office.** The President shall be appointed in accordance with Section 4.3(a) of this Article IV. The Chair, any Vice Chairs, the Secretary and the Treasurer shall be nominated by the Nominating and Governance Committee and elected annually by the Board for a term of one year and until their successors are duly elected and qualified. The Board may create and fill such other offices as it deems necessary consistent with Section 4.6.

**Section 4.3 Powers.** The officers shall have the powers and perform the duties commonly incident to their respective offices, including the powers and duties listed below.

(a) **President.** The President of the Corporation shall be appointed by the Member, following consultation with the Board. The appointed President shall serve at the pleasure of the Member.

The President shall be a person who in the judgment of the Member has the combination of education, experience, professional standards and demonstrated leadership ability to fulfill successfully the responsibilities of the position and to command the confidence and respect of the Board, employees and the community.

The President shall be delegated the responsibility for overall management of the Corporation and shall have all authority necessary to carry out this responsibility, subject only to such policies as may be adopted by the Board. The President shall act as the duly authorized representative of the Board in all matters in which the Board has not formally delegated some other person to so act. The duties, responsibilities and authority of the President shall be defined in a written statement adopted by the Member in consultation with the Board.

The President shall be a voting member of all standing committees except as otherwise specified in these Bylaws.

(b) **Chair.** The Chair of the Board shall preside at meetings of the Board. The Chair shall perform such other duties as the Board may from time to time prescribe.

(c) **Vice Chair.** The Board may designate one or more Vice Chairs, who shall exercise the powers and duties of the Chair during absence or disability. The Vice Chair(s), if any, shall perform such other duties as the Board or the Chair may from time to time prescribe.

(d) **Secretary.** The Secretary shall have the custody of the records of the Corporation pertaining to the Secretary's office, shall keep minutes of the meetings of the Board, and shall cause notice of such meetings to be given as required by law or these Bylaws. The Secretary shall perform such other duties as the Board or the Chair may from time to time prescribe.

(e) **Treasurer.** The Treasurer of the Corporation shall be responsible for the safekeeping of all funds and securities of the Corporation, shall see that proper records showing all financial transactions of the Corporation are maintained, and shall present financial reports to the Board.

#### **Section 4.4 Resignation and Removal.**

(a) An officer of the Corporation may resign at any time by giving written notice of such resignation to the Secretary. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective.

(b) The Board may remove from office any officer with or without cause; provided, however, that the President may be removed from office by the Member following consultation with the Board. Removal of an officer shall be without prejudice to the officer's contract rights, if any.

**Section 4.5 Vacancies.** In the case of the death, resignation or removal of any officer, except the President, the vacancy may be filled by the Board for the unexpired term. A vacancy in the office of President shall be filled in accordance with Section 4.3(a).

**Section 4.6 Other Officers.** The Corporation may have such other officer or officers, including assistant officers, as the Board may from time to time determine. Any such officer or assistant officer shall be appointed or elected in the manner and for the term determined by the Board, and the officer shall have the duties assigned by the Board.

### **ARTICLE V. COMMITTEES**

**Section 5.1 Classification.** There shall be such standing committees as may be provided for, from time to time, in this Article V and such other committees as shall be established by Board resolution from time to time. Standing committees shall have the powers and duties set forth in this Article V and in a charter approved by the Board. Other committees shall have the powers and duties set forth in the resolution establishing them and in a charter approved by the Board. Each committee shall periodically review its charter and revise it as necessary; provided, however, that no amendment shall become effective until approved by the Board.

**Section 5.2 Appointment of Committee Members.** Except as otherwise provided in

these Bylaws, members and chairs of all standing committees shall be appointed by the Board on nomination of the Nominating and Governance Committee. All such committee members and chairs shall serve at the pleasure of the Board until the next annual meeting of the Board and until their successors shall be chosen. All committees shall have the power to choose their own secretaries. Unless otherwise provided, individuals who are not Trustees may be appointed to committees and each such person so appointed shall have a vote and be included for purposes of determining a quorum; provided, however, that if a committee is authorized to act on behalf of the Board, any such action must be approved by a majority of the committee members who are Trustees.

**Section 5.3 Committee Governance.**

(a) **Quorum and Voting.** A majority of the committee members shall constitute a quorum at committee meetings except as otherwise provided in these Bylaws. The act of a majority of the committee members present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board or by law.

(b) **Meetings.** Except as otherwise provided in these Bylaws or by resolution of the Board, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board upon request.

**Section 5.4 Standing Committees.**

(a) **Executive Committee.** The Executive Committee shall consist of the Chair, who shall act as chair of the committee, the President, the Treasurer, and any other member of the Board that the Board may choose to appoint. The Executive Committee shall possess and may exercise in the intervals between meetings of the Board all such powers of the Board, except as may otherwise be provided by law, these Bylaws or resolution of the Board.

(b) **Nominating and Governance Committee.** The Nominating and Governance Committee shall consist of Trustees elected by the Board. The Nominating and Governance Committee shall, after consultation with the President and other Trustees, nominate candidates to be voted upon in electing officers and members of the Board and nominate for appointment by the Board the chairs and members of all standing committees. The Nominating and Governance Committee shall also review Board governance matters and recommend enhancements to strengthen the Board and ensure the comprehensiveness and efficiency of its governance process.

(c) **Finance Committee.** The Finance Committee shall have such duties as are established by the Member and set forth in the Finance Committee charter. These duties shall include, but not be limited to, approval of local operating and capital budgets and examination and monitoring of other operating and capital budgets involving the Corporation.

**Section 5.6 Other Committees.** The Board may establish and appoint from among the Trustees or others, such other committees with such powers and authority as the Board shall designate, except that no such committee may exercise the authority of the Board.

**Section 5.7 Powers of Committees.** No committee established by the Board shall have power to fill vacancies on the Board or on any of its committees, to amend the Certificate of Incorporation of the Corporation or these Bylaws, to approve a plan of merger, to approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation other than in the usual and regular course of affairs of the Corporation, to approve a proposal to dissolve, or to authorize any other action inconsistent with the Certificate of Incorporation or these Bylaws.

## ARTICLE VI. INDEMNIFICATION

The Corporation shall indemnify and defend the Corporation's Member, Trustees, officers and employees as set forth in the Certificate of Incorporation.

## ARTICLE VII. CONFLICTS OF INTEREST

The Trustees and officers of the Corporation shall comply with any Conflicts of Interest policy adopted by the Corporation, as any such policy may be amended from time to time, and with the provisions of the Nonstock Act related to disclosure and approval of "Director's conflicting interest transactions" (as such term is defined in the Nonstock Act). Consistent with the requirements of the Nonstock Act, any "Director's conflicting interest transaction" shall, when possible, be approved and authorized by either (i) the Member or (i) a majority of the disinterested Trustees voting on the transaction at a meeting at which a majority (but no fewer than two (2)) of all disinterested Trustees on the Board shall constitute a quorum, in each case following any required disclosure of the facts of the conflicting interest transaction.

## ARTICLE VIII. MISCELLANEOUS PROVISIONS

**Section 8.1 Fiscal Year.** The fiscal year of the Corporation shall begin on the first day of October and end on the last day of September in each year unless the Board of Trustees shall otherwise determine.

**Section 8.2 Execution of Deeds and Contracts.** Except as otherwise directed by the Board, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the President or such other officers or officers as may be specified by the Board or authorized by the President.

**Section 8.3 Execution of Negotiable Instruments.** All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President or such officer or officers of the Corporation as the Board may specify from time to time.

## ARTICLE IX. AMENDMENTS

Subject to approval by the Member, these Bylaws may be amended, altered, or repealed at any meeting of the Board by a majority vote of the Trustees present and voting, a quorum being present. The general nature and purpose of such proposed amendment(s) shall be set forth in the notice of the meeting, and the actual language of the proposed amendments need not be included in the notice. No amendment, alteration or repeal shall take effect until it shall have been approved by the Member.

## EXHIBIT A

### **Actions Requiring Approval of the Member**

Notwithstanding anything in these Bylaws to the contrary, neither the Board nor any officer or employce of the Corporation may take any of the following actions, or approve an Affiliate taking any of the following actions, without the prior approval of the Member:

- A. Merger, consolidation, reorganization or dissolution of this Corporation or any Affiliate and the creation or acquisition of an interest in any corporate entity, including joint ventures;
- B. Amendment or restatement of the Mission, Certificate of Incorporation or the Bylaws of this Corporation or any Affiliate, or any new or revised "doing business as" name;
- C. Adoption of operating and cash flow budgets of the Corporation or any Affiliate, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);
- D. Adoption of capital budgets and capital allocations of this Corporation or any Affiliate (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);
- E. Incurring aggregate operating or capital expenditures on an annual basis that exceed operating or capital budgets of the Corporation adopted by the Member by a specified dollar amount to be determined from time to time by the Member;
- F. Long-term or material agreements including, but not limited to, equity financings, capitalized leases, operating leases and installment contracts; and purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance of any asset, real or personal, with a fair market value in excess of a dollar amount to be determined from time to time by the Member, which shall not be less than 10% of the total annual capital budget of this Corporation;
- G. Approval of any new relationships or agreements for undergraduate or graduate medical education programs or any material amendments to or terminations of existing agreements for undergraduate or graduate medical education programs;
- H. Contracting with an unrelated third party for all or substantially all of the management of the assets or operations of this Corporation or any Affiliate;

- I. Approval of major new programs and clinical services of this Corporation or any Affiliate or discontinuation or consolidation of any such program. The Member shall from time to time define the term "major" in this context;
- J. Approval of strategic plans of this Corporation or any Affiliate;
- K. Adoption of safety and quality assurance policies not in conformity with policies established by the Member; and
- L. Adoption of any polices relating to compensation of employed physicians or the taking of any other action to establish or adjust compensation of employed physicians. For purposes hereof, compensation shall include salary, fringe benefits and deferred compensation.

#### Other Major Activities

- A. In addition, the Member shall have the authority, except as otherwise provided by the Member and after consultation with this Corporation, to require the prior review and approval of those activities of this Corporation or any subsidiary or affiliate entity that the Member determines to be "major activities."
- B. "Major activities" shall be those which the Member by a vote of not less than two-thirds (2/3) of its Board of Trustees has declared major, by written notice to this Corporation, delivered personally or transmitted by registered or certified mail return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of the Member, and shall refer to this Bylaw provision granting such approval rights to the Member. Notices received pursuant to this section shall be recorded in the minutes of this Corporation and shall be filed with the minutes of this Corporation.

Nothing in these Bylaws shall be construed in a manner that is inconsistent with the authorities with respect to the Corporation that are reserved or retained by the Member pursuant to these Bylaws and the Bylaws of the Member.

## EXHIBIT B

### **Actions Direct Authority Retained by the Member**

Notwithstanding anything in these Bylaws to the contrary, the Member retains authority to take the following actions on behalf of and in the name of this Corporation, directly and without the approval of the Board of this Corporation:

- A. Adoption of targets for the annual operating and cash flow budgets of this Corporation and its Affiliates, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation;
- B. Adoption of targets for the annual capital budgets and capital allocations of this Corporation and any Affiliate;
- C. Adoption of annual operating, cash flow and annual capital budgets for the Corporation and any Affiliate within the targets established by the Member in the event of any failure of the Corporation to do so;
- D. Issuance and incurrence of indebtedness on behalf of this Corporation;
- E. Management and control of the liquid assets of this Corporation, including the authority to cause such assets to be funded to the Member or as otherwise directed by the Member;
- F. Appointment of the independent auditor for this Corporation and each Affiliate and the management of the audit process and compliance process and procedures for this Corporation and each Affiliate; and
- G. Appointment of the President consistent with Section 4.3(a).



*Bridging Business and Community*

July 28<sup>th</sup>, 2015

Kimberly R. Martone  
Director of Operations  
Office of Health Care Access  
410 Capitol Avenue  
MS#13HCA  
P.O. Box 340308  
Hartford, CT 06134-0308



Dear Ms. Martone,

As President of the Greater Mystic Chamber of Commerce and on behalf of our Board of Directors I am writing to express our enthusiastic endorsement for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly and ever-changing health care environment, it has become increasingly difficult for not-for-profit community hospitals to remain independent. L+M has sustained their independence for over a century and Westerly Hospital had remained independent as well for over 88 years prior to their acquisition by L+M.

L+M's proposed affiliation with Yale would be very compatible. The New London based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/ angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility- particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve and the Greater Mystic Chamber of Commerce is in complete agreement.

I strongly encourage you to approve this application.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tricia Walsh', is written over a light blue horizontal line.

Tricia Walsh

# ANTONINO AUTO GROUP

543 Colman Street  
Route 184

New London, Connecticut 06320  
Groton, Connecticut 06340

Phone (203) 447-3141  
Phone (203) 448-0050

August 4, 2015

Kimberly R. Martone  
Director of Operation  
410 Capital Ave  
MS#13HCA  
PO Box 340308  
Hartford CT 06134-0308



Dear Kimberly,

I am writing this letter to express my support of the Lawrence and Memorial Hospital and Yale New Haven Hospital's affiliations.

My name is John Antonino, I am the principle of the Antonino Auto Group of Southern Connecticut. I have been in business in Connecticut for 50 years and have had many pleasurable experiences with health needs at Lawrence and Memorial Hospital. My four children and twelve grandchildren were all born at Lawrence and Memorial Hospital. I also have had four occasions with health issues that doctors and staff have helped me though, all with success. Both of my parents were also treated there in the last days of their lives, and always with respectful care.

My business employs 650 people at all skill levels, their extended family member's total over 2000 individuals. Most of our employees have health insurance coverage through us, and all enjoy the benefits of Lawrence and Memorial Hospital.

It is apparent to me that Lawrence and Memorial Hospital has always endeavored, though the years, to provide the people of Southeastern Connecticut with the most modern and up to date medical and facilities possible. An affiliation with Yale New Haven Hospital can only improve the reputable status of Lawrence and Memorial Hospital has earned, particularly the Cancer Center which is also state of the art.

It would be an injustice if affiliation of these two fine establishments were not possible. If allowed, the union would quite possibly make them the best in New England.

Thank you for your consideration.

Sincerely,

John Antonino



**Support Letter for Yale-New Haven Hospital & Yale New Haven Health System  
Re: Lawrence & Memorial Hospital Affiliation**

August 13<sup>th</sup>, 2015

Kimberly R. Martone  
Director of Operations  
Office of Health Care Access  
410 Capitol Avenue  
MS#13HCA  
P.O. Box 340308  
Hartford, CT 06134-0308

Dear Ms. Martone:

As a community partner I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Leeway, with support from Yale New Haven Health, has had a significant impact on the lives of underserved families in our region. Under the proposed affiliation agreement that is before you, YNHHS has committed to invest in the southeastern Connecticut and western Rhode Island region. This investment is built upon the enormous efficiencies that can be generated through this partnership. That is good for L+M. It is good for YNHHS. Most importantly, it is good for the communities they serve.

As you know, healthcare is undergoing significant change across our country and across our state. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will provide L+M with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and result in significant investments in clinical programs in southeastern Connecticut and western Rhode Island.

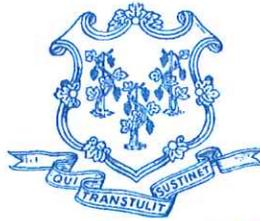
I encourage you to approve the affiliation. Thank you for the opportunity to offer my support.

Sincerely,

Heather Aaron  
Executive Director

*A Shelter From The Storm*





Connecticut General Assembly  
SENATE DEMOCRATS

Legislative Office Building, Room 3300  
Hartford, Connecticut 06106-1591



August 18, 2015

Ms. Kimberly R. Martone  
Director of Operations  
Office of Health Care Access  
410 Capitol Avenue  
MS#13HCA  
PO Box 340308  
Hartford, CT 06134-0308

Dear Ms. Martone:

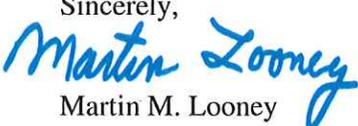
We are writing to share with you the conditions that would allow us to support the proposed affiliation between L & M Healthcare, Inc. and Yale New Haven Health System.

Our rapidly changing healthcare environment requires significant oversight to protect both patients and workers as well as to ensure that the health care market does not become increasingly distorted. It has become difficult for small not-for-profit, community hospitals to remain independent in this era of hospital consolidation. Often when a larger health system moves to acquire a community hospital, the health system promises better care and lower costs. However, the subsequent reality does not always reflect either of these goals. We write to encourage the Office of Health Care Access (OHCA) to require conditions for this acquisition that would protect patients both in terms of quality of care and cost of care. We would also encourage OHCA to protect patient quality of care by requiring the maintenance of appropriate staffing levels at these hospitals. In addition, we believe that any entity created by this affiliation must respect all existing collective bargaining agreements.

We realize that there is logic to this acquisition in that Yale already assists L & M in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery; therefore, personnel from both institutions already interact and cooperate regularly. A full affiliation has the potential to improve both organizations and expand accessibility. The joining of forces may have the potential to allow L & M to recruit and retain physicians in all areas of care. However, the state must be an active partner to ensure that the main beneficiaries of this acquisition will be the patients and not the financial bottom line of the institutions involved.

We look forward to working with you on this transaction.

Sincerely,

  
Martin M. Looney  
Senate President Pro Tem

  
Andy Maynard  
State Senator

  
Cathy Osten  
State Senator

  
Gary Winfield  
State Senator



State of Connecticut  
HOUSE OF REPRESENTATIVES  
STATE CAPITOL  
HARTFORD, CONNECTICUT 06106-1591



**REPRESENTATIVE CHRISTOPHER ROSARIO**  
128TH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING  
ROOM 5006  
CAPITOL: (860) 240-8585  
E-MAIL: Christopher.Rosario@cga.ct.gov

**MEMBER**  
APPROPRIATIONS COMMITTEE  
ENERGY COMMITTEE  
TRANSPORTATION COMMITTEE

Kimberly R. Martone  
Director of Operations  
Office of Health Care Access  
410 Capitol Avenue, MS#13HCA  
P.O. Box 340308  
Hartford, CT 06134-0308

August 20, 2015

Dear Ms. Martone:

I am writing to express my support for the proposed affiliation of Lawrence + Memorial Health with the Yale New Haven Health System which includes Bridgeport Hospital that is located within our community.

I recognize that healthcare is evolving rapidly and that an affiliation between L+M and YNHHS will drive access to high quality healthcare in the most efficient manner possible. As your agency reviews the proposed affiliation, we encourage you to consider the interests of patients in our region who will directly benefit from this partnership. I view the affiliation of L+M with Yale New Haven Health System as a critically important way to preserve access to services for patients throughout the State. Building upon a long and significant history of collaboration and alignment, we see exceptional value and unique synergies in this partnership.

This affiliation will allow L+M and YNHHS and its affiliated hospitals to continue to manage an extraordinarily complex environment and allow these organizations to deliver exceptional care to the patients in our region. We are confident that a thorough review of this affiliation will reveal the strong benefits of this affiliation and we urge its approval.

Sincerely,

Christopher Rosario  
State Representative

Kimberly R. Martone  
Director of Operations  
Office of Health Care Access  
410 Capitol Avenue  
MS#13HCA  
P.O. Box 340308  
Hartford, CT 06134-0308



Dear Ms. Martone:

I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Under the affiliation agreement, YNHHS has committed to invest in the southeastern Connecticut and western Rhode Island region. This investment is built upon the enormous efficiencies that can be generated through this partnership. That is good for L+M. It is good for YNHHS. Most importantly, it is good for patients.

I understand that healthcare is undergoing significant change. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will provide L+M with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and feature significant investments in clinical programs in both states.

Thank you for the opportunity to offer my support. I believe this affiliation should be approved.

Sincerely,

Jeffrey A. Klaus

127 Everit Street  
New Haven, CT 06511

## Greer, Leslie

---

**From:** Lazarus, Steven  
**Sent:** Friday, November 06, 2015 3:12 PM  
**To:** nancy.rosenthal@yinnh.org  
**Cc:** Greer, Leslie; Riggott, Kaila; Greci, Laurie  
**Subject:** Completeness Letter, Docket Number: 15-32032-CON  
**Attachments:** 15-32032-CL 11\_6\_15.docx

Good Afternoon Nancy,

Please see the attached Completeness Letter document in the matter of Yale-New Haven Health Services Corporation's Northeast Medical Group Inc.'s acquisition of Lawrence + Memorial Physician Association, Inc. In responding to the Completeness Letter questions, follow the instructions included in the letter and provide the response document as an attachment to an email only and emailed to [OHCA@ct.gov](mailto:OHCA@ct.gov) and copied [Laurie.Greci@ct.gov](mailto:Laurie.Greci@ct.gov) . No hard copies are required. If you have any questions regarding the Completeness Letter, please feel free to contact Laurie Greci at 860-418-7013 or at [Laurie.greci@ct.gov](mailto:Laurie.greci@ct.gov).

Sincerely,

Steven

Ps. Please respond to this email, confirming that you have received this email including the Completeness Letter. Thank you.

### *Steven W. Lazarus*

Associate Health Care Analyst  
Division of Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, CT 06134  
Phone: 860-418-7012  
Fax: 860-418-7053



Ms. Rosenthal:

On October 7, 2015, OHCA received the Certificate of Need application of Northeast Medical Group, Inc. (“NEMGP”) and L&M Physician Association, Inc. (“LMPA”) for the NEMG to acquire LMPA. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Repeat each question before providing your response and paginate and date your response, i.e., each page, in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant’s document preceding it. Please begin your submission using **Page 212** and reference “**Docket Number: 15-32032-CON.**”

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **January 5, 2016**, otherwise your application will be automatically considered withdrawn.

1. Page 24 states some (but not all) of the benefits related to the proposal, including increased ability to coordinate care across the region, enhanced clinical integration and collaboration among physicians. Explain each benefit and provide specific examples of each.
2. How does this proposal will benefit the LMPA service area residents? Provide specific examples.
3. Explain how this proposal will address existing physician shortages in primary care, pediatric subspecialists surgeons and cardiology subspecialists as stated on page 29 of the initial CON application.
4. Page 29 states that NEMG has a “culture of continuous improvement” enabling it to monitor and review performance as well as use performance data to prioritize programs to improve patient care. Explain how NEMG will bring LMPA physicians into this culture.
5. Page 30 states that with the proposal, residents will have better physician access locally and avoid unnecessary emergency room visits that can result from lack of access to primary care providers. Explain and provide specific examples on how the proposal will add physicians to the LMPA’s service area and enhance access to care.
6. Provide specific examples as to how this proposal will ensure the continuation of LMPA physicians and the continued offering of a diverse group of health care providers and maintain patient choice as stated on page 36.

7. How will the proposal lead to the reduction in the cost of delivering health care services in the LMPA's service area? Provide specific examples.
8. Identify any significant differences between the NEMG's and LMPA's existing charity care policies. What additional benefits, if any, will be realized by LMPA's patient population?
9. Provide an updated Table 5 that reports the historical utilization by physician group, fiscal year and number of visits. Report the numbers of visits for Fiscal Years 2012 through 2015 for NEMG and LMPA using the same categories. If any of the categories are not reportable for one of the physician groups, enter "0" or "NA."
10. Please provide an updated Table 6 that reports the projected utilization by service category using the same categories contained in the updated Table 5. Report the numbers of visits for Fiscal Years 2016 through 2019 for NEMG and LMPA using the same categories. If any of the categories are not reportable, enter "0" or "NA."
11. Update the financial worksheets submitted on pages 191 and 192 using the same fiscal years reported in OHCA Tables 5 and 6, i.e., Fiscal Years 2012 through 2019. Provide a detailed breakdown thoroughly explaining how all of the financial amounts, volume statistics and FTEs were derived, expanding on the assumptions provided on pages 587 and 588. In the response, be specific and also include a narrative to explain the figures. Explain the yearly losses as well as any significant incremental gains or losses reported.

## Greer, Leslie

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**From:** Lazarus, Steven  
**Sent:** Tuesday, January 05, 2016 9:05 AM  
**To:** Greer, Leslie  
**Cc:** Riggott, Kaila; Ciesones, Ron; Roberts, Karen; Greci, Laurie  
**Subject:** FW: Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA  
**Attachments:** NEMG - LMPA Completeness Questions\_01 05 16\_FINAL w attachments.pdf; NEMG - LMPA Completeness Questions\_01 05 16\_FINAL.doc; NEMG- L&MPA completeness signed cover letter.pdf; YNHHS - L+M Completeness Questions\_01 05 16 FINAL w attachments.pdf; YNHHS - L+M Completeness Questions\_01 05 16 FINAL.docx; YNHHS and L+MCompleteness Signed cover letter.pdf

Leslie,

Please add to the original files.

Thank you,  
Steve

### *Steven W. Lazarus*

Associate Health Care Analyst  
Division of Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, CT 06134  
Phone: 860-418-7012  
Fax: 860-418-7053



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**From:** Karen Banoff [<mailto:kanoff@kmbconsult.com>]  
**Sent:** Tuesday, January 05, 2016 7:41 AM  
**To:** Martone, Kim  
**Cc:** Lazarus, Steven; Greci, Laurie  
**Subject:** Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA

Good morning and Happy New Year Kim-

As per OHCA's completeness letter, I am sending responses to the completeness questions for the above referenced dockets via email. As requested, an Adobe Acrobat and MS Word File is included for each. A cover letter pertaining to each application is also included.

I would appreciate receiving an email confirmation that the documents have been received.

Thank you for your time and attention to this matter.

Sincerely, Karen



*Karen M. Banoff, DNP, RN*  
*Principal*  
*203- 459-1601 (office)*  
*203-209-0681 (mobile)*

Northeast Medical Group, Inc.  
L&M Physician Association, Inc.

Proposal for Merger of L&M Physician Association, Inc.  
and Northeast Medical Group, Inc.  
Docket Number: 15-32032-CON

Responses to Completeness Questions

January 5, 2016

1. Page 24 states some (but not all) of the benefits related to the proposal, including increased ability to coordinate care across the region, enhanced clinical integration and collaboration among physicians. Explain each benefit and provide specific examples of each.

**Response**

The proposed merger of L&M Physician Association, Inc. (L&MPA) with and into Northeast Medical Group, Inc. (NEMG) will increase the ability of L&MPA to coordinate care across the region, and enhance clinical integration and collaboration among physicians through a number of initiatives, tools and systems that have already been developed and/or implemented by NEMG. Coordination of care, clinical integration and collaboration among physicians are interrelated, and described in more detail below.

First, a critical need for managing and coordinating the health of any population is having access to current and historical patient health information across care settings. This proposal will enable utilization of the same Epic EMR at NEMG and L&MPA practices which will permit access to patient information for all providers on the care team at any NEMG or Yale New Haven Health System (YNHHS) hospital location. Easy access to shared medical records, with information about previous hospitalizations, physician office visits or ancillary testing, facilitates the delivery of efficient care that avoids unnecessary duplication of services.

Secondly, access to robust and actionable clinical and utilization data that is shared across practices and collected via the same EMR system will drive clinical integration and physician collaboration. The proposal will enhance utilization of consistent data across the region which will help to guide collaboration and integration between physicians regarding the delivery of more efficient and effective care while minimizing wasteful, duplicative utilization.

For example, physicians at NEMG currently receive regular dashboard reports regarding their adherence to a number of quality indicators such as screenings, preventative care and medication adherence. This will be implemented at the L&MPA sites, and provides a consistent platform for discussion and analysis between and among providers across the region regarding the quality of care. Moreover, NEMG also prepares regular reports that capture the utilization of hospital services, emergency room visits, primary care visits, and post-acute care across a physician's patient panel. These reports enable physicians to view the entirety of an episode of care, and collaborate with others at NEMG to identify the most efficient and effective way to manage a patient population. These types of reports and data analytics will be offered to a broader group of physicians via the merger of L&MPA with and into NEMG which will aid in improving the health outcomes of patients in the region.

NEMG physicians will share clinical pathways and protocols with L&MPA physicians. These pathways and protocols have been established to provide evidence-based practice information to providers to help guide them in selecting the appropriate tests and interventions. L&MPA physicians, as part of NEMG, will have opportunities to participate in the development of additional pathways and protocols in the future.

NEMG currently offers care management services through care coordinators who follow common clinical pathways, address post-acute care needs and have a major focus on reducing unnecessary emergency room visits and 30-day readmissions. This is not the current practice at L&MPA. Depending on the size of a practice and need of its patient panel, care coordinators are either physically located in practices or provide services remotely to help patients find their way to the appropriate care setting. These services will be extended to L&MPA practices once part of NEMG and are critical for coordinating care across the region. The care coordinators have a major role in ensuring patients understand their care plan, have access to services needed and receive timely, appropriate follow-up.

2. How does this proposal benefit the L&MPA service area residents? Provide specific examples.

**Response**

Please see the response to Question 1. In addition, this proposal, and the broader affiliation of L+M with YNHHS, will enhance access to health care for residents in the service area by improving the system and affiliates' ability to attract and retain top clinical talent for the community. As health care advances, practitioners are increasingly seeking employment and collaboration with large, academically affiliated health systems. This type of physician arrangement provides the opportunity for clinicians to stay abreast of cutting edge treatments and technology, while engaging in the new wave of population health initiatives that require scale and breadth to manage risk across a larger population. Physicians do not have these same opportunities at smaller unaffiliated hospitals and health systems. Thus, this proposal will benefit service area residents via increased access to providers in clinical areas that have been challenging to recruit (e.g. primary care, surgeons) without the high quality system structure provided by YNHHS. Enhanced access to care is a key driver to improving overall health as residents can receive appropriate care, in their local community, in a timely fashion.

Also, through the affiliation, L+M and its system affiliates, including L+MH and L&MPA, will have access to a population health analytic infrastructure employed by YNHHS to enable the hospital and its system affiliates to collect and analyze data on segments of the service area population to manage specific diseases within that population. With the tools in place to not only collect data, but take action on the basis of it, residents will benefit from more coordinated care.

Lastly, L+M and YNHHS will engage in an ongoing and deliberate strategic planning process that will be focused upon enhancing the quality and breadth of clinical services that are mutually identified as needed by the community serviced by L+M and L&MPA. Direct benefits to service area residents include increased local access to high quality clinical programs and providers, and reduced need to travel outside of the region for care.

3. Explain how this proposal will address existing physician shortages in primary care, pediatric subspecialists, surgeons and cardiology subspecialists as stated on page 29 of the initial CON application.

**Response**

As stated in the original CON application, the merger of L&MPA with and into NEMG is directly attributed to the affiliation between YNHHS and L+M. For many of the same reasons noted in response to question 2, the affiliation of L+M with YNHHS will enable L+M to be more competitive in recruiting physicians and clinicians necessary to serve the community, and priority will be given to those areas with the greatest need (e.g., primary care, surgery, cardiology subspecialists, and pediatric subspecialists).

In some areas, like pediatric subspecialties, market demand may not warrant the full-time presence of a physician. If this proposal is approved, however, L+M can partner with YNHHS and its affiliates (e.g. Yale Medical Group (YMG)) to support local access on a part-time or as needed basis. Although L+M and YNHHS already have these arrangements for select services (such as oncology and cardiology), a formalized relationship will only strengthen these efforts, and will allow deeper integration and collaboration than would otherwise be permitted.

4. Page 29 states that NEMG has a “culture of continuous improvement” enabling it to monitor and review performance as well as use performance data to prioritize programs to improve patient care. Explain how NEMG will bring L&MPA physicians into this culture.

**Response**

NEMG strives to improve patient experience through continuous improvement, and will work to integrate L&MPA physicians into this process. The major features of NEMG’s culture of continuous improvement include the following:

- 1) Quality Process Improvement Committee – This is a physician committee that is focused on determining measures and processes to enhance care delivery and quality across the continuum of care. The group establishes metrics and works collaboratively to ensure improvements are achieved across the NEMG practice sites. These measures are based on the domains in the Accountable Care Organization measure set.
- 2) LEAN – NEMG has initiated LEAN as one of the main drivers for process improvement. LEAN is an approach that supports continuous improvement by achieving changes in processes to improve efficiency and quality. The early successes from this approach have increased physician engagement, patient satisfaction, and patient access. There is a multi-disciplinary oversight group engaged in this cultural and process change effort across NEMG.
- 3) Patient Experience – NEMG continues to focus on already very high Press Ganey patient satisfaction results in physician practices. Press Ganey is a national firm that works with over 20,000 organizations to help understand and improve the entire patient experience. The Chief Experience Officer at NEMG works with providers and office staff to develop, implement and monitor the success of improvement plans related to patient experience. NEMG also offers training and coaching opportunities that have been essential for the cultural shift to improve the patient experience within NEMG offices.

- 4) Operational Improvements – NEMG completes physician practice assessments to ensure standard processes and workflows that allow for optimal patient and provider experience. NEMG operations leadership has significant experience in this area and identifies opportunities for improvement and engagement to achieve success in all of its practices. Additionally, NEMG has developed standard operational dashboards distributed monthly to support improvement efforts.
- 5) NEMG Onboarding – NEMG has created a standard onboarding process that introduces the mission, vision, values and patient expectations for any new physician group practice. This is led by a multidisciplinary team and starts with an orientation led by the NEMG’s CEO and leadership team to establish our priority around patient care.

NEMG will continue to implement and enhance its culture of continuous improvement following the merger of L&MPA, and will institute all of the above tools for use in L&MPA practice locations. The features noted above enable NEMG to monitor and review performance as well as use performance data to prioritize programs to improve patient care at the L&MPA practice sites across the service area. If the overall affiliation is approved, NEMG and L&MPA will develop detailed integration plans that address both the mechanics of implementing these approaches and the challenges of cultural integration.

5. Page 30 states that with the proposal, residents will have better physician access locally and avoid unnecessary emergency room visits that can result from lack of access to primary care providers. Explain and provide specific examples on how the proposal will add physicians to the L&MPA’s service area and enhance access to care.

### **Response**

The *Statewide Facilities Plan – 2014 Supplement* notes the “misuse of the ED for non-emergent care or visits for health issues that could be more appropriately treated in other settings,” and stresses that non-emergent care is best treated at the patient’s medical home or usual sources of primary care. According to the Robert Wood Johnson Foundation, “County Health Rankings and Rankings” (included as Attachment I), New London, Litchfield, Tolland and Windham Counties have the highest population to primary care provider ratio in 2015 in the State of Connecticut. The Connecticut average is 1190:1 and New London is 1594:1. The ratio for the top U.S. Performers is 1045:1. In terms of total health (health outcomes and health factors), New London County ranks 6 out of the 8 Connecticut counties and as a result, has the highest rate of emergency department (ED) utilization in the state at 528 visits per 1,000 persons according to FY 2013 data from the *Statewide Facilities Plan – 2014 Supplement*.

Physician manpower studies completed by L+M have noted double-digit deficits in primary care supply when considering the size and age of the market. Despite the large need, L&MPA has faced challenges recruiting and retaining physicians, including primary care. As noted previously, L+M’s affiliation with YNHHS and L&MPA’s merger into NEMG is expected to enhance the ability to attract and keep top talent in the service area. Recruitment of additional primary care physicians to the service area has been identified as a top priority

given the need and immediate benefits to the community. L&MPA, as part of NEMG, will have the financial backing and resources to recruit, support, and promote these physicians. This expansion of the primary care network should result in lower cost to the statewide health care system due to the anticipated reduction in unnecessary ED utilization.

Access to physicians and care also will be enhanced with the proposal due to NEMG's on-line scheduling system which facilitates scheduling appointments. Patients can access the NEMG website at any time of the day or night and schedule an appointment with many NEMG providers. In addition, many of NEMG's primary care physicians offer "after-hour" office hours to help minimize the need to access the emergency department. These extended hours will also enhance access to care.

6. Provide specific examples as to how this proposal will ensure the continuation of L&MPA physicians and the continued offering of a diverse group of health care providers and maintain patient choice as stated on page 36.

**Response**

With the merger, current L&MPA physicians will become employees of NEMG. There will be no disruption in the continuity of medical services provided to existing patients and the community. Current L&MPA office locations will continue to provide the same level of access for patients who seek treatment for medical care. And implementation teams comprising L&MPA and NEMG members from information technology (IT), finance, billing, human resources, operations, marketing, and supply chain, will ensure there is not any disruption in operations at or following the closing of the transaction. These teams will work to develop plans for the transition, as well as longer term operational plans.

The proposal will have no negative impact on the diversity of health care providers offered in the community. In Attachment XII of the original CON, a listing of existing community physicians was provided to OHCA. There will be no alterations to this list as a result of the L&MPA merger alone. Service area residents will continue to select medical providers of their choice, and the affiliation should in fact increase provider diversity with the recruitment of much needed primary care providers and the placement of specialty and subspecialty services where appropriate to enhance access to care.

7. How will the proposal lead to the reduction in the cost of delivering health care services in the L&MPA's service area? Provide specific examples.

**Response**

NEMG has established several programs and information support systems to reduce the cost of delivering health care services, including practices that address health care utilization and help practices address unnecessary emergency department visits and readmissions within 30 days. These types of programs and initiatives are not currently in practice or available to L&MPA without significant investment in enhanced population health infrastructure. NEMG will help to reduce the cost of care delivery in the L&MPA service area by

implementing some of the unique services and features that NEMG currently employs at the newly merged L&MPA practice locations, including the following:

- NEMG will help to implement care management services at L&MPA through the use of coordinators which work either in a physician practice or virtually and target patients at high risk for hospital readmission or emergency department visits;
- NEMG will ensure that office visits are scheduled within 7-10 days following a hospitalization to help minimize visits to the emergency department or hospital readmission;
- NEMG will share clinical pathways and protocols with L&MPA physicians that have been established to provide evidence-based practice information to providers to help guide them in selecting the appropriate tests and interventions;
- NEMG will ensure that L&MPA primary care practices are required to offer “after-hour” office hours to help minimize the need to access the emergency department; and
- NEMG will share robust and actionable data reports with L&MPA providers including comparative information about patient utilization and other key metrics.

All of these efforts help to reduce the cost of delivery health care services and will be incorporated into L&MPA practices following the merger into NEMG.

8. Identify any significant differences between the NEMG’s and L&MPA’s existing charity care policies. What additional benefits, if any, will be realized by L&MPA’s patient population?

**Response**

There are very few differences between NEMG’s and L&MPA’s existing charity care policies; however, NEMG’s policies are slightly more generous. The differences are noted below. Please note that NEMG has one charity care policy for its community-based physicians and another for its hospital-based physicians. Unlike NEMG, L&MPA does not have two separate charity care policies for community-based and hospital-based physicians.

	<b>NEMG Policy</b>	<b>LMPA Policy</b>
Sliding scale cap	None (both hospital based & community practices)	400% of federal poverty guidelines
Requests for Assistance – time limit	None (both hospital based & community based practices)	2 years after date of service
Payroll stub requirement	2; also allow patients and/or employer to provide written verification of income. (hospital based services only. community practices do not require payroll stub requirement.)	3; only employer can provide written verification of income
Free care eligibility	6 months plus discounted care eligibility for 1 year	6 months

	<b>NEMG Policy</b>	<b>LMPA Policy</b>
	(hospital based services only.)	
Monthly payment plan - # months and minimum payment amount	48 months; \$50 minimum payment for hospital based services  24 months; \$50 minimum payment for community practice services	Does not have a structured monthly payment plan
Prompt pay discount	Up to 40% of balance due	25% of balance due
Asset test requirement	No (both hospital based & community practices)	Yes

9. Provide an updated Table 5 that reports the historical utilization by physician group, fiscal year and number of visits. Report the numbers of visits for Fiscal Years 2012 through 2015 for NEMG and L&MPA using the same categories. If any of the categories are not reportable for one of the physician groups, enter "0" or "NA."

### Response

As shown below, Table 5 has been updated to include FY 2012 through FY 2015 for NEMG and L&MPA using the same categories.

Table 5 Updated: NEMG

NEMG	FY2012	FY2013	FY2014	FY2015
Behavioral Health	14,356	16,410	15,385	16,943
Cardiology	118,515	118,654	118,301	129,726
Dermatology	-	-	-	-
Endocrinology	4,269	5,330	7,471	6,996
Gastroenterology	2,254	2,904	20,372	19,899
General Surgery	45,972	45,351	59,426	69,517
Geriatrics	28,021	29,622	29,181	31,397
Infectious Disease	-	-	-	-
Internal Medicine	116,845	138,821	153,191	177,796
Neonatology	9,850	10,457	10,190	14,334
Neuropsychology	-	-	-	-
Neurology	-	-	-	-
Neurosurgery	-	-	-	-
OBGYN	40,212	47,620	46,308	50,951
Oncology	15,262	19,869	20,696	20,865
Orthopedics	-	-	-	-
Pain Management	877	1,142	1,366	1,197
Palliative Care	2,379	3,611	4,297	3,132
Pediatrics	21,839	48,406	63,354	74,404
Podiatry	5,181	4,792	5,388	7,430
Primary Care	59,204	155,441	339,887	649,703
Physiatry	-	-	-	-
Plastic Surgery	-	-	-	-
Rheumatology	4,154	5,408	5,994	10,233
Sleep Medicine	7,083	7,350	7,461	6,730
Vascular Surgery	-	-	-	-
Wound care	3,004	4,455	4,777	4,897
<b>Total</b>	<b>499,277</b>	<b>665,643</b>	<b>913,045</b>	<b>1,296,150</b>

Table 5 Updated: L&amp;MPA

LMMG	FY2012	FY2013	FY2014	FY2015
Behavioral Health	-	13,850	21,884	19,861
Cardiology	36,313	67,994	68,736	62,237
Dermatology	-	3,265	11,292	10,283
Endocrinology	-	831	8,396	13,670
Gastroenterology	-	-	-	-
General Surgery	12,051	16,034	21,671	21,774
Geriatrics	-	-	-	-
Infectious Disease	-	-	126	1,801
Internal Medicine	-	-	-	-
Neonatology	2	2	5,195	1,573
Neuropsychology	1	3	-	253
Neurology	710	2,804	2,879	2,916
Neurosurgery	7,892	8,240	6,142	6,509
OBGYN	5,496	11,082	17,089	15,919
Oncology	-	-	-	-
Orthopedics	105	5,559	9,176	9,858
Pain Management	-	2,934	10,849	12,205
Palliative Care	-	98	481	62
Pediatrics	-	894	3,176	3,872
Podiatry	-	-	-	-
Primary Care	53,947	60,792	70,848	71,872
Physiatry	9,692	9,615	10,520	9,686
Plastic Surgery	1,528	10	-	-
Rheumatology	-	-	-	-
Sleep Medicine	-	-	1,721	4,807
Vascular Surgery	-	-	-	3,206
Wound Care	-	-	-	35
<b>Total</b>	<b>127,737</b>	<b>204,007</b>	<b>270,181</b>	<b>272,399</b>

10. Please provide an updated Table 6 that reports the projected utilization by service category using the same categories contained in the updated Table 5. Report the numbers of visits for Fiscal Years 2016 through 2019 for NEMG and L&MPA using the same categories. If any of the categories are not reportable, enter “0” or “NA.”

### **Response**

As shown below, Table 6 has been updated to include FY 2016 through FY 2019 for NEMG (including L&MPA) using the same categories.

Table 6 Updated: NEMG (including L&amp;MPA)

NEMG	FY 2016	FY 2017	FY 2018	FY 2019
Behavioral Health	26,900	37,000	37,100	37,200
Cardiology	161,300	193,200	193,900	194,700
Dermatology	5,100	10,300	10,300	10,400
Endocrinology	13,900	20,800	20,800	20,900
Gastroenterology	20,000	20,100	20,100	20,200
General Surgery	80,600	91,900	92,300	92,600
Geriatrics	31,500	31,600	31,800	31,900
Infectious Disease	900	1,800	1,800	1,800
Internal Medicine	178,300	179,100	180,000	180,800
Neonatology	15,200	16,000	16,100	16,200
Neuropsychology	100	300	300	300
Neurology	1,500	2,900	2,900	2,900
Neurosurgery	3,300	6,500	6,500	6,600
OBGYN	59,100	67,300	67,600	67,900
Oncology	20,900	21,000	21,100	21,200
Orthopedics	4,900	9,900	9,900	9,900
Pain Management	7,300	13,500	13,500	13,500
Palliative Care	3,200	3,200	3,200	3,200
Pediatrics	76,600	78,900	79,200	79,600
Podiatry	7,500	7,500	7,500	7,600
Primary Care	687,400	726,800	730,200	733,100
Physiatry	4,900	9,700	9,700	9,800
Plastic Surgery	-	-	-	-
Rheumatology	10,300	10,300	10,400	10,400
Sleep Medicine	9,200	11,600	11,600	11,700
Vascular Surgery	1,600	3,200	3,200	3,200
Wound care	4,900	5,000	5,000	5,000
<b>Total</b>	<b>1,436,400</b>	<b>1,579,400</b>	<b>1,586,000</b>	<b>1,592,600</b>

11. Update the financial worksheets submitted on pages 191 and 192 using the same fiscal years reported in OHCA Tables 5 and 6, i.e., Fiscal Years 2012 through 2019. Provide a detailed breakdown thoroughly explaining how all of the financial amounts, volume statistics and FTEs were derived, expanding on the assumptions provided on pages 587 and 588. In the response, be specific and also include a narrative to explain the figures. Explain the yearly losses as well as any significant incremental gains or losses reported.

### **Response**

Financial worksheets have been updated to reflect the same fiscal years reported in Tables 5 and 6. Please see Attachment II for copies of the financial worksheets and associated assumptions.

**ATTACHMENT I**

**PRIMARY CARE PHYSICIANS IN**

**CONNECTICUT – COUNTY HEALTH RANKINGS**

**AND ROADMAPS**

## HEALTH FACTORS - PRIMARY CARE PHYSICIANS

### Description

Ratio of population to primary care physicians

### Ranking Methodology

Summary Measure:	Health Factors - Clinical Care (Access to Care)
Weight in Health Factors:	3%
Years of Data Used:	2012

### Summary Information

Range in Connecticut (Min-Max):	1,867:1-1,081:1
Overall in Connecticut:	1,190:1
Top U.S. Performers:	1,045:1 (90th percentile)

### Primary care physicians

Place	# Primary Care Physicians	PCP Ratio	Z-Score
Windham	63	1,867:1	1.22
Tolland	85	1,783:1	1.06
New London	172	1,594:1	0.65
Litchfield	120	1,563:1	0.58
Middlesex	128	1,294:1	-0.25
Fairfield	831	1,124:1	-0.97
Hartford	820	1,094:1	-1.11
New Haven	798	1,081:1	-1.18

**ATTACHMENT II**  
**UPDATED FINANCIAL WORKSHEETS**

**Applicant: Northeast Medical Group**  
**Financial Worksheet (A)**

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

**NON-PROFIT**

LINE	Total Entity:	NON-PROFIT															
		FY2012	FY2013	(1)	FY2015	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
	Description	Actual Results	Actual Results	Actual Results	Actual Results	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON
<b>A. OPERATING REVENUE</b>																	
1	Total Gross Patient Revenue	\$142,289,126	\$334,422,474	\$376,215,038	\$478,243,141	\$484,453,440	\$31,578,011	\$516,031,451	\$494,142,509	\$63,156,022	\$557,298,531	\$504,025,359	\$63,156,022	\$567,181,381	\$514,105,866	\$63,156,022	\$577,261,888
2	Less: Allowances	\$86,354,887	\$233,754,220	\$246,273,458	\$297,035,867	\$305,809,574	\$15,727,593	\$321,537,167	\$311,925,765	\$30,562,862	\$342,488,627	\$318,164,280	\$30,554,866	\$348,719,146	\$324,527,565	\$30,546,710	\$355,074,275
3	Less: Charity Care	\$150,161	\$584,885	\$1,429,735	\$1,474,584	\$1,547,288	\$73,739	\$1,621,027	\$1,578,234	\$147,478	\$1,725,712	\$1,609,799	\$147,478	\$1,757,277	\$1,641,995	\$147,478	\$1,789,473
4	Less: Other Deductions	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	<b>Net Patient Service Revenue</b>	<b>\$55,784,078</b>	<b>\$100,083,369</b>	<b>\$128,511,845</b>	<b>\$179,732,690</b>	<b>\$177,096,578</b>	<b>\$15,776,679</b>	<b>\$192,873,257</b>	<b>\$180,638,510</b>	<b>\$32,445,682</b>	<b>\$213,084,192</b>	<b>\$184,251,280</b>	<b>\$32,453,678</b>	<b>\$216,704,958</b>	<b>\$187,936,306</b>	<b>\$32,461,834</b>	<b>\$220,398,140</b>
5	Medicare	\$13,751,791	\$24,672,373	\$31,826,641	\$44,307,382	\$43,657,532	\$5,224,382	\$48,881,914	\$43,657,532	\$10,448,764	\$54,106,296	\$43,657,532	\$10,448,764	\$54,106,296	\$43,657,532	\$10,448,764	\$54,106,296
6	Medicaid	\$5,823,614	\$10,448,266	\$17,736,956	\$18,763,307	\$18,488,108	\$2,068,665	\$20,556,773	\$18,488,108	\$4,137,330	\$22,625,438	\$18,488,108	\$4,137,330	\$22,625,438	\$18,488,108	\$4,137,330	\$22,625,438
7	CHAMPUS & TriCare	\$211,414	\$379,302	\$630,050	\$681,163	\$671,172	\$460,567	\$1,131,739	\$671,172	\$921,134	\$1,592,306	\$671,172	\$921,134	\$1,592,306	\$671,172	\$921,134	\$1,592,306
8	Other	\$14,694	\$26,364	\$52,188	\$47,344	\$46,650	\$0	\$46,650	\$46,650	\$0	\$46,650	\$46,650	\$0	\$46,650	\$46,650	\$0	\$46,650
	<b>Total Government</b>	<b>\$19,801,513</b>	<b>\$35,526,305</b>	<b>\$50,245,835</b>	<b>\$63,799,196</b>	<b>\$62,863,462</b>	<b>\$7,753,614</b>	<b>\$70,617,076</b>	<b>\$62,863,462</b>	<b>\$15,507,228</b>	<b>\$78,370,690</b>	<b>\$62,863,462</b>	<b>\$15,507,228</b>	<b>\$78,370,690</b>	<b>\$62,863,462</b>	<b>\$15,507,228</b>	<b>\$78,370,690</b>
9	Commercial Insurers	\$31,145,540	\$55,878,858	\$68,689,261	\$100,348,914	\$98,877,112	\$7,459,587	\$106,336,699	\$102,111,924	\$14,919,173	\$117,031,097	\$105,411,432	\$14,919,173	\$120,330,605	\$108,776,930	\$14,919,173	\$123,696,103
10	Uninsured	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
11	Self Pay	\$4,725,984	\$8,478,985	\$9,116,881	\$15,226,813	\$15,003,484	\$115,925	\$15,119,409	\$15,303,554	\$231,854	\$15,535,408	\$15,609,625	\$231,854	\$15,841,479	\$15,921,818	\$231,854	\$16,153,672
12	Workers Compensation	\$111,041	\$199,221	\$459,868	\$357,767	\$352,520	\$246,209	\$598,729	\$359,570	\$492,415	\$851,985	\$366,761	\$492,415	\$859,176	\$374,096	\$492,415	\$866,511
13	Other	\$0	\$0	\$0	\$0	\$0	\$201,314	\$201,314	\$0	\$1,295,012	\$1,295,012	\$0	\$1,303,008	\$1,303,008	\$0	\$1,311,164	\$1,311,164
	<b>Total Non-Government</b>	<b>\$35,982,565</b>	<b>\$64,557,064</b>	<b>\$78,266,010</b>	<b>\$115,933,494</b>	<b>\$114,233,116</b>	<b>\$8,023,035</b>	<b>\$122,256,151</b>	<b>\$117,775,048</b>	<b>\$16,938,454</b>	<b>\$134,713,502</b>	<b>\$121,387,818</b>	<b>\$16,946,450</b>	<b>\$138,334,268</b>	<b>\$125,072,844</b>	<b>\$16,954,606</b>	<b>\$142,027,450</b>
	<b>Net Patient Service Revenue<sup>a</sup> (Government+Non-Government)</b>	<b>\$55,784,078</b>	<b>\$100,083,369</b>	<b>\$128,511,845</b>	<b>\$179,732,690</b>	<b>\$177,096,578</b>	<b>\$15,776,649</b>	<b>\$192,873,227</b>	<b>\$180,638,510</b>	<b>\$32,445,682</b>	<b>\$213,084,192</b>	<b>\$184,251,280</b>	<b>\$32,453,678</b>	<b>\$216,704,958</b>	<b>\$187,936,306</b>	<b>\$32,461,834</b>	<b>\$220,398,140</b>
14	Less: Provision for Bad Debts	\$2,289,563	\$3,353,860	\$5,357,134	\$3,244,864	\$2,010,662	\$225,521	\$2,236,183	\$2,050,875	\$451,042	\$2,501,917	\$2,091,893	\$451,042	\$2,542,935	\$2,133,731	\$451,042	\$2,584,773
	<b>Net Patient Service Revenue less provision for bad debts</b>	<b>\$53,494,515</b>	<b>\$96,729,569</b>	<b>\$123,154,711</b>	<b>\$176,487,826</b>	<b>\$175,085,916</b>	<b>\$15,551,158</b>	<b>\$190,637,074</b>	<b>\$178,587,635</b>	<b>\$31,994,640</b>	<b>\$210,582,275</b>	<b>\$182,159,387</b>	<b>\$32,002,636</b>	<b>\$214,162,023</b>	<b>\$185,802,575</b>	<b>\$32,010,792</b>	<b>\$217,813,367</b>
15	Other Operating Revenue	\$28,495,767	\$27,949,404	\$81,519,629	\$93,477,279	\$111,849,712	\$4,621,670	\$116,471,382	\$115,205,203	\$9,243,341	\$124,448,544	\$118,661,359	\$9,243,341	\$127,904,700	\$122,221,200	\$9,243,341	\$131,464,541
17	Net Assets Released from Restrictions	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	<b>TOTAL OPERATING REVENUE</b>	<b>\$81,990,282</b>	<b>\$124,678,973</b>	<b>\$204,674,340</b>	<b>\$269,965,105</b>	<b>\$286,935,628</b>	<b>\$20,172,828</b>	<b>\$307,108,456</b>	<b>\$293,792,838</b>	<b>\$41,237,981</b>	<b>\$335,030,819</b>	<b>\$300,820,746</b>	<b>\$41,245,977</b>	<b>\$342,066,723</b>	<b>\$308,023,775</b>	<b>\$41,254,133</b>	<b>\$349,277,908</b>
<b>B. OPERATING EXPENSES</b>																	
1	Salaries and Wages	\$51,172,346	\$80,831,152	\$125,799,688	\$154,074,374	\$156,090,918	\$17,409,636	\$173,500,554	\$159,212,736	\$33,914,309	\$193,127,045	\$162,396,991	\$34,423,024	\$196,820,015	\$165,644,931	\$34,939,369	\$200,584,300
2	Fringe Benefits	\$10,110,740	\$15,273,257	\$22,402,600	\$32,054,326	\$33,996,352	\$4,209,835	\$38,206,187	\$34,676,279	\$8,032,008	\$42,708,287	\$35,369,805	\$8,098,343	\$43,468,148	\$36,077,201	\$8,165,437	\$44,242,638
3	Physicians Fees	\$15,707,188	\$26,117,607	\$44,540,230	\$67,175,188	\$67,504,504	\$2,401,946	\$69,906,450	\$68,854,594	\$5,792,648	\$74,647,242	\$70,231,686	\$5,694,828	\$75,926,514	\$71,636,320	\$5,777,314	\$77,413,634
4	Supplies and Drugs	\$1,430,000	\$2,583,500	\$4,924,592	\$11,404,986	\$10,822,628	\$1,191,483	\$12,014,111	\$11,039,081	\$2,394,882	\$13,433,963	\$11,259,863	\$2,429,368	\$13,689,231	\$11,485,060	\$2,463,865	\$13,948,925
5	Depreciation and Amortization	\$794,240	\$2,414,030	\$2,234,709	\$3,147,161	\$3,037,202	\$121,124	\$3,158,326	\$3,037,202	\$256,365	\$3,293,567	\$3,037,202	\$258,725	\$3,295,927	\$3,037,202	\$268,149	\$3,305,351
6	Provision for Bad Debts-Other <sup>b</sup>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7	Interest Expense	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
8	Malpractice Insurance Cost	\$6,382,669	\$7,100,790	\$8,287,313	\$7,184,984	\$7,027,742	\$1,295,970	\$8,323,712	\$7,168,297	\$2,592,355	\$9,760,652	\$7,311,663	\$2,592,780	\$9,904,443	\$7,457,896	\$2,593,213	\$10,051,109
9	Lease Expense	\$2,744,274	\$4,867,876	\$6,686,530	\$10,810,856	\$10,938,366	\$1,067,938	\$12,006,304	\$11,157,133	\$2,135,875	\$13,293,008	\$11,380,276	\$2,135,875	\$13,516,151	\$11,607,882	\$2,135,875	\$13,743,757
10	Other Operating Expenses	\$20,158,881	\$23,062,282	\$35,419,734	\$38,044,141	\$52,287,420	\$2,441,402	\$54,728,822	\$53,333,168	\$4,884,892	\$58,218,060	\$54,399,831	\$4,934,805	\$59,334,636	\$55,487,828	\$4,982,826	\$60,470,654
	<b>TOTAL OPERATING EXPENSES</b>	<b>\$108,500,338</b>	<b>\$162,250,494</b>	<b>\$250,295,396</b>	<b>\$323,896,016</b>	<b>\$341,705,132</b>	<b>\$30,139,334</b>	<b>\$371,844,466</b>	<b>\$348,478,490</b>	<b>\$60,003,334</b>	<b>\$408,481,824</b>	<b>\$355,387,317</b>	<b>\$60,567,748</b>	<b>\$415,955,065</b>	<b>\$362,434,320</b>	<b>\$61,326,048</b>	<b>\$423,760,368</b>
	<b>INCOME/(LOSS) FROM OPERATIONS</b>	<b>(\$26,510,056)</b>	<b>(\$37,571,521)</b>	<b>(\$45,621,056)</b>	<b>(\$53,930,911)</b>	<b>(\$54,769,504)</b>	<b>(\$9,966,506)</b>	<b>(\$64,736,010)</b>	<b>(\$54,685,652)</b>	<b>(\$18,765,353)</b>	<b>(\$73,451,005)</b>	<b>(\$54,566,571)</b>	<b>(\$19,321,771)</b>	<b>(\$73,888,342)</b>	<b>(\$54,410,545)</b>	<b>(\$20,071,915)</b>	<b>(\$74,482,460)</b>
	<b>NON-OPERATING REVENUE</b>	<b>\$0</b>															
	<b>EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES</b>	<b>(\$26,510,056)</b>	<b>(\$37,571,521)</b>	<b>(\$45,621,056)</b>	<b>(\$53,930,911)</b>	<b>(\$54,769,504)</b>	<b>(\$9,966,506)</b>	<b>(\$64,736,010)</b>	<b>(\$54,685,652)</b>	<b>(\$18,765,353)</b>	<b>(\$73,451,005)</b>	<b>(\$54,566,571)</b>	<b>(\$19,321,771)</b>	<b>(\$73,888,342)</b>	<b>(\$54,410,545)</b>	<b>(\$20,071,915)</b>	<b>(\$74,482,460)</b>
	Principal Payments	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>C. PROFITABILITY SUMMARY</b>																	
1	Hospital Operating Margin	-32.3%	-30.1%	-22.3%	-20.0%	-19.1%	-49.4%	-21.1%	-18.6%	-45.5%	-21.9%	-18.1%	-46.8%	-21.6%	-17.7%	-48.7%	-21.3%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	-32.3%	-30.1%	-22.3%	-20.0%	-19.1%	-49.4%	-21.1%	-18.6%	-45.5%	-21.9%	-18.1%	-46.8%	-21.6%	-17.7%	-48.7%	-21.3%
	<b>D. FTEs</b>	<b>720</b>	<b>739</b>	<b>1,147</b>	<b>1,175</b>	<b>1,175</b>	<b>181</b>	<b>1,356</b>	<b>1,175</b>	<b>326</b>	<b>1,501</b>	<b>1,175</b>	<b>326</b>	<b>1,501</b>	<b>1,175</b>	<b>326</b>	<b>1,501</b>
<b>E. VOLUME STATISTICS<sup>c</sup></b>																	
1	Inpatient Visits	225,283	253,946	274,973	319,218	320,000	19,700	339,700	321,000	39,500	360,500	322,000	39,600	361,600	323,000	39,700	362,700
2	Outpatient Visits	273,994	411,697	638,072	976,932	980,000	116,700	1,096,700	985,000	233,900	1,218,900	990,000	234,400	1,224,400	995,000	234,900	1,229,900
	<b>TOTAL VOLUME</b>	<b>499,277</b>	<b>665,643</b>	<b>913,045</b>	<b>1,296,150</b>	<b>1,300,000</b>	<b>136,400</b>	<b>1,436,400</b>	<b>1,306,000</b>	<b>273,400</b>	<b>1,579,400</b>	<b>1,312,000</b>	<b>274,000</b>	<b>1,586,000</b>	<b>1,318,000</b>	<b>274,600</b>	<b>1,592,600</b>

<sup>a</sup>Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

<sup>b</sup>Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

<sup>c</sup>Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

LINE	Total Entity: L&MPA	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Actual	Actual	Actual	Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
Description		Results	Results	Results	Results	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON
<b>A. OPERATING REVENUE</b>																	
1	Total Gross Patient Revenue	\$26,380,297	\$40,324,589	\$57,932,612	\$59,663,678	\$62,659,913	(\$31,329,957)	\$31,329,957	\$65,166,310	(\$65,166,310)	\$0	\$67,772,962	(\$67,772,962)	\$0	\$70,483,880	(\$70,483,880)	\$0
2	Less: Allowances	\$12,587,896	\$19,242,992	\$28,598,828	\$29,591,966	\$31,256,579	(\$15,628,290)	\$15,628,290	\$32,857,155	(\$32,857,155)	\$0	\$35,458,689	(\$35,458,689)	\$0	\$38,164,285	(\$38,164,285)	\$0
3	Less: Charity Care	\$51,796	\$79,175	\$113,747	\$95,886	\$123,029	(\$61,514)	\$61,514	\$127,950	(\$127,950)	\$0	\$133,068	(\$133,068)	\$0	\$138,391	(\$138,391)	\$0
4	Less: Other Deductions	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	<b>Net Patient Service Revenue</b>	<b>\$13,740,605</b>	<b>\$21,002,422</b>	<b>\$29,220,037</b>	<b>\$29,975,826</b>	<b>\$31,280,305</b>	<b>(\$15,640,153)</b>	<b>\$15,640,153</b>	<b>\$32,181,205</b>	<b>(\$32,181,205)</b>	<b>\$0</b>	<b>\$32,181,205</b>	<b>(\$32,181,205)</b>	<b>\$0</b>	<b>\$32,181,205</b>	<b>(\$32,181,205)</b>	<b>\$0</b>
5	Medicare	\$4,596,155	\$7,025,191	\$9,811,985	\$10,026,744	\$10,128,591	(\$5,064,295)	\$5,064,295	\$10,429,936	(\$10,429,936)	\$0	\$10,429,936	(\$10,429,936)	\$0	\$10,429,936	(\$10,429,936)	\$0
6	Medicaid	\$1,828,023	\$2,794,120	\$3,902,508	\$3,987,924	\$4,028,432	(\$2,014,216)	\$2,014,216	\$4,148,286	(\$4,148,286)	\$0	\$4,148,286	(\$4,148,286)	\$0	\$4,148,286	(\$4,148,286)	\$0
7	CHAMPUS & TriCare	\$405,780	\$620,233	\$866,270	\$885,230	\$894,222	(\$447,111)	\$447,111	\$920,827	(\$920,827)	\$0	\$920,827	(\$920,827)	\$0	\$920,827	(\$920,827)	\$0
8	Other	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	<b>Total Government</b>	<b>\$6,829,958</b>	<b>\$10,439,544</b>	<b>\$14,580,763</b>	<b>\$14,899,899</b>	<b>\$15,051,244</b>	<b>(\$7,525,622)</b>	<b>\$7,525,622</b>	<b>\$15,499,049</b>	<b>(\$15,499,049)</b>	<b>\$0</b>	<b>\$15,499,049</b>	<b>(\$15,499,049)</b>	<b>\$0</b>	<b>\$15,499,049</b>	<b>(\$15,499,049)</b>	<b>\$0</b>
9	Commercial Insurers	\$6,588,659	\$10,070,720	\$14,065,632	\$14,373,493	\$14,519,491	(\$7,259,746)	\$7,259,746	\$14,951,476	(\$14,951,476)	\$0	\$14,951,476	(\$14,951,476)	\$0	\$14,951,476	(\$14,951,476)	\$0
10	Uninsured	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
11	Self Pay	\$102,430	\$156,564	\$218,670	\$223,457	\$225,726	(\$112,863)	\$112,863	\$232,442	(\$232,442)	\$0	\$232,442	(\$232,442)	\$0	\$232,442	(\$232,442)	\$0
12	Workers Compensation	\$219,558	\$335,594	\$468,719	\$478,978	\$483,843	(\$241,922)	\$241,922	\$498,238	(\$498,238)	\$0	\$498,238	(\$498,238)	\$0	\$498,238	(\$498,238)	\$0
13	Other	\$0	\$0	\$0	\$0	\$1,000,000	(\$500,000)	\$500,000	\$1,000,000	(\$1,000,000)	\$0	\$1,000,000	(\$1,000,000)	\$0	\$1,000,000	(\$1,000,000)	\$0
	<b>Total Non-Government</b>	<b>\$6,910,647</b>	<b>\$10,562,878</b>	<b>\$14,753,021</b>	<b>\$15,075,927</b>	<b>\$16,229,061</b>	<b>(\$8,114,530)</b>	<b>\$8,114,530</b>	<b>\$16,682,156</b>	<b>(\$16,682,156)</b>	<b>\$0</b>	<b>\$16,682,156</b>	<b>(\$16,682,156)</b>	<b>\$0</b>	<b>\$16,682,156</b>	<b>(\$16,682,156)</b>	<b>\$0</b>
	<b>Net Patient Service Revenue<sup>a</sup> (Government+Non-Government)</b>	<b>\$13,740,605</b>	<b>\$21,002,422</b>	<b>\$29,333,784</b>	<b>\$29,975,826</b>	<b>\$31,280,305</b>	<b>(\$15,640,153)</b>	<b>\$15,640,153</b>	<b>\$32,181,205</b>	<b>(\$32,181,205)</b>	<b>\$0</b>	<b>\$32,181,205</b>	<b>(\$32,181,205)</b>	<b>\$0</b>	<b>\$32,181,205</b>	<b>(\$32,181,205)</b>	<b>\$0</b>
14	Less: Provision for Bad Debts	\$206,109	\$315,036	\$534,484	\$886,077	\$569,951	(\$284,976)	\$284,976	\$586,366	(\$586,366)	\$0	\$586,366	(\$586,366)	\$0	\$586,366	(\$586,366)	\$0
	<b>Net Patient Service Revenue less provision for bad debts</b>	<b>\$13,534,496</b>	<b>\$20,687,386</b>	<b>\$28,685,553</b>	<b>\$29,089,749</b>	<b>\$30,710,354</b>	<b>(\$15,355,177)</b>	<b>\$15,355,177</b>	<b>\$31,594,839</b>	<b>(\$31,594,839)</b>	<b>\$0</b>	<b>\$31,594,839</b>	<b>(\$31,594,839)</b>	<b>\$0</b>	<b>\$31,594,839</b>	<b>(\$31,594,839)</b>	<b>\$0</b>
15	Other Operating Revenue	\$2,464,499	\$5,172,964	\$4,787,661	\$8,944,425	\$9,243,341	(\$4,621,670)	\$4,621,670	\$9,243,341	(\$9,243,341)	\$0	\$9,243,341	(\$9,243,341)	\$0	\$9,243,341	(\$9,243,341)	\$0
17	Net Assets Released from Restriction	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	<b>TOTAL OPERATING REVENUE</b>	<b>\$15,998,995</b>	<b>\$25,860,350</b>	<b>\$33,473,214</b>	<b>\$38,034,174</b>	<b>\$39,953,695</b>	<b>(\$19,976,847)</b>	<b>\$19,976,847</b>	<b>\$40,838,180</b>	<b>(\$40,838,180)</b>	<b>\$0</b>	<b>\$40,838,180</b>	<b>(\$40,838,180)</b>	<b>\$0</b>	<b>\$40,838,180</b>	<b>(\$40,838,180)</b>	<b>\$0</b>
<b>B. OPERATING EXPENSES</b>																	
1	Salaries and Wages	\$19,234,424	\$26,540,185	\$37,356,344	\$37,208,008	\$34,819,271	(\$17,409,636)	\$17,409,636	\$33,914,309	(\$33,914,309)	\$0	\$34,423,024	(\$34,423,024)	\$0	\$34,939,369	(\$34,939,369)	\$0
2	Fringe Benefits	\$3,410,611	\$4,434,983	\$6,483,081	\$6,855,301	\$7,149,250	(\$3,574,625)	\$3,574,625	\$6,736,181	(\$6,736,181)	\$0	\$6,776,599	(\$6,776,599)	\$0	\$6,817,258	(\$6,817,258)	\$0
3	Physicians Fees	\$1,125,676	\$1,859,333	\$3,462,524	\$4,338,255	\$4,361,920	(\$2,180,960)	\$2,180,960	\$5,341,838	(\$5,341,838)	\$0	\$5,235,001	(\$5,235,001)	\$0	\$5,308,291	(\$5,308,291)	\$0
4	Supplies and Drugs	\$763,510	\$870,017	\$1,334,391	\$1,600,252	\$2,382,967	(\$1,191,483)	\$1,191,483	\$2,394,882	(\$2,394,882)	\$0	\$2,429,368	(\$2,429,368)	\$0	\$2,463,865	(\$2,463,865)	\$0
5	Depreciation and Amortization	\$243,129	\$243,331	\$234,268	\$227,378	\$242,248	(\$121,124)	\$121,124	\$256,365	(\$256,365)	\$0	\$258,725	(\$258,725)	\$0	\$268,149	(\$268,149)	\$0
6	Provision for Bad Debts-Other <sup>b</sup>						\$0	\$0		\$0	\$0		\$0	\$0		\$0	\$0
7	Interest Expense	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
8	Malpractice Insurance Cost	\$1,792,790	\$1,812,312	\$2,279,903	\$2,919,392	\$2,571,122	(\$1,285,561)	\$1,285,561	\$2,571,122	(\$2,571,122)	\$0	\$2,571,122	(\$2,571,122)	\$0	\$2,571,122	(\$2,571,122)	\$0
9	Lease Expense	\$1,142,818	\$1,399,742	\$2,135,875	\$2,867,891	\$2,135,875	(\$1,067,938)	\$1,067,938	\$2,135,875	(\$2,135,875)	\$0	\$2,135,875	(\$2,135,875)	\$0	\$2,135,875	(\$2,135,875)	\$0
10	Other Operating Expenses	\$1,582,213	\$2,743,261	\$3,433,970	\$3,921,038	\$4,778,425	(\$2,389,212)	\$2,389,212	\$4,778,425	(\$4,778,425)	\$0	\$4,826,209	(\$4,826,209)	\$0	\$4,872,058	(\$4,872,058)	\$0
	<b>TOTAL OPERATING EXPENSES</b>	<b>\$29,295,171</b>	<b>\$39,903,164</b>	<b>\$56,720,356</b>	<b>\$59,937,515</b>	<b>\$58,441,079</b>	<b>(\$29,220,539)</b>	<b>\$29,220,539</b>	<b>\$58,128,997</b>	<b>(\$58,128,997)</b>	<b>\$0</b>	<b>\$58,655,923</b>	<b>(\$58,655,923)</b>	<b>\$0</b>	<b>\$59,375,987</b>	<b>(\$59,375,987)</b>	<b>\$0</b>
	<b>INCOME/(LOSS) FROM OPERATIO</b>	<b>(\$13,296,176)</b>	<b>(\$14,042,814)</b>	<b>(\$23,247,142)</b>	<b>(\$21,903,341)</b>	<b>(\$18,487,384)</b>	<b>\$9,243,692</b>	<b>(\$9,243,692)</b>	<b>(\$17,290,818)</b>	<b>\$17,290,818</b>	<b>\$0</b>	<b>(\$17,817,743)</b>	<b>\$17,817,743</b>	<b>\$0</b>	<b>(\$18,537,808)</b>	<b>\$18,537,808</b>	<b>\$0</b>
	<b>NON-OPERATING REVENUE</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
	<b>EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES</b>	<b>(\$13,296,176)</b>	<b>(\$14,042,814)</b>	<b>(\$23,247,142)</b>	<b>(\$21,903,341)</b>	<b>(\$18,487,384)</b>	<b>\$9,243,692</b>	<b>(\$9,243,692)</b>	<b>(\$17,290,818)</b>	<b>\$17,290,818</b>	<b>\$0</b>	<b>(\$17,817,743)</b>	<b>\$17,817,743</b>	<b>\$0</b>	<b>(\$18,537,808)</b>	<b>\$18,537,808</b>	<b>\$0</b>
	Principal Payments	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>C. PROFITABILITY SUMMARY</b>																	
1	Hospital Operating Margin	-83.1%	-54.3%	-69.4%	-57.6%	-46.3%	-46.3%	-46.3%	-42.3%	-42.3%	0.0%	-43.6%	-43.6%	0.0%	-45.4%	-45.4%	0.0%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	-83.1%	-54.3%	-69.4%	-57.6%	-46.3%	-46.3%	-46.3%	-42.3%	-42.3%	0.0%	-43.6%	-43.6%	0.0%	-45.4%	-45.4%	0.0%
	<b>D. FTEs</b>	<b>191</b>	<b>257</b>	<b>354</b>	<b>355</b>	<b>361</b>	<b>(\$181)</b>	<b>\$181</b>	<b>326</b>	<b>(\$326)</b>	<b>\$0</b>	<b>326</b>	<b>(\$326)</b>	<b>\$0</b>	<b>326</b>	<b>(\$326)</b>	<b>\$0</b>
<b>E. VOLUME STATISTICS<sup>c</sup></b>																	
1	Inpatient Discharges	25,358	38,343	48,222	48,406	39,328	(\$19,664)	\$19,664	39,328	(39,328)	\$0	39,328	(39,328)	\$0	39,328	(\$39,328)	\$0
2	Outpatient Visits	109,560	165,665	221,959	222,806	228,895	(\$114,448)	\$114,448	228,895	(228,895)	\$0	228,895	(228,895)	\$0	228,895	(\$228,895)	\$0
	<b>TOTAL VOLUME</b>	<b>134,918</b>	<b>204,008</b>	<b>270,181</b>	<b>271,212</b>	<b>268,223</b>	<b>(134,112)</b>	<b>134,112</b>	<b>268,223</b>	<b>(268,223)</b>	<b>0</b>	<b>268,223</b>	<b>(268,223)</b>	<b>0</b>	<b>268,223</b>	<b>(268,223)</b>	<b>0</b>

<b>NEMG Financial Assumptions</b>	<b>Without the CON</b>	<b>With the CON- Assumed 4/1/16 start date</b>
Revenues	Annual increase of 2% assumed from baseline, approximately 1.5% for payor rate increases and 0.5% for volume growth.	Revenues without the CON for NEMG were increased in accordance with LMPA's projected revenues with the affiliation.
Expenses	Annual increase of 2% assumed for all expense categories.	Expenses without the CON for NEMG were increased in accordance with LMPA's projected expenses with the affiliation.  Additions were made to the expenses to account for fringe benefit changes associated with the integration of LMPA with NEMG.
FTEs	No increases in FTEs without the CON due to minimal volume growth.	Incremental FTEs represent the FTEs from LMPA that will be incorporated into NEMG.

<b>L&amp;MPA Financial Assumptions</b>	<b>Without the CON</b>	<b>With the CON- Assumed 4/1/16 start date</b>
Revenues	An increase of 2.8% assumed for FY 2016 and remains flat per year after that point.	Revenues for FY 2016 were reduced in half as these services would be reallocated to NEMG as of April 2016. Subsequent years are reduced 100 % as these services would be reallocated to NEMG.
Expenses	<p>Annual increase of approximately 1% assumed for salaries, fringe benefits, outside services, supplies and other operating expenses in addition to other initiatives expected for these categories.</p> <p>Adjustments were made to the multiyear forecast to account for anticipated savings activities that are aimed at decreasing operating expense. These changes are necessary to generate a positive margin to have a sustainable bottom line for the Lawrence + Memorial Healthcare System.</p>	Expenses for FY 2016 were reduced in half as these services would be reallocated to NEMG as of April 2016. Subsequent years are reduced 100 % as these services would be reallocated to NEMG.
FTEs	Decreases in FTEs without the CON correspond to adjustments to decrease operating expenses.	FTE's for FY 2016 were reduced in half as these services would be reallocated to NEMG as of April 2016. Subsequent years are reduced 100 % as these services would be reallocated to NEMG.

## Greer, Leslie

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**From:** Lazarus, Steven  
**Sent:** Thursday, January 21, 2016 3:07 PM  
**To:** Greer, Leslie  
**Cc:** Ciesones, Ron; Carney, Brian; Riggott, Kaila  
**Subject:** FW: Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA  
**Attachments:** L+M\_L+MH Updated Financial Worksheets A\_For OHCA.xlsx; YNHHS Updated Financial Worksheet A\_For OHCA.xlsx

Please add to the original file.

Thank you,  
Steve

### *Steven W. Lazarus*

Associate Health Care Analyst  
Division of Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, CT 06134  
Phone: 860-418-7012  
Fax: 860-418-7053



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**From:** Karen Banoff [<mailto:kbanoff@kmbconsult.com>]  
**Sent:** Thursday, January 21, 2016 3:06 PM  
**To:** Lazarus, Steven  
**Subject:** RE: Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA

Hi Steve-

Here are the Excel Files as you requested. Please let me know if these files meet your needs. Thanks, Karen



*Karen M. Banoff, DNP, RN  
Principal*

203- 459-1601 (office)  
203-209-0681 (mobile)

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**From:** Lazarus, Steven [<mailto:Steven.Lazarus@ct.gov>]  
**Sent:** Tuesday, January 19, 2016 3:28 PM  
**To:** Karen Banoff  
**Subject:** RE: Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA

Karen,

Can you please forward pages 855-860, electronic copy (Excel) of the financial worksheets. Some of the print is too small to read on the paper copy.

Thanks,  
Steve

*Steven W. Lazarus*

Associate Health Care Analyst  
Division of Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, CT 06134  
Phone: 860-418-7012  
Fax: 860-418-7053



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**From:** Karen Banoff [<mailto:kbanoff@kmbconsult.com>]  
**Sent:** Tuesday, January 05, 2016 7:41 AM  
**To:** Martone, Kim  
**Cc:** Lazarus, Steven; Greci, Laurie  
**Subject:** Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA

Good morning and Happy New Year Kim-

As per OHCA's completeness letter, I am sending responses to the completeness questions for the above referenced dockets via email. As requested, an Adobe Acrobat and MS Word File is included for each. A cover letter pertaining to each application is also included.

I would appreciate receiving an email confirmation that the documents have been received.

Thank you for your time and attention to this matter.

Sincerely, Karen



kmb consulting, llc

*Karen M. Banoff, DNP, RN*  
*Principal*  
*203- 459-1601 (office)*  
*203-209-0681 (mobile)*

LINE	Total Entity:L+M Hospital	FY 2014	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	Results	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON
<b>A. OPERATING REVENUE</b>															
1	Total Gross Patient Revenue	\$795,287,303	\$843,024,228	\$860,182,747	\$14,094,145	\$874,276,892	\$894,590,057	\$37,459,572	\$932,049,629	\$930,373,659	\$53,320,158	\$983,693,817	\$967,588,605	\$68,907,570	\$1,036,496,176
2	Less: Allowances	\$450,251,022	\$485,513,042	\$487,243,916	\$8,281,757	\$495,525,673	\$521,291,544	\$22,590,447	\$543,881,991	\$553,773,091	\$32,780,153	\$586,553,244	\$590,539,350	\$43,351,970	\$633,891,321
3	Less: Charity Care	\$5,449,069	\$5,427,817	\$5,893,713	\$96,569	\$5,990,282	\$6,374,640	\$266,928	\$6,641,568	\$6,894,811	\$395,145	\$7,289,956	\$7,457,427	\$531,086	\$7,988,514
4	Less: Other Deductions	\$2,458,020	\$12,801,007	\$18,201,787	\$0	\$18,201,787	\$18,201,787	\$0	\$18,201,787	\$18,201,787	\$0	\$18,201,787	\$18,201,787	\$0	\$18,201,787
	<b>Net Patient Service Revenue</b>	<b>\$337,129,192</b>	<b>\$339,282,362</b>	<b>\$348,843,331</b>	<b>\$5,715,818</b>	<b>\$354,559,149</b>	<b>\$348,722,086</b>	<b>\$14,602,197</b>	<b>\$363,324,283</b>	<b>\$351,503,970</b>	<b>\$20,144,860</b>	<b>\$371,648,830</b>	<b>\$351,390,041</b>	<b>\$25,024,513</b>	<b>\$376,414,554</b>
5	Medicare	\$116,154,499	\$120,428,761	\$123,580,930	\$1,924,467	\$125,505,397	\$123,539,459	\$4,916,434	\$128,455,893	\$124,490,992	\$6,782,601	\$131,273,593	\$124,452,023	\$8,425,538	\$132,877,561
6	Medicaid	\$36,747,588	\$36,099,829	\$39,097,075	\$608,840	\$39,705,915	\$39,083,955	\$1,555,403	\$40,639,358	\$39,384,989	\$2,145,799	\$41,530,788	\$39,372,661	\$2,665,572	\$42,038,233
7	CHAMPUS & TriCare	\$10,981,081	\$11,385,164	\$11,683,166	\$181,936	\$11,865,102	\$11,679,245	\$464,793	\$12,144,038	\$11,769,202	\$641,217	\$12,410,419	\$11,765,518	\$796,538	\$12,562,056
8	Other	(\$2,458,020)	(\$12,801,007)	(\$18,201,787)	\$0	(\$18,201,787)	(\$18,201,787)	\$0	(\$18,201,787)	(\$18,201,787)	\$0	(\$18,201,787)	(\$18,201,787)	\$0	(\$18,201,787)
	<b>Total Government</b>	<b>\$161,425,149</b>	<b>\$157,112,747</b>	<b>\$156,159,384</b>	<b>\$2,715,243</b>	<b>\$158,874,627</b>	<b>\$156,100,872</b>	<b>\$6,936,630</b>	<b>\$163,037,502</b>	<b>\$157,443,396</b>	<b>\$9,569,618</b>	<b>\$167,013,013</b>	<b>\$157,388,414</b>	<b>\$11,887,649</b>	<b>\$169,276,063</b>
9	Commercial Insurers	\$163,214,231	\$169,220,201	\$173,649,464	\$2,704,160	\$176,353,624	\$173,591,191	\$6,908,316	\$180,499,507	\$174,928,235	\$9,530,556	\$184,458,791	\$174,873,478	\$11,839,126	\$186,712,603
10	Uninsured	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
11	Self Pay	\$5,131,510	\$5,320,340	\$5,459,598	\$85,020	\$5,544,617	\$5,457,766	\$217,200	\$5,674,965	\$5,499,803	\$299,644	\$5,799,447	\$5,498,081	\$372,226	\$5,870,307
12	Workers Compensation	\$7,358,302	\$7,629,074	\$7,828,761	\$121,914	\$7,950,675	\$7,826,134	\$311,452	\$8,137,586	\$7,886,413	\$429,673	\$8,316,086	\$7,883,944	\$533,752	\$8,417,696
13	Other	\$0	\$0	\$5,746,124	\$89,482	\$5,835,606	\$5,746,124	\$228,599	\$5,974,723	\$5,746,124	\$315,370	\$6,061,494	\$5,746,124	\$391,761	\$6,137,885
	<b>Total Non-Government</b>	<b>\$175,704,043</b>	<b>\$182,169,615</b>	<b>\$192,683,947</b>	<b>\$3,000,575</b>	<b>\$195,684,522</b>	<b>\$192,621,214</b>	<b>\$7,665,567</b>	<b>\$200,286,781</b>	<b>\$194,060,574</b>	<b>\$10,575,243</b>	<b>\$204,635,817</b>	<b>\$194,001,627</b>	<b>\$13,136,865</b>	<b>\$207,138,492</b>
	<b>Net Patient Service Revenue<sup>a</sup> (Government+Non-Government)</b>	<b>\$337,129,192</b>	<b>\$339,282,362</b>	<b>\$348,843,331</b>	<b>\$5,715,818</b>	<b>\$354,559,149</b>	<b>\$348,722,086</b>	<b>\$14,602,197</b>	<b>\$363,324,283</b>	<b>\$351,503,970</b>	<b>\$20,144,860</b>	<b>\$371,648,830</b>	<b>\$351,390,041</b>	<b>\$25,024,513</b>	<b>\$376,414,554</b>
14	Less: Provision for Bad Debts	\$14,930,302	\$12,821,337	\$13,803,283	\$210,310	\$14,013,593	\$13,798,485	\$537,280	\$14,335,765	\$13,908,561	\$741,219	\$14,649,780	\$13,904,053	\$920,763	\$14,824,816
	<b>Net Patient Service Revenue less provision for bad debts</b>	<b>\$322,198,890</b>	<b>\$326,461,025</b>	<b>\$335,040,048</b>	<b>\$5,505,508</b>	<b>\$340,545,556</b>	<b>\$334,923,601</b>	<b>\$14,064,917</b>	<b>\$348,988,518</b>	<b>\$337,595,409</b>	<b>\$19,403,641</b>	<b>\$356,999,050</b>	<b>\$337,485,988</b>	<b>\$24,103,750</b>	<b>\$361,589,738</b>
15	Other Operating Revenue	\$28,151,061	\$30,874,305	\$31,185,817	\$0	\$31,185,817	\$31,185,817	\$0	\$31,185,817	\$31,185,817	\$0	\$31,185,817	\$31,185,817	\$0	\$31,185,817
17	Net Assets Released from Restrictions	\$671,797	\$577,092	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	<b>TOTAL OPERATING REVENUE</b>	<b>\$351,021,748</b>	<b>\$357,912,422</b>	<b>\$366,225,866</b>	<b>\$5,505,508</b>	<b>\$371,731,374</b>	<b>\$366,109,418</b>	<b>\$14,064,917</b>	<b>\$380,174,335</b>	<b>\$368,781,227</b>	<b>\$19,403,641</b>	<b>\$388,184,868</b>	<b>\$368,671,806</b>	<b>\$24,103,750</b>	<b>\$392,775,556</b>
<b>B. OPERATING EXPENSES</b>															
1	Salaries and Wages	\$143,838,674	\$140,605,613	\$143,576,703	\$603,987	\$144,180,691	\$140,019,192	\$760,868	\$140,780,059	\$141,973,430	\$754,514	\$142,727,944	\$143,983,025	\$1,270,138	\$145,253,163
2	Fringe Benefits	\$51,044,718	\$51,698,355	\$54,026,420	\$847,885	\$54,874,305	\$52,456,564	\$1,228,742	\$53,685,306	\$52,771,303	\$1,254,900	\$54,026,203	\$53,087,931	\$1,407,884	\$54,495,815
3	Physicians Fees	\$38,647,767	\$29,998,356	\$30,254,332	\$2,845,324	\$33,099,655	\$22,993,292	\$4,677,729	\$27,671,021	\$22,533,426	\$4,788,754	\$27,322,180	\$22,848,894	\$4,921,640	\$27,770,534
4	Supplies and Drugs	\$59,538,141	\$63,622,692	\$64,288,904	\$55,178	\$64,344,082	\$64,610,349	\$345,629	\$64,955,978	\$65,540,738	\$651,937	\$66,192,675	\$66,471,416	\$917,694	\$67,389,110
5	Depreciation and Amortization	\$22,728,484	\$23,639,711	\$26,054,143	\$77,061	\$26,131,204	\$27,572,414	\$154,122	\$27,726,536	\$27,826,240	\$154,122	\$27,980,362	\$28,839,752	\$154,122	\$28,993,874
6	Provision for Bad Debts-Other <sup>b</sup>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7	Interest Expense	\$3,542,721	\$3,553,690	\$3,368,376	\$0	\$3,368,376	\$3,167,699	\$0	\$3,167,699	\$2,973,808	\$0	\$2,973,808	\$2,749,451	\$0	\$2,749,451
8	Malpractice Insurance Cost	\$4,538,822	\$4,818,820	\$4,812,632	\$0	\$4,812,632	\$4,812,632	\$0	\$4,812,632	\$4,812,632	\$0	\$4,812,632	\$4,812,632	\$0	\$4,812,632
9	Lease Expense	\$4,618,504	\$4,647,875	\$4,852,308	\$0	\$4,852,308	\$4,852,308	\$0	\$4,852,308	\$4,852,308	\$0	\$4,852,308	\$4,852,308	\$0	\$4,852,308
10	Other Operating Expenses	\$25,332,830	\$30,741,467	\$30,490,536	\$0	\$30,490,536	\$30,490,536	\$0	\$30,490,536	\$30,795,441	\$0	\$30,795,441	\$29,255,669	\$0	\$29,255,669
	<b>TOTAL OPERATING EXPENSES</b>	<b>\$353,830,661</b>	<b>\$353,326,579</b>	<b>\$361,724,355</b>	<b>\$4,429,435</b>	<b>\$366,153,790</b>	<b>\$350,974,986</b>	<b>\$7,167,089</b>	<b>\$358,142,075</b>	<b>\$354,079,327</b>	<b>\$7,604,227</b>	<b>\$361,683,554</b>	<b>\$356,901,079</b>	<b>\$8,671,477</b>	<b>\$365,572,556</b>
	<b>INCOME/(LOSS) FROM OPERATIONS</b>	<b>(\$2,808,913)</b>	<b>\$4,585,843</b>	<b>\$4,501,511</b>	<b>\$1,076,073</b>	<b>\$5,577,584</b>	<b>\$15,134,432</b>	<b>\$6,897,828</b>	<b>\$22,032,260</b>	<b>\$14,701,900</b>	<b>\$11,799,414</b>	<b>\$26,501,313</b>	<b>\$11,770,727</b>	<b>\$15,432,273</b>	<b>\$27,202,999</b>
	<b>NON-OPERATING REVENUE</b>	<b>\$8,788,601</b>	<b>\$9,936,909</b>	<b>\$8,262,701</b>	<b>\$0</b>	<b>\$8,262,701</b>	<b>\$8,262,701</b>	<b>\$0</b>	<b>\$8,262,701</b>	<b>\$8,262,701</b>	<b>\$0</b>	<b>\$8,262,701</b>	<b>\$8,262,701</b>	<b>\$0</b>	<b>\$8,262,701</b>
	<b>EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES</b>	<b>\$5,979,688</b>	<b>\$14,522,752</b>	<b>\$12,764,212</b>	<b>\$1,076,073</b>	<b>\$13,840,285</b>	<b>\$23,397,133</b>	<b>\$6,897,828</b>	<b>\$30,294,961</b>	<b>\$22,964,601</b>	<b>\$11,799,414</b>	<b>\$34,764,014</b>	<b>\$20,033,428</b>	<b>\$15,432,273</b>	<b>\$35,465,700</b>
	Principal Payments	\$5,152,609	\$5,316,471	\$5,510,844	\$0	\$5,510,844	\$5,725,738	\$0	\$5,725,738	\$5,911,163	\$0	\$5,911,163	\$6,137,126	\$0	\$6,137,126
<b>C. PROFITABILITY SUMMARY</b>															
1	Hospital Operating Margin	-0.8%	1.3%	1.2%	19.5%	1.5%	4.1%	49.0%	5.8%	4.0%	60.8%	6.8%	3.2%	64.0%	6.9%
2	Hospital Non Operating Margin	2.3%	2.6%	2.3%	0.0%	2.2%	2.3%	0.0%	2.2%	2.2%	0.0%	2.1%	2.2%	0.0%	2.1%
3	Hospital Total Margin	1.7%	4.1%	3.5%	19.5%	3.7%	6.4%	49.0%	8.0%	6.2%	60.8%	9.0%	5.4%	64.0%	9.0%
	<b>D. FTEs</b>	<b>1,849</b>	<b>1,835</b>	<b>1,827</b>	<b>2</b>	<b>1,829</b>	<b>1,755</b>	<b>3</b>	<b>1,758</b>	<b>1,745</b>	<b>7</b>	<b>1,752</b>	<b>1,735</b>	<b>18</b>	<b>1,753</b>
<b>E. VOLUME STATISTICS<sup>c</sup></b>															
1	Inpatient Discharges	14,153	14,076	14,212	179	14,391	14,083	329	14,412	13,940	478	14,418	13,823	627	14,450
2	Outpatient Visits	458,110	449,789	455,077	3,462	458,539	455,077	10,930	469,007	455,077	14,489	469,566	455,077	17,407	472,484
	<b>TOTAL VOLUME</b>	<b>472,263</b>	<b>463,865</b>	<b>469,289</b>	<b>3,641</b>	<b>472,930</b>	<b>469,160</b>	<b>11,259</b>	<b>480,419</b>	<b>469,017</b>	<b>14,967</b>	<b>483,984</b>	<b>468,900</b>	<b>18,035</b>	<b>486,935</b>

LINE	Total Entity: L+M w/o LMPA	FY 2014	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Actual	Projected	Projected	Projected									
	Operating	Results	Results	W/out CON	Incremental	W/ CON									
<b>A. OPERATING REVENUE</b>															
1	Total Gross Patient Revenue	\$1,078,626,933	\$1,138,758,476	\$1,166,642,891	(\$15,527,210)	\$1,151,115,681	\$1,213,308,606	(\$24,164,292)	\$1,189,144,314	\$1,261,840,951	(\$9,784,371)	\$1,252,056,580	\$1,312,314,589	\$3,738,813	\$1,316,053,401
2	Less: Allowances	\$615,856,880	\$664,069,131	\$673,832,103	(\$6,485,677)	\$667,346,426	\$717,135,552	(\$8,304,750)	\$708,830,803	\$762,088,601	\$104,770	\$762,193,372	\$811,978,164	\$8,494,495	\$820,472,659
3	Less: Charity Care	\$6,782,933	\$6,124,509	\$7,336,420	\$37,861	\$7,374,281	\$7,629,877	\$129,891	\$7,759,768	\$7,935,072	\$231,593	\$8,166,665	\$8,252,475	\$328,358	\$8,580,833
4	Less: Other Deductions	\$2,458,020	\$12,801,007	\$18,201,787	\$0	\$18,201,787	\$18,201,787	\$0	\$18,201,787	\$18,201,787	\$0	\$18,201,787	\$18,201,787	\$0	\$18,201,787
	<b>Net Patient Service Revenue</b>	<b>\$453,529,100</b>	<b>\$455,763,829</b>	<b>\$467,272,580</b>	<b>(\$9,079,394)</b>	<b>\$458,193,186</b>	<b>\$470,341,390</b>	<b>(\$15,989,434)</b>	<b>\$454,351,956</b>	<b>\$473,615,490</b>	<b>(\$10,120,734)</b>	<b>\$463,494,756</b>	<b>\$473,882,163</b>	<b>(\$5,084,040)</b>	<b>\$468,798,123</b>
5	Medicare	\$161,243,669	\$165,691,332	\$169,559,164	(\$2,853,646)	\$166,705,519	\$170,162,485	(\$4,893,784)	\$165,268,700	\$171,320,254	(\$2,848,199)	\$168,472,056	\$171,414,554	(\$1,093,576)	\$170,320,977
6	Medicaid	\$48,109,726	\$49,436,760	\$50,590,792	(\$1,354,632)	\$49,236,160	\$50,770,802	(\$2,496,483)	\$48,274,320	\$51,116,242	(\$1,886,148)	\$49,230,094	\$51,144,378	(\$1,362,627)	\$49,781,751
7	CHAMPUS & TriCare	\$12,447,146	\$12,790,482	\$13,089,058	(\$276,461)	\$12,812,597	\$13,135,631	(\$493,466)	\$12,642,165	\$13,225,005	(\$335,557)	\$12,889,447	\$13,232,284	(\$200,110)	\$13,032,174
8	Other	(\$2,458,020)	(\$12,801,007)	(\$18,201,787)	\$0	(\$18,201,787)	(\$18,201,787)	\$0	(\$18,201,787)	(\$18,201,787)	\$0	(\$18,201,787)	(\$18,201,787)	\$0	(\$18,201,787)
	<b>Total Government</b>	<b>\$219,342,521</b>	<b>\$215,117,567</b>	<b>\$215,037,227</b>	<b>(\$4,484,738)</b>	<b>\$210,552,489</b>	<b>\$215,867,131</b>	<b>(\$7,883,733)</b>	<b>\$207,983,399</b>	<b>\$217,459,714</b>	<b>(\$5,069,904)</b>	<b>\$212,389,810</b>	<b>\$217,589,429</b>	<b>(\$2,656,314)</b>	<b>\$214,933,115</b>
9	Commercial Insurers	\$215,639,465	\$221,587,554	\$226,760,205	(\$4,072,006)	\$222,688,199	\$227,567,057	(\$7,250,433)	\$220,316,624	\$229,115,401	(\$4,516,815)	\$224,598,587	\$229,241,513	(\$2,170,433)	\$227,071,080
10	Uninsured	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
11	Self Pay	\$9,955,354	\$10,229,957	\$10,468,761	\$23,625	\$10,492,386	\$10,506,011	\$109,366	\$10,615,377	\$10,577,493	\$235,662	\$10,813,155	\$10,583,315	\$343,995	\$10,927,309
12	Workers Compensation	\$8,591,760	\$8,828,750	\$9,034,845	(\$124,129)	\$8,910,717	\$9,066,993	(\$203,248)	\$8,863,745	\$9,128,684	(\$94,251)	\$9,034,433	\$9,133,708	(\$757)	\$9,132,952
13	Other	\$0	\$0	\$5,971,541	(\$422,145)	\$5,549,396	\$7,334,198	(\$761,386)	\$6,572,812	\$7,334,198	(\$675,427)	\$6,658,771	\$7,334,198	\$1,232,319	\$8,566,517
	<b>Total Non-Government</b>	<b>\$234,186,579</b>	<b>\$240,646,262</b>	<b>\$252,235,353</b>	<b>(\$4,594,655)</b>	<b>\$247,640,697</b>	<b>\$254,474,259</b>	<b>(\$8,105,701)</b>	<b>\$246,368,558</b>	<b>\$256,155,776</b>	<b>(\$5,050,830)</b>	<b>\$251,104,946</b>	<b>\$256,292,734</b>	<b>(\$594,877)</b>	<b>\$255,697,857</b>
	<b>Net Patient Service Revenue<sup>a</sup> (Government+Non-Government)</b>	<b>\$453,529,100</b>	<b>\$455,763,829</b>	<b>\$467,272,580</b>	<b>(\$9,079,394)</b>	<b>\$458,193,186</b>	<b>\$470,341,390</b>	<b>(\$15,989,434)</b>	<b>\$454,351,956</b>	<b>\$473,615,490</b>	<b>(\$10,120,734)</b>	<b>\$463,494,756</b>	<b>\$473,882,163</b>	<b>(\$3,251,190)</b>	<b>\$470,630,973</b>
14	Less: Provision for Bad Debts	\$20,298,386	\$16,683,423	\$17,177,163	(\$53,652)	\$17,123,511	\$17,239,519	(\$289,105)	\$16,950,414	\$17,359,178	(\$291,154)	\$17,068,024	\$17,368,924	(\$291,320)	\$17,077,604
	<b>Net Patient Service Revenue less provision for bad debts</b>	<b>\$433,230,714</b>	<b>\$439,080,406</b>	<b>\$450,095,417</b>	<b>(\$9,025,742)</b>	<b>\$441,069,675</b>	<b>\$453,101,871</b>	<b>(\$15,700,329)</b>	<b>\$437,401,542</b>	<b>\$456,256,312</b>	<b>(\$9,829,580)</b>	<b>\$446,426,732</b>	<b>\$456,513,239</b>	<b>(\$4,792,721)</b>	<b>\$451,720,518</b>
15	Other Operating Revenue	\$20,795,287	\$16,375,817	\$18,625,441	(\$4,621,670)	\$14,003,771	\$18,625,441	(\$9,243,341)	\$9,382,100	\$18,625,441	(\$9,243,341)	\$9,382,100	\$18,625,441	(\$9,243,341)	\$9,382,100
17	Net Assets Released from Restrictions	\$876,203	\$4,831,645	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	<b>TOTAL OPERATING REVENUE</b>	<b>\$454,902,204</b>	<b>\$460,287,868</b>	<b>\$468,720,858</b>	<b>(\$13,647,412)</b>	<b>\$455,073,446</b>	<b>\$471,727,312</b>	<b>(\$24,943,670)</b>	<b>\$446,783,642</b>	<b>\$474,881,753</b>	<b>(\$19,072,921)</b>	<b>\$455,808,832</b>	<b>\$475,138,680</b>	<b>(\$14,036,062)</b>	<b>\$461,102,618</b>
<b>B. OPERATING EXPENSES</b>															
1	Salaries and Wages	\$213,467,507	\$212,124,691	\$221,742,774	(\$16,503,691)	\$205,239,083	\$218,731,892	(\$32,626,276)	\$186,105,616	\$220,764,261	(\$33,138,558)	\$187,625,703	\$223,223,873	(\$32,878,788)	\$190,345,085
2	Fringe Benefits	\$59,185,837	\$59,040,657	\$61,335,944	(\$2,486,287)	\$58,849,657	\$59,361,624	(\$4,867,704)	\$54,493,920	\$59,610,824	(\$4,866,259)	\$54,744,565	\$59,979,697	(\$4,677,288)	\$55,302,409
3	Physicians Fees	\$54,475,011	\$39,607,243	\$36,262,759	\$11,192,773	\$47,455,533	\$29,552,481	\$16,362,803	\$45,915,284	\$29,230,792	\$17,197,407	\$46,428,199	\$29,614,758	\$18,070,023	\$47,684,781
4	Supplies and Drugs	\$71,998,110	\$76,774,253	\$77,727,905	(\$1,407,896)	\$76,320,009	\$78,132,953	(\$2,332,868)	\$75,800,085	\$79,257,684	(\$1,760,116)	\$77,497,568	\$80,382,942	(\$1,273,097)	\$79,109,845
5	Depreciation and Amortization	\$27,479,122	\$28,953,704	\$28,415,203	\$40,565	\$28,455,768	\$30,071,062	\$67,013	\$30,138,075	\$30,347,890	\$64,653	\$30,412,543	\$31,453,247	\$55,229	\$31,508,476
6	Provision for Bad Debts-Other <sup>b</sup>				\$0	\$0		\$0	\$0		\$0	\$0		\$0	\$0
7	Interest Expense	\$3,554,919	\$3,553,690	\$3,368,376	\$0	\$3,368,376	\$3,167,699	\$0	\$3,167,699	\$2,973,808	\$0	\$2,973,808	\$2,749,451	\$0	\$2,749,451
8	Malpractice Insurance Cost	\$14,513,454	\$17,152,933	\$16,833,046	(\$1,285,561)	\$15,547,485	\$16,833,046	(\$2,571,122)	\$14,261,924	\$16,833,046	(\$2,571,122)	\$14,261,924	\$16,833,046	(\$2,571,122)	\$14,261,924
9	Lease Expense	\$6,969,829	\$7,693,864	\$7,964,369	(\$1,067,938)	\$6,896,432	\$7,964,369	(\$2,135,875)	\$5,828,494	\$7,964,369	(\$2,135,875)	\$5,828,494	\$7,964,369	(\$2,135,875)	\$5,828,494
10	Other Operating Expenses	\$21,943,887	\$25,385,377	\$23,767,337	(\$2,057,025)	\$21,710,311	\$20,618,407	(\$4,115,241)	\$16,503,166	\$21,103,061	(\$4,127,570)	\$16,975,491	\$21,576,050	(\$4,137,325)	\$17,438,725
	<b>TOTAL OPERATING EXPENSES</b>	<b>\$473,587,676</b>	<b>\$470,286,412</b>	<b>\$477,417,713</b>	<b>(\$13,575,060)</b>	<b>\$463,842,653</b>	<b>\$464,433,533</b>	<b>(\$32,219,270)</b>	<b>\$432,214,263</b>	<b>\$468,085,735</b>	<b>(\$31,337,441)</b>	<b>\$436,748,294</b>	<b>\$473,777,432</b>	<b>(\$29,548,243)</b>	<b>\$444,229,190</b>
	<b>INCOME/(LOSS) FROM OPERATIONS</b>	<b>(\$18,685,472)</b>	<b>(\$9,998,544)</b>	<b>(\$8,696,855)</b>	<b>(\$72,353)</b>	<b>(\$8,769,207)</b>	<b>\$7,293,779</b>	<b>\$7,275,601</b>	<b>\$14,569,379</b>	<b>\$6,796,018</b>	<b>\$12,264,521</b>	<b>\$19,060,538</b>	<b>\$1,361,248</b>	<b>\$15,512,181</b>	<b>\$16,873,429</b>
	<b>NON-OPERATING REVENUE</b>	<b>\$15,297,404</b>	<b>\$11,832,973</b>	<b>\$8,858,736</b>	<b>\$0</b>	<b>\$8,858,736</b>									
	<b>EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES</b>	<b>(\$3,388,068)</b>	<b>\$1,834,429</b>	<b>\$161,881</b>	<b>(\$72,353)</b>	<b>\$89,529</b>	<b>\$16,152,515</b>	<b>\$7,275,601</b>	<b>\$23,428,115</b>	<b>\$15,654,754</b>	<b>\$12,264,521</b>	<b>\$27,919,274</b>	<b>\$10,219,984</b>	<b>\$15,512,181</b>	<b>\$25,732,165</b>
	Principal Payments	\$5,152,609	\$5,316,471	\$5,510,844		\$5,510,844	\$5,725,738		\$5,725,738	\$5,911,163		\$5,911,163	\$6,137,126		\$6,137,126
<b>C. PROFITABILITY SUMMARY</b>															
1	Hospital Operating Margin	-4.1%	-2.2%	-1.9%	0.5%	-1.9%	1.5%	-29.2%	3.3%	1.4%	-64.3%	4.2%	0.3%	-110.5%	3.7%
2	Hospital Non Operating Margin	3.4%	2.6%	1.9%	0.0%	1.9%	1.9%	0.0%	2.0%	1.9%	0.0%	1.9%	1.9%	0.0%	1.9%
3	Hospital Total Margin	-0.7%	0.4%	0.0%	0.5%	0.0%	3.4%	-29.2%	5.2%	3.3%	-64.3%	6.1%	2.2%	-110.5%	5.6%
	<b>D. FTEs</b>	<b>2,849</b>	<b>2,822</b>	2,821	(181)	2,641	2,711	(325)	2,386	2,701	(323)	2,378	2,691	(313)	2,378
	FTE reduction is a transfer to NEMG see separate CON														
<b>E. VOLUME STATISTICS<sup>c</sup></b>															
1	Inpatient Discharges	17,288	17,000	17,243	211	17,454	17,081	393	17,474	16,900	574	17,474	16,753	755	17,508
2	Outpatient Visits	585,965	570,156	618,543	4,554	623,097	620,364	11,880	632,244	621,913	15,630	637,543	621,913	18,558	640,471
	<b>TOTAL VOLUME</b>	<b>603,253</b>	<b>587,156</b>	<b>635,786</b>	<b>4,765</b>	<b>640,551</b>	<b>637,445</b>	<b>12,273</b>	<b>649,718</b>	<b>638,813</b>	<b>16,204</b>	<b>655,017</b>	<b>638,666</b>	<b>19,313</b>	<b>657,979</b>

LINE	Total Entity:L+M Hospital	FY 2014	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	Results	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON
<b>A. OPERATING REVENUE</b>															
1	Total Gross Patient Revenue	\$788,136,573	\$839,272,512	\$852,448,517	\$14,023,919	\$866,472,437	\$886,546,458	\$37,272,979	\$923,819,437	\$922,008,316	\$53,052,862	\$975,061,178	\$958,888,649	\$68,562,223	\$1,027,450,872
2	Less: Allowances	\$446,502,255	\$483,244,808	\$480,941,850	\$8,211,581	\$489,153,431	\$514,682,289	\$22,403,989	\$537,086,278	\$546,844,451	\$32,513,069	\$579,357,519	\$583,278,646	\$43,006,907	\$626,285,554
3	Less: Charity Care	\$5,424,367	\$5,405,542	\$5,866,995	\$96,520	\$5,963,515	\$6,345,742	\$266,793	\$6,612,536	\$6,863,555	\$394,933	\$7,258,487	\$7,423,621	\$530,802	\$7,954,423
4	Less: Other Deductions	\$2,458,020	\$12,801,007	\$18,201,787	\$0	\$18,201,787	\$18,201,787	\$0	\$18,201,787	\$18,201,787	\$0	\$18,201,787	\$18,201,787	\$0	\$18,201,787
	<b>Net Patient Service Revenue</b>	<b>\$333,751,931</b>	<b>\$337,821,155</b>	<b>\$347,437,885</b>	<b>\$5,715,818</b>	<b>\$353,153,703</b>	<b>\$347,316,640</b>	<b>\$14,602,197</b>	<b>\$361,918,837</b>	<b>\$350,098,524</b>	<b>\$20,144,860</b>	<b>\$370,243,384</b>	<b>\$349,984,595</b>	<b>\$25,024,513</b>	<b>\$375,009,108</b>
5	Medicare	\$114,777,095	\$119,697,210	\$122,862,324	\$1,920,631	\$124,782,955	\$122,820,933	\$4,906,633	\$127,727,566	\$123,770,627	\$6,769,080	\$130,539,707	\$123,731,733	\$8,408,743	\$132,140,476
6	Medicaid	\$36,357,088	\$38,918,186	\$38,918,186	\$608,384	\$39,526,570	\$38,905,075	\$1,554,238	\$40,459,313	\$39,205,902	\$2,144,191	\$41,350,094	\$39,193,582	\$2,663,575	\$41,857,157
7	CHAMPUS & TriCare	\$10,871,028	\$11,337,033	\$11,636,815	\$181,911	\$11,818,726	\$11,632,894	\$464,728	\$12,097,622	\$11,722,844	\$641,128	\$12,363,972	\$11,719,160	\$796,428	\$12,515,588
8	Other	(\$2,458,020)	(\$12,801,007)	(\$18,201,787)	\$0	(\$18,201,787)	(\$18,201,787)	\$0	(\$18,201,787)	(\$18,201,787)	\$0	(\$18,201,787)	(\$18,201,787)	\$0	(\$18,201,787)
	<b>Total Government</b>	<b>\$159,547,191</b>	<b>\$156,148,833</b>	<b>\$155,215,538</b>	<b>\$2,710,926</b>	<b>\$157,926,463</b>	<b>\$155,157,115</b>	<b>\$6,925,599</b>	<b>\$162,082,714</b>	<b>\$156,497,586</b>	<b>\$9,554,400</b>	<b>\$166,051,986</b>	<b>\$156,442,688</b>	<b>\$11,868,745</b>	<b>\$168,311,434</b>
9	Commercial Insurers	\$161,745,469	\$168,678,963	\$173,139,286	\$2,706,579	\$175,845,865	\$173,080,956	\$6,914,496	\$179,995,452	\$174,419,278	\$9,539,082	\$183,958,360	\$174,364,469	\$11,849,716	\$186,214,185
10	Uninsured	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
11	Self Pay	\$5,109,407	\$5,328,430	\$5,469,328	\$85,499	\$5,554,827	\$5,467,486	\$218,423	\$5,685,909	\$5,509,762	\$301,332	\$5,811,094	\$5,508,031	\$374,323	\$5,882,354
12	Workers Compensation	\$7,349,864	\$7,664,928	\$7,867,610	\$122,989	\$7,990,599	\$7,864,959	\$314,201	\$8,179,160	\$7,925,774	\$433,465	\$8,359,238	\$7,923,283	\$538,462	\$8,461,745
13	Other	\$0	\$0	\$5,746,124	\$89,826	\$5,835,950	\$5,746,124	\$229,477	\$5,975,601	\$5,746,124	\$316,582	\$6,062,706	\$5,746,124	\$393,267	\$6,139,391
	<b>Total Non-Government</b>	<b>\$174,204,740</b>	<b>\$181,672,322</b>	<b>\$192,222,347</b>	<b>\$3,004,893</b>	<b>\$195,227,240</b>	<b>\$192,159,525</b>	<b>\$7,676,597</b>	<b>\$199,836,123</b>	<b>\$193,600,938</b>	<b>\$10,590,460</b>	<b>\$204,191,398</b>	<b>\$193,541,907</b>	<b>\$13,155,768</b>	<b>\$206,697,675</b>
	<b>Net Patient Service Revenue<sup>a</sup> (Government+Non-Government)</b>	<b>\$333,751,931</b>	<b>\$337,821,155</b>	<b>\$347,437,885</b>	<b>\$5,715,818</b>	<b>\$353,153,703</b>	<b>\$347,316,640</b>	<b>\$14,602,197</b>	<b>\$361,918,837</b>	<b>\$350,098,524</b>	<b>\$20,144,860</b>	<b>\$370,243,384</b>	<b>\$349,984,595</b>	<b>\$25,024,513</b>	<b>\$375,009,108</b>
14	Less: Provision for Bad Debts	\$14,966,698	\$12,798,310	\$13,779,946	\$210,310	\$13,990,256	\$13,775,137	\$537,280	\$14,312,417	\$13,885,471	\$741,219	\$14,626,690	\$13,880,952	\$920,763	\$14,801,715
	<b>Net Patient Service Revenue less provision for bad debts</b>	<b>\$318,785,233</b>	<b>\$325,022,845</b>	<b>\$333,657,939</b>	<b>\$5,505,508</b>	<b>\$339,163,447</b>	<b>\$333,541,503</b>	<b>\$14,064,917</b>	<b>\$347,606,420</b>	<b>\$336,213,053</b>	<b>\$19,403,641</b>	<b>\$355,616,694</b>	<b>\$336,103,643</b>	<b>\$24,103,750</b>	<b>\$360,207,393</b>
15	Other Operating Revenue	\$29,607,174	\$30,854,159	\$31,179,479	\$0	\$31,179,479	\$31,179,479	\$0	\$31,179,479	\$31,179,479	\$0	\$31,179,479	\$31,179,479	\$0	\$31,179,479
17	Net Assets Released from Restrictions	\$671,797	\$577,092	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	<b>TOTAL OPERATING REVENUE</b>	<b>\$349,064,204</b>	<b>\$356,454,096</b>	<b>\$364,837,419</b>	<b>\$5,505,508</b>	<b>\$370,342,927</b>	<b>\$364,720,983</b>	<b>\$14,064,917</b>	<b>\$378,785,900</b>	<b>\$367,392,533</b>	<b>\$19,403,641</b>	<b>\$386,796,174</b>	<b>\$367,283,122</b>	<b>\$24,103,750</b>	<b>\$391,386,872</b>
<b>B. OPERATING EXPENSES</b>															
1	Salaries and Wages	\$142,343,619	\$140,640,103	\$143,576,703	\$603,987	\$144,180,691	\$140,019,192	\$760,868	\$140,780,059	\$141,973,430	\$754,514	\$142,727,944	\$143,983,025	\$1,270,138	\$145,253,163
2	Fringe Benefits	\$50,942,363	\$51,694,855	\$54,026,420	\$847,885	\$54,874,305	\$52,456,564	\$1,228,742	\$53,685,306	\$52,771,303	\$1,254,900	\$54,026,203	\$53,087,931	\$1,407,884	\$54,495,815
3	Physicians Fees	\$37,964,369	\$29,627,730	\$29,986,525	\$2,845,324	\$32,831,849	\$22,789,759	\$4,677,729	\$27,467,488	\$22,333,964	\$4,788,754	\$27,122,718	\$22,646,640	\$4,921,640	\$27,568,280
4	Supplies and Drugs	\$59,512,480	\$63,622,692	\$64,288,904	\$55,178	\$64,344,082	\$64,610,349	\$345,629	\$64,955,978	\$65,540,738	\$651,937	\$66,192,675	\$66,471,416	\$917,694	\$67,389,110
5	Depreciation and Amortization	\$22,728,484	\$23,639,711	\$26,054,143	\$77,061	\$26,131,204	\$27,572,414	\$154,122	\$27,276,536	\$27,826,240	\$154,122	\$27,980,362	\$28,839,752	\$154,122	\$28,993,874
6	Provision for Bad Debts-Other <sup>b</sup>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7	Interest Expense	\$3,542,721	\$3,553,690	\$3,368,376	\$0	\$3,368,376	\$3,167,699	\$0	\$3,167,699	\$2,973,808	\$0	\$2,973,808	\$2,749,451	\$0	\$2,749,451
8	Malpractice Insurance Cost	\$4,538,822	\$4,818,820	\$4,812,632	\$0	\$4,812,632	\$4,812,632	\$0	\$4,812,632	\$4,812,632	\$0	\$4,812,632	\$4,812,632	\$0	\$4,812,632
9	Lease Expense	\$4,618,504	\$4,647,875	\$4,852,308	\$0	\$4,852,308	\$4,852,308	\$0	\$4,852,308	\$4,852,308	\$0	\$4,852,308	\$4,852,308	\$0	\$4,852,308
10	Other Operating Expenses	\$22,334,118	\$27,882,477	\$27,596,503	\$0	\$27,596,503	\$27,596,503	\$0	\$27,596,503	\$27,872,468	\$0	\$27,872,468	\$26,478,844	\$0	\$26,478,844
	<b>TOTAL OPERATING EXPENSES</b>	<b>\$348,525,480</b>	<b>\$350,127,953</b>	<b>\$358,562,515</b>	<b>\$4,429,435</b>	<b>\$362,991,950</b>	<b>\$347,877,420</b>	<b>\$7,167,089</b>	<b>\$355,044,509</b>	<b>\$350,956,891</b>	<b>\$7,604,227</b>	<b>\$358,561,119</b>	<b>\$353,921,999</b>	<b>\$8,671,477</b>	<b>\$362,593,477</b>
	<b>INCOME/(LOSS) FROM OPERATIONS</b>	<b>\$538,724</b>	<b>\$6,326,143</b>	<b>\$6,274,904</b>	<b>\$1,076,073</b>	<b>\$7,350,977</b>	<b>\$16,843,563</b>	<b>\$6,897,828</b>	<b>\$23,741,391</b>	<b>\$16,435,641</b>	<b>\$11,799,414</b>	<b>\$28,235,055</b>	<b>\$13,361,123</b>	<b>\$15,432,273</b>	<b>\$28,793,396</b>
	<b>NON-OPERATING REVENUE</b>	<b>\$8,788,601</b>	<b>\$9,936,909</b>	<b>\$8,262,701</b>	<b>\$0</b>	<b>\$8,262,701</b>	<b>\$8,262,701</b>	<b>\$0</b>	<b>\$8,262,701</b>	<b>\$8,262,701</b>	<b>\$0</b>	<b>\$8,262,701</b>	<b>\$8,262,701</b>	<b>\$0</b>	<b>\$8,262,701</b>
	<b>EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES</b>	<b>\$9,327,325</b>	<b>\$16,263,052</b>	<b>\$14,537,605</b>	<b>\$1,076,073</b>	<b>\$15,613,678</b>	<b>\$25,106,264</b>	<b>\$6,897,828</b>	<b>\$32,004,092</b>	<b>\$24,698,342</b>	<b>\$11,799,414</b>	<b>\$36,497,756</b>	<b>\$21,623,824</b>	<b>\$15,432,273</b>	<b>\$37,056,097</b>
	Principal Payments	\$5,152,609	\$5,316,471	\$5,510,844	\$0	\$5,510,844	\$5,725,738	\$0	\$5,725,738	\$5,911,163	\$0	\$5,911,163	\$6,137,126	\$0	\$6,137,126
<b>C. PROFITABILITY SUMMARY</b>															
1	Hospital Operating Margin	0.2%	1.8%	1.7%	19.5%	2.0%	4.6%	49.0%	6.3%	4.5%	60.8%	7.3%	3.6%	64.0%	7.4%
2	Hospital Non Operating Margin	2.3%	2.6%	2.3%	0.0%	2.2%	2.3%	0.0%	2.2%	2.2%	0.0%	2.1%	2.2%	0.0%	2.1%
3	Hospital Total Margin	2.7%	4.6%	4.0%	19.5%	4.2%	6.9%	49.0%	8.4%	6.7%	60.8%	9.4%	5.9%	64.0%	9.5%
<b>D. FTEs</b>															
		1,849	1,835	1,827	2	1,829	1,755	3	1,758	1,745	7	1,752	1,735	18	1,753
<b>E. VOLUME STATISTICS<sup>c</sup></b>															
1	Inpatient Discharges	14,153	14,076	14,212	179	14,391	14,083	329	14,412	13,940	478	14,418	13,823	627	14,450
2	Outpatient Visits	458,110	449,789	455,077	3,462	458,539	455,077	10,930	466,007	455,077	14,489	469,566	455,077	17,407	472,484
	<b>TOTAL VOLUME</b>	<b>472,263</b>	<b>463,865</b>	<b>469,289</b>	<b>3,641</b>	<b>472,930</b>	<b>469,160</b>	<b>11,259</b>	<b>480,419</b>	<b>469,017</b>	<b>14,967</b>	<b>483,984</b>	<b>468,900</b>	<b>18,035</b>	<b>486,935</b>

## Greer, Leslie

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**From:** Greci, Laurie  
**Sent:** Monday, February 01, 2016 11:37 AM  
**To:** nancy.rosenthal@greenwichhospital.org  
**Cc:** Greer, Leslie; Riggott, Kaila  
**Subject:** Request for Additional Information Regarding CON Application 15-32032  
**Attachments:** 15-32032-CL 2nd 02012016.docx

Dear Ms. Rosenthal,

Please see attached request for additional information regarding CON application 15-32032 -- Transfer of Ownership of Group Practice by Merger of L&M Physicians Association into Northeast Medical Group.

Please contact me if you have any questions. Responses are due by **Friday, April 1, 2016**.

Regards,

Laurie Greci

Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Tel: 860-418-7001  
Fax: 860-418-7053  
mailto: [laurie.greci@ct.gov](mailto:laurie.greci@ct.gov)  
Web: [www.ct.gov/ohca](http://www.ct.gov/ohca)



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.  
Acting Commissioner



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

February 1, 2016

Via Email Only

[nancy.rosenthal@ynhh.org](mailto:nancy.rosenthal@ynhh.org)

Nancy Rosenthal  
Senior Vice President, Health Systems Development  
Yale New Haven Health System  
789 Howard Avenue  
New Haven, CT 06519

RE: Certificate of Need Application; Docket Number: 15-32032-CON  
Transfer of Ownership of Group Practice by Merger of L&M Physicians Association into  
Northeast Medical Group  
Certificate of Need Second Completeness Letter

Dear Ms. Rosenthal:

On January 5, 2016, OHCA received the requested responses to questions concerning the Certificate of Need application of Northeast Medical Group, Inc. ("NEMGP") and L&M Physician Association, Inc. ("LMPA") for the NEMGP to acquire LMPA. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email. *Please email your responses to all of the following email addresses: [OHCA@ct.gov](mailto:OHCA@ct.gov); [laurie.greci@ct.gov](mailto:laurie.greci@ct.gov); and [kaila.riggott@ct.gov](mailto:kaila.riggott@ct.gov).*

Repeat each question before providing your response and paginate and date your response, i.e., each page, in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using **Page 229** and reference "**Docket Number: 15-32032-CON.**"



Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611  
410 Capitol Avenue, P.O. Box 340308  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **April 1, 2016**, otherwise your application will be automatically considered withdrawn.

1. On pages 225 and 226 submitted with the completeness response, the following information was provided:

APPLICANTS' PROJECTED LOSSES FROM OPERATIONS WITH THE PROPOSAL\*

	FY 2016	FY 2017	FY 2018	FY 2019
Revenues from Operations	\$307,108	\$335,031	\$342,067	\$349,278
Total Operating Expense	371,884	408,482	415,955	423,760
Loss from Operations	\$(64,736)	\$(73,451)	\$(73,888)	\$(74,482)

\* Amounts in thousands, rounded.

Page 33 of the initial CON application states that Yale New Haven Health System, the parent corporation of NEMG, has the financial stability to support NEMG after the merger in order to achieve its charitable goals. Please provide a discussion that addresses the losses experienced by NEMG. Provide documentation that specifically demonstrates YNHHS's ability to cover the expenses of NEMG.

2. Confirm that the patient population currently served by LMPA physicians will benefit from the policies or protocols of NEMG, including NEMG's charity care policy.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7001 or (860) 418-7045.

Sincerely,

Laurie Greci  
Associate Research Analyst

Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Tel: 860-418-7001  
Fax: 860-418-7053  
mailto: [laurie.greci@ct.gov](mailto:laurie.greci@ct.gov)  
Web: [www.ct.gov/ohca](http://www.ct.gov/ohca)

## Greer, Leslie

---

**From:** Martone, Kim  
**Sent:** Thursday, March 03, 2016 10:20 AM  
**To:** Hansted, Kevin  
**Cc:** Greer, Leslie  
**Subject:** FW: Docket No: 15-32033-CON and Docket No: 15-32032-CON  
**Attachments:** Letter.pdf

---

**From:** Feldman, Joan [<mailto:JFeldman@goodwin.com>]  
**Sent:** Thursday, March 03, 2016 10:18 AM  
**To:** Martone, Kim  
**Subject:** Docket No: 15-32033-CON and Docket No: 15-32032-CON

Please see attached letter.

Thank you.

Joan

**Shipman & Goodwin** LLP  
C O U N S E L O R S   A T   L A W

**Joan W. Feldman**  
Partner  
One Constitution Plaza  
Hartford, CT 06103-1919

Tel (860) 251-5104  
Fax (860) 251-5211  
[jfeldman@goodwin.com](mailto:jfeldman@goodwin.com)  
[www.shipmangoodwin.com](http://www.shipmangoodwin.com)

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 please consider the environment before printing this message



**SHIPMAN & GOODWIN** LLP®  
COUNSELORS AT LAW

Joan W. Feldman  
Phone: (860) 251-5104  
Fax: (860) 251-5211  
jfeldman@goodwin.com

March 3, 2016

Kimberly Martone  
Director of Operations  
State of Connecticut Office of Health Care Access  
410 Capitol Avenue  
MS #13HCA  
P.O. Box 340308  
Hartford, CT 06106

Re: Docket Number: 15-32033-CON (known as “Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation”);  
Docket Number: 15-32032-CON (known as “Proposal for Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc.”)

Dear Kim:

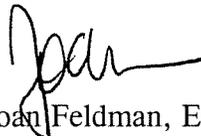
In light of Governor Malloy’s Executive Order No. 51, dated February 25, 2016, I am writing to inform you that the applicants in the above-referenced matters plan to proceed, within the applicable statutory and regulatory framework, to complete the Certificate of Need process as it relates to both applications. In particular, with respect to Docket Number: 15-32033, the applicants will timely submit their completeness questions and await a determination from OHCA that the subject application is complete. Once deemed complete, we expect that OHCA would conduct a hearing and render a decision within ninety (90) days of the date of the application being deemed complete. With respect to Docket Number: 15-32032-CON, it is our opinion that Executive Order No. 51 is inapplicable and thus, this application should proceed as it would have prior to the issuance of the Governor’s Executive Order No. 51.

Finally, with respect to Docket No-32033-CON, I am writing to confirm that OHCA, to the extent that Executive Order No. 51 remains in effect, will deny the application pursuant to Executive Order No. 51 should the application proceed to the point within the regulatory process wherein OHCA is required to render a final decision.

Kimberly Martone  
March 3, 2016  
Page 2

If you have any questions, or disagree with our approach or interpretation, we would appreciate hearing from you no later than March 9, 2016.

Very truly yours,

A handwritten signature in black ink, appearing to read "Joan", with a long horizontal flourish extending to the right.

Joan Feldman, Esq.

JWF:mg  
4607846v3

cc: Janet Brancifort, M.P.H., Deputy Commissioner  
William Aseltyne, Esq.  
Maureen Anderson, Esq.



**SHIPMAN & GOODWIN** LLP®  
COUNSELORS AT LAW

Joan W. Feldman  
Phone: (860) 251-5104  
Fax: (860) 251-5211  
jfeldman@goodwin.com



March 3, 2016

Kimberly Martone  
Director of Operations  
State of Connecticut Office of Health Care Access  
410 Capitol Avenue  
MS #13HCA  
P.O. Box 340308  
Hartford, CT 06106

Re: Docket Number: 15-32033-CON (known as "Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation");  
Docket Number: 15-32032-CON (known as "Proposal for Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc.")

Dear Kim:

In light of Governor Malloy's Executive Order No. 51, dated February 25, 2016, I am writing to inform you that the applicants in the above-referenced matters plan to proceed, within the applicable statutory and regulatory framework, to complete the Certificate of Need process as it relates to both applications. In particular, with respect to Docket Number: 15-32033, the applicants will timely submit their completeness questions and await a determination from OHCA that the subject application is complete. Once deemed complete, we expect that OHCA would conduct a hearing and render a decision within ninety (90) days of the date of the application being deemed complete. With respect to Docket Number: 15-32032-CON, it is our opinion that Executive Order No. 51 is inapplicable and thus, this application should proceed as it would have prior to the issuance of the Governor's Executive Order No. 51.

Finally, with respect to Docket No-32033-CON, I am writing to confirm that OHCA, to the extent that Executive Order No. 51 remains in effect, will deny the application pursuant to Executive Order No. 51 should the application proceed to the point within the regulatory process wherein OHCA is required to render a final decision.

Kimberly Martone  
March 3, 2016  
Page 2

If you have any questions, or disagree with our approach or interpretation, we would appreciate hearing from you no later than March 9, 2016.

Very truly yours,

A handwritten signature in blue ink, appearing to read "Joan", with a long horizontal flourish extending to the right.

Joan Feldman, Esq.

JWF:mg  
4607846v3

cc: Janet Brancifort, M.P.H., Deputy Commissioner  
William Aseltyne, Esq.  
Maureen Anderson, Esq.

## Greer, Leslie

---

**Subject:** FW: DN15:32032 NEMG LMPA Second Set of Completeness Responses  
**Attachments:** DN 15\_32032 NEMG - LMPA Completeness2\_FINAL03 30 2016.pdf; DN 15\_32032 NEMG - LMPA Completeness2\_FINAL03 30 2016.docx; nancyr\_3-30-2016\_15-19-29.pdf

---

**From:** Rosenthal, Nancy [<mailto:Nancy.Rosenthal@greenwichhospital.org>]  
**Sent:** Wednesday, March 30, 2016 3:27 PM  
**To:** Martone, Kim; Riggott, Kaila  
**Subject:** FW: DN15:32032 NEMG LMPA Second Set of Completeness Responses

Kim, Laurie and Kaila,

Attached is the cover letter and Word/Adobe responses to the second set of completeness questions for the merger of NEMG/LMPA. Thank you for your consideration of this important project.

Please forward to Laurie as I don't have her current email and I don't see it posted on the website.

Thank you.

Nancy

**Nancy Rosenthal**  
V.P., Strategy and Regulatory Planning

**Yale New Haven Health System**  
2 Howe Street, Room 307  
New Haven, CT 06511

203-688-5721

[Nancy.Rosenthal@ynhh.org](mailto:Nancy.Rosenthal@ynhh.org)  
[www.ynhhs.org](http://www.ynhhs.org)

Please consider the [environment](#)  
before printing this email.

This message originates from the Yale New Haven Health System. The information contained in this message may be privileged and confidential. If you are the intended recipient you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you.



March 30, 2016

Ms. Kimberly Martone  
Director of Operations  
Office of Healthcare Access  
410 Capitol Avenue  
MS #13HCA  
P.O. Box 340308  
Hartford, CT 06106

Re: Proposal for Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc. (DN: 15-32032-CON) – 2<sup>nd</sup> Completeness Letter Response

Dear Ms. Martone:

Please find attached to this email communication, an MS Word and Adobe Acrobat file containing the responses to the second set of completeness questions posed by the Office of Healthcare Access on February 1, 2015.

We appreciate OHCA's time and effort related to this critically important proposal. Please feel free to contact me at (203) 688-5721 with any questions.

Sincerely,

A handwritten signature in purple ink, appearing to read 'Nancy Rosenthal', with a long, sweeping underline.

Nancy Rosenthal  
Vice President, Strategy and Regulatory Planning

Copy to: Laurie Greci  
Kaila Riggott

Enclosures

Northeast Medical Group, Inc.  
L&M Physician Association, Inc.

Proposal for Merger of L&M Physician Association, Inc.  
and Northeast Medical Group, Inc.  
Docket Number: 15-32032-CON

Responses to Completeness Questions – 2<sup>nd</sup> Letter

March 30, 2016

1. On pages 225 and 226 submitted with the completeness response, the following information was provided:

**APPLICANTS' PROJECTED LOSSES FROM OPERATIONS WITH THE PROPOSAL\***

	<b>FY 2016</b>	<b>FY 2017</b>	<b>FY 2018</b>	<b>FY 2019</b>
Revenues from Operations	\$307,108	\$335,031	\$342,067	\$349,278
Total Operating Expense	371,884	408,482	415,955	423,760
Loss from Operations	\$(64,736)	\$(73,451)	\$(73,888)	\$(74,482)

\* Amounts in thousands, rounded.

Page 33 of the initial CON application states that Yale New Haven Health System, the parent corporation of NEMG, has the financial stability to support NEMG after the merger in order to achieve its charitable goals. Please provide a discussion that addresses the losses experienced by NEMG. Provide documentation that specifically demonstrates YNHHS's ability to cover the expenses of NEMG.

**Response:**

Although YNHHS provides financial support to NEMG in order to further YNHHS' charitable goals, the practice is continuously working to improve its overall financial performance. There are a number of initiatives underway that are expected to enhance revenue or reduce operating expenses which are described below.

- a) NEMG is currently modifying its revenue cycle process to reduce the amount of manual intervention involved in processing and collecting claims. As a result of these efforts and over time, it is expected that overhead expenses associated with these activities will be reduced.
- b) LEAN initiatives are underway throughout NEMG focusing on the most efficient use of Epic, standardization of scheduling practices, and more efficient use of medical assistants based on patient volumes at multiple practices. Recent changes to medical assistant staffing now permit them to work at various locations based on daily schedule volume and have reduced the need for per diem and some part-time positions.
- c) Revisions have been made to Hospitalists' work schedules at YNHHS. Alternative shifts have been established which have resulted in significant reductions in "moonlighting" expenses.

- d) NEMG plans to consolidate locations and significantly reduce lease expenses for office space over the next 3-4 years.

In addition to the activities discussed above for NEMG, L&MPA also works regularly on improving its financial performance and efficiency, as well as improving access to physician services in the community. Such improvements will be further enhanced if L&MPA joins NEMG and benefits from NEMG's initiatives described above. Some of L&MPA's recent initiatives are as follows:

- a) Standardization of appointment scheduling to improve practice efficiency and increase access;
- b) Patient education in prescription refill management to reduce unnecessary refill calls ;
- c) After-hours appointment options to improve patient convenience and access as well as practice productivity;
- d) Initiatives around charge capture and billing and collections practices;
- e) Use of non-physician providers to improve patient access and physician productivity;
- f) Personal system of appointment reminder calls and letters to reduce no-show rates; and
- g) Evaluation of support services contracted for across practices (i.e. waste management) to improve pricing/reduce cost of support services.

With respect to YNHHS's ability to cover the expenses of NEMG, YNHHS' financial and enterprise profile is strong as evidenced by the long-term bond ratings of its obligated group of AA- (Stable Outlook) by Fitch, Aa3 (Stable Outlook) by Moody's, and A+ (Positive Outlook) by S&P (S&P revised its outlook in July 2015 from "Stable"). These credit ratings reflect the financial strength of YNHHS, thus demonstrating that YNHHS has the ability to cover any losses NEMG experiences, including the additional losses noted above which are projected to occur as a result of the merger of LMMG with and into NEMG. Further evidence of YNHHS' financial strength can be found in the audited financial statements of YNHHS previously submitted to OHCA, and Financial Worksheet A submitted as part of Docket No. 15-30233 CON (the overall affiliation of L+M Corporation with YNHHS).

YNHHS also is committed to maintaining NEMG as a viable organization. As noted on page 20 of the CON, NEMG furthers the charitable mission of YNHHS by providing much-needed physician services, including in specialties such as primary care and geriatrics where patient care revenues are often not sufficient to support a practice in the community. In addition, NEMG participates in the YNHHS Financial Assistance Policies, which offer discounted services to patients that ordinarily are not available in private physician practices.

NEMG also is critical to YNHHS' strategy to address changes in health care delivery and payment, including the move from volume to value and innovative models such as payments based on population health or outcomes measures. Further, as indicated in our completeness responses to OHCA's questions in Docket No. 15-30233 CON (the overall affiliation of L+M Corporation with YNHHS), NEMG is part of the YNHHS Obligated Group, and as such YNHHS has a direct interest in ensuring NEMG covers its expenses and meets its financial obligations. YNHHS has provided mission support to NEMG since its launch in 2010, and anticipates continuing to do so for so long as NEMG is part of Yale New Haven Health System.

2. Confirm that the patient population currently served by LMPA physicians will benefit from the policies or protocols of NEMG, including NEMG's charity care policy.

**Response:**

If the CON is approved and the merger occurs, LMPA practice locations and LMPA physicians will be covered by all NEMG policies, including but not limited to the YNHHS Financial Assistance policy.

## Greer, Leslie

---

**From:** Carney, Brian  
**Sent:** Tuesday, May 10, 2016 10:59 AM  
**To:** Nancy.Rosenthal@ynhh.org; Rosenthal, Nancy  
**Cc:** Martone, Kim; Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Ciesones, Ron; Greer, Leslie  
**Subject:** Docket numbers: 15-32032-CON & 15-32033-CON Deemed Complete  
**Attachments:** 15-32032-con\_201605101034.pdf; 15-32033-con\_201605101035.pdf

Nancy,

As directed, please see attached letters deeming complete docket numbers: 15-32032-CON & 15-32033-CON.

Please respond to confirm receipt of this email.

Thanks,  
Brian Carney

**Brian A. Carney, MBA**

Associate Research Analyst  
Office of Health Care Access  
CT Department of Public Health  
410 Capitol Avenue, MS #13HCA  
P.O. Box 340308  
Hartford, CT 06134-0308

Phone: (860) 418-7014  
Fax: (860) 418 7053  
Email: [brian.carney@ct.gov](mailto:brian.carney@ct.gov)  
Web: [www.ct.gov/ohca](http://www.ct.gov/ohca)



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

May 10, 2016

Via Email Only

[nancy.rosenthal@ynhh.org](mailto:nancy.rosenthal@ynhh.org)  
Nancy Rosenthal  
Senior Vice President, Health Systems Development  
Yale New Haven Health System  
789 Howard Avenue  
New Haven, CT 06519

RE: Certificate of Need Application, Docket Number: 15-32032-CON  
Transfer of Ownership of Group Practice by Merger of L&M Physicians Association into  
Northeast Medical Group

Certificate of Need Completeness Letter

Dear Ms. Rosenthal:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of May 10, 2016.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7012.

Sincerely,

A handwritten signature in black ink that reads "Steven Lazarus" with a circled "SLR" next to it.

Steven W. Lazarus  
Associate Health Care Analyst



Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611  
410 Capitol Avenue, P.O. Box 340308  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

## Greer, Leslie

---

**From:** Rosenthal, Nancy <Nancy.Rosenthal@greenwichhospital.org>  
**Sent:** Tuesday, May 10, 2016 11:41 AM  
**To:** Carney, Brian  
**Cc:** Martone, Kim; Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Ciesones, Ron; Greer, Leslie  
**Subject:** RE: Docket numbers: 15-32032-CON & 15-32033-CON Deemed Complete

Thank you all!

**Nancy Rosenthal**  
V.P., Strategy and Regulatory Planning

**Yale New Haven Health System**  
2 Howe Street, Room 307  
New Haven, CT 06511

203-688-5721

[Nancy.Rosenthal@ynhh.org](mailto:Nancy.Rosenthal@ynhh.org)  
[www.ynhhs.org](http://www.ynhhs.org)

Please consider the [environment](#)  
before printing this email.

---

**From:** Carney, Brian [<mailto:Brian.Carney@ct.gov>]  
**Sent:** Tuesday, May 10, 2016 10:59 AM  
**To:** Rosenthal, Nancy; Rosenthal, Nancy  
**Cc:** Martone, Kim; Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Ciesones, Ron; Greer, Leslie  
**Subject:** Docket numbers: 15-32032-CON & 15-32033-CON Deemed Complete

Nancy,

As directed, please see attached letters deeming complete docket numbers: 15-32032-CON & 15-32033-CON.

Please respond to confirm receipt of this email.

Thanks,  
Brian Carney

**Brian A. Carney, MBA**  
Associate Research Analyst  
Office of Health Care Access  
CT Department of Public Health  
410 Capitol Avenue, MS #13HCA  
P.O. Box 340308  
Hartford, CT 06134-0308

Phone: (860) 418-7014  
Fax: (860) 418 7053

Email: [brian.carney@ct.gov](mailto:brian.carney@ct.gov)

Web: [www.ct.gov/ohca](http://www.ct.gov/ohca)



This message originates from the Yale New Haven Health System. The information contained in this message may be privileged and confidential. If you are the intended recipient you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you.

## Greer, Leslie

---

**From:** Greer, Leslie  
**Sent:** Wednesday, May 11, 2016 5:13 PM  
**To:** 'nancy.rosenthal@ynhh.org'  
**Cc:** Carney, Brian; Lazarus, Steven; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara  
**Subject:** Yale New Haven Health System Hearing Notice DN's 15-32032-CON & 15-32033-CON  
**Attachments:** 15-32032-CON 15-32033-CON.pdf

<b>Tracking:</b>	<b>Recipient</b>	<b>Delivery</b>
	'nancy.rosenthal@ynhh.org'	
	Carney, Brian	Delivered: 5/11/2016 5:14 PM
	Lazarus, Steven	Delivered: 5/11/2016 5:14 PM
	Riggott, Kaila	Delivered: 5/11/2016 5:14 PM
	Hansted, Kevin	Delivered: 5/11/2016 5:14 PM
	Martone, Kim	Delivered: 5/11/2016 5:14 PM
	Olejarz, Barbara	Delivered: 5/11/2016 5:14 PM

Ms. Rosenthal,  
Attached is the hearing notice for DN's 15-32032-CON and 15-32033-CON being held on June 15, 2016.

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

May 11, 2016

Nancy Rosenthal  
SVP, Strategy and Regulatory Planning  
Yale-New Haven Health System  
5 Perryridge Road  
Greenwich, CT 06830

RE: Certificate of Need Application, Docket Number 15-32032-CON and 15-32033-CON  
**Docket Number: 15-32032-CON**

Northeast Medical Group ("NMG") and L&M Physician Association  
("L&MPA")

Transfer of Ownership of a Group Practice by Merger of L&MPA into NMG

**Docket Number: 15-32033-CON**

Yale New Haven Health Services Corporation ("YNHHSC") and Lawrence +  
Memorial Corporation ("L+M")

Acquisition of L+M by YNHHSC

Dear Ms. Rosenthal,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Northeast Medical Group, Inc., L&M Physician Association, Inc., Yale New Haven Health Services Corporation and L&M Corporation ("Applicants") on April 29, 2016, the Office of Health Care Access ("OHCA") has initiated its review of the CON applications identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

Applicant(s): Northeast Medical Group, Inc.  
L&M Physician Association, Inc.

Docket Number: 15-32032-CON

Proposal: Transfer of Ownership of a Group Practice by Merger of L&M Physicians  
Association into Northeast Medical Group

Applicant(s): Yale New Haven Health Services Corporation  
L&M Corporation

Docket Number: 15-32033-CON

Proposal: Acquisition of L+M by YNHHSC

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: June 15, 2016

Time: 3:00 p.m.

Place: Connecticut College  
Blaustein Humanities Center, Building #8  
Ernst Common Room (Corner of Cro Blvd/Chapel Way)  
270 Mohegan Avenue  
New London, CT 06320

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in *The Day* pursuant to General Statutes § 19a-639a (f) and 19a-486 (f).

NMG and L&MPA  
YNHHSC and L+M

May 11, 2016

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

Sincerely,



Kimberly R. Martone  
Director of Operations  
Enclosure

cc: Henry Salton, Esq., Office of the Attorney General  
Antony Casagrande, Department of Public Health  
Kevin Hansted, Department of Public Health  
Wendy Furniss, Department of Public Health  
Maura Downes, Department of Public Health  
Jill Kentfield, Department of Public Health  
Chris Stan, Department of Public Health  
DeVaughn Ward, Department of Public Health  
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC:lmg

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

May 11, 2016

P.O. #54772

The Day  
47 Eugene O'Neil Drive  
New London, CT 06320

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, May 13, 2016**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Handwritten signature of Kimberly R. Martone in black ink.

Kimberly R. Martone  
Director of Operations

Attachment

cc: Danielle Pare, DPH  
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC;lmg



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

Statute Reference: 19a-638

Applicant(s): Northeast Medical Group, Inc.  
L&M Physician Association, Inc.

Town: Stratford

Docket Number: 15-32032-CON

Proposal: Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group

Applicant(s): Yale New Haven Health Services Corporation  
L&M Corporation

Town: New London

Docket Number: 15-32033-CON

Proposal: Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation

Date: June 15, 2016

Time: 3:00 p.m.

Place: Connecticut College  
Blaustein Humanities Center, Building #8  
Ernst Common Room (Corner of Cro Blvd/Chapel Way)  
270 Mohegan Avenue

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 10, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at [www.ct.gov/ohca](http://www.ct.gov/ohca) for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

## Greer, Leslie

---

**From:** ADS <ADS@graystoneadv.com>  
**Sent:** Wednesday, May 11, 2016 4:12 PM  
**To:** Greer, Leslie  
**Subject:** Re: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Good day!

Thanks so much for your ad submission.  
We will be in touch shortly and look forward to serving you.

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PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for \$115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,  
Graystone Group Advertising

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Bridgeport, CT 06604  
Phone: 800-544-0005  
Fax: 203-549-0061

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<http://www.graystoneadv.com/>

---

**From:** "Greer, Leslie" <[Leslie.Greer@ct.gov](mailto:Leslie.Greer@ct.gov)>  
**Date:** Wednesday, May 11, 2016 at 4:05 PM  
**To:** Ads Desk <[ads@graystoneadv.com](mailto:ads@graystoneadv.com)>  
**Cc:** "Olejarz, Barbara" <[Barbara.Olejarz@ct.gov](mailto:Barbara.Olejarz@ct.gov)>  
**Subject:** DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 5/13. For billing purposes, please refer to P.O. 54772. In addition, when the "proof of publication" becomes available, please forward me a copy.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)

## Greer, Leslie

---

**From:** Robert Taylor <RTaylor@graystoneadv.com>  
**Sent:** Thursday, May 12, 2016 4:19 PM  
**To:** Greer, Leslie  
**Subject:** FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice  
**Attachments:** 15-32032 and 15-32033 The Day.docx

Good afternoon,

This notice is set to publish tomorrow.  
\$483.18

Thanks,

Robert Taylor  
Graystone Group Advertising  
[www.graystoneadv.com](http://www.graystoneadv.com)  
2710 North Avenue, Suite 200  
Bridgeport, CT 06604  
Phone: 203-549-0060  
Toll Free: 800-544-0005  
Fax: 203-549-0061

---

**From:** ADS <[ADS@graystoneadv.com](mailto:ADS@graystoneadv.com)>  
**Date:** Wed, 11 May 2016 16:12:03 -0400  
**To:** RTaylor <[rtaylor@graystoneadv.com](mailto:rtaylor@graystoneadv.com)>  
**Subject:** FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice

---

**From:** "Greer, Leslie" <[Leslie.Greer@ct.gov](mailto:Leslie.Greer@ct.gov)>  
**Date:** Wednesday, May 11, 2016 at 4:05 PM  
**To:** Ads Desk <[ads@graystoneadv.com](mailto:ads@graystoneadv.com)>  
**Cc:** "Olejarsz, Barbara" <[Barbara.Olejarsz@ct.gov](mailto:Barbara.Olejarsz@ct.gov)>  
**Subject:** DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 5/13. For billing purposes, please refer to P.O. 54772. In addition, when the "proof of publication" becomes available, please forward me a copy.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)

Classified

MARKETPLACE

PLACE YOUR AD ANYTIME AT theday.com/classified

Customer Service: Monday-Friday 8:00AM - 4:30PM | class@theday.com | 1.860.701.4200

Public Notices



City of New London Connecticut LEAD HAZARD REDUCTION PROGRAM (L-HARP) 181 State Street New London, CT 06320 (860) 447-5243

INVITATION FOR BIDS

The City of New London, through the Lead Hazard Reduction Program (L-HARP), will receive bids for residential lead abatement for:

63 Faire Harbour Place & 32 South Ledyard Street New London, CT 06320

Thursday, May 19, 2016 at 2:00 p.m. Friday, May 20, 2016 at 9:00 a.m.

32 South Ledyard Street: Thursday, May 19, 2016 at 2:45 p.m. Friday, May 20, 2016 at 9:45 a.m.

A site inspection is mandatory for all contractors planning to bid. Sealed bids will be accepted at 181 State Street, New London, Connecticut until:

63 Faire Harbour Place: 2:00 p.m. on Friday, May 27, 2016 2:05 p.m. on Friday, May 27, 2016

At which time all bids will be opened publicly. Only bids by pre-registered contractors will be accepted.

Documents pertaining to the scope of work and specifications may be obtained from the L-HARP Office at the above address, telephone (860) 437-6327. Addenda, if any, will be issued only to contractors who, by our records, have obtained the original specifications.

The City of New London hereby notifies all bidders that it will affirmatively insure that in any contract entered into pursuant to this advertisement, qualified Minority Business Enterprises will be afforded full opportunity to submit bids in response to this invitation and that they will not be discriminated against on the grounds of race, color, national origin, sex, mental retardation or physical disability including but not limited to blindness, in consideration for an award.

The City is an Equal Opportunity Employer and adheres to the practices of Fair Housing and Affirmative Action.

21024

Office of Health Care Access Public Hearings

Statute Reference: 19a-638

Applicant(s): Northeast Medical Group, Inc. L&M Physician Association, Inc

Town: Stratford

Docket Number: 15-32032-CON

Proposal: Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group

Applicant(s): Yale New Haven Health Services Corporation L&M Corporation

Town: New London

Docket Number: 15-32033-CON

Proposal: Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation

Date: June 15, 2016

Time: 3:00 p.m.

Place: Connecticut College Blaustein Humanities Center, Building #8 Ernst Common Room (Corner of Cro Blvd/Chapel Way) 270 Mohegan Avenue

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 10, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHC's website at www.ct.gov/ohca for more information or call OHC directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

20966

PLANNING AND ZONING COMMISSION TOWN OF STONINGTON

NOTICE OF PUBLIC HEARING

Pursuant to the General Statutes of the State of Connecticut revision of 1958 and all amendments thereto, and pursuant to the Zoning Regulations for the Town of Stonington, Connecticut, the Planning and Zoning Commission hereby gives notice that it will hold a Public Hearing at the Mystic Middle School, 204 Mistuxet Ave., Mystic, CT, on Tuesday, May 17, 2016 at 7:30 p.m. on the following application(s):

PZ1608SUP Goran & Desiree Subotic - Special Use Permit application to extend the current permitted hours of operation to Monday thru Saturday, 9:00 AM to 9:30PM, and Sunday, no later than 8:00 PM. Property located at 325 Mistuxet Ave., Mystic. Assessor's Map 133 Block 6 Lot 5B. Zone RA-40.

PZ1610SPA New Prospect, LLC (Dan Barber) - Site Plan application for the renewal of previously approved Site Plan Application for the development of a 28-unit attached housing project (Prospect Place), Properties located on Mechanic and Prospect Streets, Pawcatuck, CT. Assessor's Map 4, Block 18, Lot 3B & Map 4, Block 16, Lot 7. Zone NDD-1.

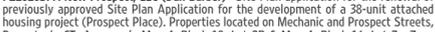
AT SUCH HEARING ANY PARTY MAY APPEAR IN PERSON OR BE REPRESENTED BY AN AGENT OR BY AN ATTORNEY.

Any disabled person requiring auxiliary aids or services for effective communication or access at this hearing should contact the Department of Planning at (860) 535-5095 ten days prior to the hearing date.

Dated at Stonington, Connecticut, this 3rd day of May, 2016.

John Prue, Chairman

21037



Town of Waterford Board of Selectmen Invitation to Bid Oversized Bulky Waste Disposal #16-123

The Purchasing Agent will accept sealed bids for Oversized Bulky Waste Disposal until 11:00 am on May 31, 2016. Please see the Town of Waterford website at http://www.waterford.org for packets and all information regarding this Bid. Packets may also be picked up in the Purchasing Office. Any questions regarding this proposal are to be directed to the Purchasing Agent at krotella@waterfordct.org. The Board of Selectmen reserves the right to reject any or all bids, in whole or in part, and to waive any informality in any bid when such action is deemed in the best interest of the Town; their decision is final.

Kate Rotella Purchasing Agent

21008

PUBLIC AUCTION

Of abandoned mobile home located at Yoselevsky's Mobile Home Park 8A Meetinghouse Lane, Montville, CT 06353

Supplemental Notice of Public Hearing at Norwich Docket # KNO - CV15-6100919-5 the undersigned has been authorized to sell the following property under terms and conditions hereinafter set forth: PROPERTY: Ritz Craft Mobile Manufactured Home, Model Number: CMDL 550 Serial Number: 010687260 Year of Manufacturer: 1986 DATE OF SALE : Saturday, May 21, 2016 TIME OF SALE : 12 O'Clock-Noon PLACE OF SALE : 8A Meetinghouse Lane, Montville, CT INSPECTION : One half-hour before sale DEPOSIT : 10% of accepted bid (certified funds/bank draft or cash)

PURSUANT TO CONNECTICUT GENERAL STATUTES SECTION 21-80(e)(4), THE SALE OF THIS PROPERTY WILL EXTINGUISH ALL PREVIOUS OWNERSHIP AND LIEN RIGHTS. For further information, contact Attorney Nancy Z. Dubicki, Attorney for MAY REALTY, LLC Telephone Number-860-443-1864 Subject to other terms and conditions to be announced at the time of sale.

Public Notices

TOWN OF WATERFORD Representative Town Meeting District 2 Notice of Vacancy & Special Election

Pursuant to Section 3.1.10 of the Charter of the Town of Waterford, Connecticut, notice is hereby given that a vacancy in the membership of the Waterford Representative Town Meeting in the Second Voting District has occurred by reason of the resignation of Theodore Olynch. Said vacancy shall be filled for the term, ending December 4, 2017, at a Special Meeting of the representatives from the Second Voting District at 7:10 P.M., Monday, June 6, 2016, in the Office of the Town Clerk, 15 Rope Ferry Road.

Dated at Waterford, Connecticut, this 10th day of May, 2016.

David L. Campo Waterford Town Clerk

20942

STATE OF CONNECTICUT SUPERIOR COURT

Judicial District of NORWICH/ NEW LONDON At: NEW LONDON Docket Number: FKNLVC1360166545 Plaintiff's Name: RBS Citizens, N.A. Defendant's Name: Rodriguez, Erik D Ct AI Order Regarding: 04/06/2016 107.00 Motion for Order of Notice

This proceeding, having been considered by the Court, is hereby: Order: Granted Notice to: ERIK D. Rodriguez and Leticia Mercado

The plaintiff has named you as a defendant in the complaint brought to the above named court seeking foreclosure of the mortgage on the property located at 24 BLOOMINGDALE ROAD, QUAKER HILL, CT 06365. This complaint was returnable to the above named court on 3/13/2015 and is now pending therein.

The court finds that the defendant (s)listed below has (have) not appeared in this action, and so far as the plaintiff knows, has (have) not received actual notice of the institution or pendency of it; that so far as its known each resides at 3123 MESA VERDE DRIVE, APT. 2707, ORLANDO, FLORIDA 32837.

Now therefore, it is hereby ordered that further notice of the institution and pendency of this action be given to each such defendant by some proper officer (or person) causing a true and attested copy of this order to be published in ORLANDO SENTINEL AND THE NEW LONDON DAY once a week for 2 successive weeks, commencing on or before 6/2/2016 and then return of such service to made to this court.

Judicial Notice (JDNO) sent regarding this order. Order Number 419136 Judge: EMMET CROUVÉ ATTEST: A TRUE COPY Joseph LoGioco, State Marshall

OS4156296 5/6, 5/13/2016

20941

MEETING

All qualified voters of the Stonington Fire District are hereby warned that a meeting of said Fire District will be held on May 16, 2016 at 7:00PM at the Stonington Community Center, 28 Cutler Street, Stonington CT for the purpose of the following:

- 1. Call meeting to order.
- 2. Reading of the Secretary's minutes.
- 3. Reading of the Treasurers Report.
- 4. Reading of the Tax Collectors Report.
- 5. Election of Officers
- 6. Old Business
- 7. New business
- 8. Accepted proposed budget
- 9. Other business brought before the voters
- 10. Adjournment

William B. McDonough Secretary/Treasurer

21028

ZONING BOARD OF APPEALS TOWN OF STONINGTON, CONNECTICUT NOTICE OF DECISION

At the Regular Meeting of the Zoning Board of Appeals held on May 10, 2016 the following decisions were made:

ZBA #16-06 JBRV LLC (Robert Valenti) - Seeking a variance from ZR 7.12.1.2 to increase the allowed wall signage from 48.5 sq. ft. to 106 sq. ft. Property located at 72 Jerry Browne Rd., Mystic CT 06355. Assessor's Map 164 Block 2 Lot 3. Zone GC-60. "FORD" SIGN APPROVED/"VALENTI" SIGN-DENIED.

ZBA #16-07 Regis & Dolphine Doyonnas - Seeking a variance from ZR 5.1.1 to reduce the 50' front yard setback to 25' to construct a deck and one story addition. Property located on 74 Wolf Neck Road, Stonington, Assessor's Map 139 Block 2 Lot 1; Zone RR-80. APPROVED.

Dated at Stonington, CT this 11th day of May, 2016

Bill Lyman, Acting Chairman

21029

Notice of Permit Application Town: New London

Notice is hereby given that The Thames Shipyard & Repair Company will submit to the Department of Energy and Environmental Protection an application under Section(s) Section 22a-361 to conduct work in tidal coastal or navigable waters of the state. Specifically, the applicant proposes to conduct maintenance dredging at the North Pier and entrance channel to the facility. The proposed dredging is necessary to ensure ongoing operations of this existing water dependent use. The proposed activity will take place at 50 Farnsworth Street, New London and will potentially affect: coastal or aquatic resources and the Thames River. Interested persons may obtain copies of the application from Becky Meyer, Milone & MacBroom, Inc., 99 Realty Drive, Cheshire, CT 06410; (203) 271-1773. The application will be available for inspection at the Office of the Department of Energy and Environmental Protection, Office of Long Island Sound Programs, 79 Elm Street, Hartford, CT 06106-5127 telephone 860-424-3034 from 8:30 to 4:30 Monday through Friday. Please call in advance to schedule review of the application.

21032

TOWN OF LEDYARD INLAND WETLANDS & WATERCOURSE COMMISSION NOTICE OF DECISIONS

On May 3, 2016 the Ledyard IWWC rendered decisions on the following applications:

IW 16-2: Ledyard Meadows Estates, LLC, 809 Colonel Ledyard Hwy for proposed 2-lot re-subdivision and construction of a multi-family residential apartment community. APPROVED with stipulations.

IW 16-5 AR: Mark Perkins, 576 Lantern Hill Rd.-As of Right determination for clearing property in the Upland Review Area for agricultural purposes. APPROVED

A copy of these applications and decisions is available in the Land Use Office, 741 Colonel Ledyard Hwy, Ledyard, CT (860) 464-3266. Any person aggrieved by these decisions may appeal to the Superior Court within 15 days of this notice.

21013

TOWN OF LEDYARD NOTICE OF DEMOCRATIC CAUCUS

To enrolled members of the Democratic Party of the Town of Ledyard, Connecticut. Pursuant to the Rules of the Democratic Party and State election laws, you are hereby notified that a caucus will be held on Thursday, May 19, 2016, at 7:00 P.M. at the Town Hall Annex, 741 Colonel Ledyard Highway, Ledyard, CT to endorse selection for Registrar of Voters and to transact other business as may be proper to come before said caucus. Dated at Ledyard, Connecticut, on May 11, 2016, by Ledyard Democratic Town Committee Chairperson, Elizabeth Peterson.

Public Notices

COURT OF PROBATE, Niantic Regional Probate District NOTICE TO CREDITORS. ESTATE OF Alton Carney Trusler (16-0186) The Hon. Jeffrey A. McNamara, Judge of the Court of Probate, District of Niantic Regional Probate District, by decree dated May 10, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Kathryn Treadow, Assistant Clerk. The fiduciary is: Virginia Kay Trusler, 6 Hathaway Road, East Lyme, CT 06333

General Help

INSURANCE CUSTOMER SERVICE REP Griswold area, license preferred but not required. Send resume to jay@saagencies.com



Is looking to Hire a PAINTER Seeking experienced and reliable Painter for apartments in Groton/ New London area. Valid driver's license & vehicle required. Must be able to do quality work. Must pass background checks & drug test. Benefits available.

Small Resumes to: careers@landingsgroup.com or Apply at: 11-0 Anthony Road New London, CT

Notes of Interest

CT SCRAP Will buy your scrap steel, copper & aluminum. 33 Pequot Rd. Uxville, CT 06339-3366



1968 CORVETTE Transmission Rebuilt Muncie 4 Speed Rally Wheel, Derbi Caps & (2) 15x7 Rally Wheels CALL 860-376-3305

Snow tires - New Firestone Winterforce, size 205/65-R15, 4 / \$240. 860-443-6603

Automobiles

1993 LINCOLN TOWN CAR: Black, 89K, MINT Int. Needs Brakes, \$2750.00 Call 860-287-1929

2004 Toyota Tacoma Xtracab 40K HONEST mi; 2wd 4cyl 5spd stick LineX; mint cond. \$10K. 860-572-2928 --

Buick LeSabre 2004 -- auto, air cond, 119K. Good cond. \$2,350. 860-235-9147 or cell 860-625-9369

WE BUY CARS, TRUCKS, & SUV'S All Makes & Models. Ask For Pete Sabo. Bob Valenti Auto Mall. 860-536-4931

Recreational Vehicles

Class A Itasca Sunova 33C, excellent condition, many options, 31,900 miles, desirable floor plan, new tires, batteries. Can be seen in Mystic. For Additional info call 860-614-8837

2003 Dodge-4dr, 2500 series, Hemi, 127k, new paint/tires, brakes & recent tuneup. \$6,500.00. 860-604-3316.

Trucks

ROSS RECYCLING WILL BUY YOUR Junk Cars, Trucks, Trailers Pick Up is Available Call 860-848-3366

Employment

DRIVER'S WANTED! Seasonal Neighborhood Ice Cream Truck. Weekdays & Weekends. CALL 860-739-0532

CDL Class B Driver/ Groundman Position/Climber Allied Tree Experts FT, CDL license required. Will train the right person. 860-572-7199

General Help

CDL Class B Driver/ Groundman Position/Climber Allied Tree Experts FT, CDL license required. Will train the right person. 860-572-7199

Hotel / Restaurant / Food

Now Hiring! •HOUSEKEEPERS •RESTAURANT SERVERS •HOSTESS •DISHWASHERS •FRONT DESK •MARINA STAFF •CULINARY •HOUSE PERSONS (3rd Shift, \$12 per hour/ Negotiable based on experience)

Apply online at: www.saybrook.com or stop by 2 Bridge St., Old Saybrook 860-395-2000

Garage Sales / Flea Market

Gales Ferry ESTATE SALE. Fri & Sat, 8-2, 41 Woodridge Circle Large Home. Mid century modern/Asian www.wemakeitbetter.com

GALES FERRY MOVING SALE! Everyday for rest of month. 150B Military Hwy. COME WHENEVER!

GROTON - MULTI FAMILY, Sat, 9-3, 107 Morse Ave. Motorcycle parts, HH goods and more. ESTATE SALE Sat 9-3, 120 Morse Ave. Some furn, clothing & HH.

GROTON: Sat, 9-2pm, 23 Nicholas Ave. Decor, Vintage-Antiques,Collectibles, Jewelry, Sea-Themed Stuff. Newer Clothes & More!

Hamburg Lyme - 3 Families, Sat/Sale 56 Sterling City Rd. Sat 5/14, 9-3pm. Rain date 5/15

Garage Sales / Flea Market

Lyme - 6 Old Hamburg Rd. 5/14 - 5/15 Antiques, Sporting Electronics, Furniture, Home Goods, Tools, Toys, Games, Much More.

LYME: RI-156 Congregational Church ANNUAL SPRING RUMMAGE SALE Sat, May 21st, 9am - 1pm. Donations accepted between May 16th - 19th. CALL 860-434-0220 For More Information

MYSTIC ST. PATRICK ANNUAL YARD SALE & SILENT AUCTION Sat 5/14 9-3 Furniture, Tools, Collectibles, Oil Lamps, Longaberger, Electronics, more!

Mystic - Yard Sale: 15 Burrows St. Sat, 5/14 - Sun 5/15 9-3 Furniture, Tools, Collectibles, Oil Lamps, Longaberger, Electronics, more!

Garage Sales / Flea Market

NEW LONDON OCEAN BEACH BOARDWALK Sat, May 14th, 9AM - 3PM (Rain Date: May 21st) Toy/Gift Sale, 50/50 Raffle. NO EARLY BIRDS! More Info Call Marie 860-235-6997 After 2:30pm

Norwich - 49 Case St. Sat May 14 8-11am antiques Furniture, desks, beds, rugs, lamps, golf clubs, dishes

OAKDALE: 11 Velouose Rd. (Off Raymond Hill Rd.) 6 FAMILY SALE! Sat - 3pm TODAY!

Pawcatuck - Estate Sale, Sat 5/14 9-3pm, 65 Courtland St. Whole house, great stuff. Loaded. Worth it!

Garage Sales / Flea Market

Salem - 553 Hartford RD Sat, 05/14 9AM-12PM jute box, antique love seat, 05 Johnson 25 HP misc items WATERFORD ESTATE SALE! Fri & Sat, May 13th & 14th, 9am - 2pm

5 Trumbull Rd. HH, Clothes, Collectibles, Garden, Books, Kids' Toys, Books & Rocking Horse

WATERFORD HUGE SALE: Sat, 9-3pm, 211 Great Neck Rd. Antiques, Furn, HH, Tools, Garden, Toys, Fabric, Fishing, Books & More

Waterford - Multi Family Sat, 8-3pm, 59 Gallup Lane. Tools, original photographs. Great prices.

Waterford - Multi Family Sat, only, 8-12pm, 9 Rock Ridge Drive (off of Crossroads). Something for everyone. 11-room fill a bag for \$4

Lawn / Garden Items

PERENNIAL PLANTS - LARGE VARIETIES LOCALLY GROWN \$4 EACH 860-464-8500

SEEDS - ANNUAL & PERENNIAL LG. ASST. UNUSUAL VARIETIES \$50 PER PACK 860-464-8500

Musical Instruments

Baldwin piano - Console style in good shape great for beginners. \$199.00 possible help w/ delivery

Other Miscellaneous

NASCAR TICKETS 2 Nascar Tickets Dover Int. Speedway 5/15/16 @ 1:00 Start/Finish Line Petty Section 100 Row 42 Seats 15 & 16 \$225.00 Call 860-884-7339

NASCAR TICKETS 2 Nascar Tickets Dover Int. Speedway 5/15/16 @ 1:00 Turn 2 Section 204 Row 36, Seats 7 & 8 \$150.00 Call 860-884-7339

Teac Reel to Reel Tape Recorder - Comes with all accessories & spare tapes. \$200. 860-572-0281

Sporting Goods

Brunswick Pool Table - 48x, Comes with all accessories. \$250. 860-572-0281

Stereo, TV, Radio

CD Player's Disc Changer - Technics SL-P067, Remote Manual & Wires. 1994/ Japan. \$50. 860.535.0099

JBL Pro Computer/TV/Tablet Speakers - Complete w/All Cables & Power Cord. Excellent Condition. \$20 860.917.6364

Toshiba DVD Player - SD-4100. Sleek Black Color. Slimline Design. 17 1/2 x 8 1/2 x 1 1/2". \$15. 860.917.6364

Vintage Stereo Receiver - GE RA200A. 1957 Japanese. Analog. Wood Case. Excellent Cond. \$100. 860.535.0099

Wanted to Buy

A AAKIN ANTIQUES Cash for Coins, Gold, Silver, Watches, And All Jewelry, Dolls, Wind-up Toys, Anything Military, All Music Instruments, M.I.'s, Speakers, Amps. Anything Old. FREE HOUSE CALLS 860-445-4463 / 860-235-7318

Antiques/Collectibles/Art

WE BUY Old/Antique Oriental RUGS In Almost Any Condition Call 401-500-2758 BILL TREMBLAY Carpet Cleaning Experts

Furniture

LOVE SEAT/ RECLINERS SOFA RECLINERS Navy, 1 Year Old. Asking \$900!!

Household Goods

Lenox China ( Somers Set) Gold Rim - Made in USA. Service for 12 + extra pcs. \$900.00. 860-442-7290

Weber 22" Kettle Charcoal Grill - Used 3 times. \$40 860-443-6603

Weber Gas Grill - Spirit E-210, 2 burner, excellent condition. Inc tank w/gas & cover \$85. 860-691-0512.

Lawn / Garden Items

2007 CRAFTSMAN Garden Tractor: 20 HP, 46" Mower Deck, 3 Bagger. New Battery, 4900 Hours. Serviced Annually. \$600 or B/O. Call 860-444-0233

ARBORVITAE SPRING SALE! Dark Green, Emerald's, Green Giant, For Beautiful Privacy Borders. FREE DELIVERY & Planting! Sun or 559 860-712-5359 cttrees.com

COW MANURE COMPOST \$10 a Tubor Bucket. 9-11 on Sat. Chuck Hill Farm Rt. 164, Preston. 860-949-2434

DWARF LIL

## Greer, Leslie

---

**From:** Greer, Leslie  
**Sent:** Thursday, June 02, 2016 2:01 PM  
**To:** 'nancy.rosenthal@ynhh.org'  
**Cc:** Lazarus, Steven; 'Carney, Brian'; Riggott, Kaila; Hansted, Kevin; Martone, Kim  
**Subject:** Lawrence & Memorial Hospital Hearing Notice  
**Attachments:** 32032 & 32033.pdf

<b>Tracking:</b>	<b>Recipient</b>	<b>Delivery</b>
	'nancy.rosenthal@ynhh.org'	
	Lazarus, Steven	Delivered: 6/2/2016 2:01 PM
	'Carney, Brian'	Delivered: 6/2/2016 2:01 PM
	Riggott, Kaila	Delivered: 6/2/2016 2:01 PM
	Hansted, Kevin	Delivered: 6/2/2016 2:01 PM
	Martone, Kim	Delivered: 6/2/2016 2:01 PM

Ms. Rosenthal,  
Attached is the replacement hearing notice for Lawrence & Memorial Hospital being held on June 27, 2016.

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

### Office of Health Care Access

June 2, 2016

Nancy Rosenthal  
SVP, Strategy and Regulatory Planning  
Yale-New Haven Health System  
5 Perryridge Road  
Greenwich, CT 06830

RE: Certificate of Need Application, Docket Number 15-32032-CON and 15-32033-CON  
**Docket Number: 15-32032-CON**  
Northeast Medical Group ("NMG") and L&M Physician Association  
("L&MPA")  
Transfer of Ownership of a Group Practice by Merger of L&MPA into NMG  
**Docket Number: 15-32033-CON**  
Yale New Haven Health Services Corporation ("YNHHSC") and Lawrence +  
Memorial Corporation ("L+M")  
Acquisition of L+M by YNHHSC

Dear Ms. Rosenthal,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Northeast Medical Group, Inc., L&M Physician Association, Inc., Yale New Haven Health Services Corporation and L&M Corporation ("Applicants") on April 29, 2016, the Office of Health Care Access ("OHCA") has initiated its review of the CON applications identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

Applicant(s): Northeast Medical Group, Inc.  
L&M Physician Association, Inc.

Docket Number: 15-32032-CON

Proposal: Transfer of Ownership of a Group Practice by Merger of L&M Physicians  
Association into Northeast Medical Group

Applicant(s): Yale New Haven Health Services Corporation  
L&M Corporation

Docket Number: 15-32033-CON

Proposal: Acquisition of L+M by YNHHSC

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: June 27, 2016

Time: 3:00 p.m.

Place: New London High School (Auditorium)  
490 Jefferson Avenue  
New London, CT 06320

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in *The Day* pursuant to General Statutes § 19a-639a (f) and 19a-486 (f).

Sincerely,



Kimberly R. Martone  
Director of Operations  
Enclosure

NMG and L&MPA  
YNHHSC and L+M

June 2, 2016

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

cc: Henry Salton, Esq., Office of the Attorney General  
Antony Casagrande, Department of Public Health  
Kevin Hansted, Department of Public Health  
Wendy Furniss, Department of Public Health  
Maura Downes, Department of Public Health  
Jill Kentfield, Department of Public Health  
Chris Stan, Department of Public Health  
DeVaughn Ward, Department of Public Health  
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC:lmg

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

June 2, 2016

P.O. #54772

The Day  
47 Eugene O'Neil Drive  
New London, CT 06320

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, June 3, 2016**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

A handwritten signature in blue ink, appearing to read "Kim Martone".

---

Kimberly R. Martone  
Director of Operations

Attachment

cc: Danielle Pare, DPH  
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC;lmg



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

Statute Reference: 19a-638

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L&M Physician Association, Inc.

Town: Stratford

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L&M Corporation

Town: New London

Docket Number: 15-32033-CON

Proposal: Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation

Date: June 27, 2016

Time: 3:00 p.m.

Place: New London High School  
490 Jefferson Avenue  
New London, CT 06320

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 22, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at [www.ct.gov/ohca](http://www.ct.gov/ohca) for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

## Greer, Leslie

---

**From:** ADS <ADS@graystoneadv.com>  
**Sent:** Thursday, June 02, 2016 11:48 AM  
**To:** Greer, Leslie  
**Subject:** Re: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Good day!

Thanks so much for your ad request.  
We will be in touch shortly and look forward to serving you.

*Remember to ask about diversity options when you receive your quote. Remember, "Quotes are Free". You only pay for the placements you approve.*

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for \$115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,  
Graystone Group Advertising

2710 North Avenue  
Bridgeport, CT 06604  
Phone: 800-544-0005  
Fax: 203-549-0061

**E-mail new ad requests to:** [ads@graystoneadv.com](mailto:ads@graystoneadv.com)  
<http://www.graystoneadv.com/>

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**From:** "Greer, Leslie" <[Leslie.Greer@ct.gov](mailto:Leslie.Greer@ct.gov)>  
**Date:** Thursday, June 2, 2016 at 11:29 AM  
**To:** Ads Desk <[ads@graystoneadv.com](mailto:ads@graystoneadv.com)>  
**Subject:** DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 6/3/16. For billing purposes, please refer to P.O. 54772. In addition, when the "proof of publication" becomes available, please forward me a copy.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)

## Greer, Leslie

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**From:** Robert Taylor <RTaylor@graystoneadv.com>  
**Sent:** Thursday, June 02, 2016 4:47 PM  
**To:** Greer, Leslie  
**Subject:** FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice  
**Attachments:** 15-32032 and 15-32033 The Day REVISED.docx

Good afternoon,

This notice is set to publish tomorrow.  
\$453.51

Thanks,

Robert Taylor  
Graystone Group Advertising  
[www.graystoneadv.com](http://www.graystoneadv.com)  
2710 North Avenue, Suite 200  
Bridgeport, CT 06604  
Phone: 203-549-0060  
Toll Free: 800-544-0005  
Fax: 203-549-0061

---

**From:** ADS <[ADS@graystoneadv.com](mailto:ADS@graystoneadv.com)>  
**Date:** Thu, 2 Jun 2016 11:47:34 -0400  
**To:** RTaylor <[rtaylor@graystoneadv.com](mailto:rtaylor@graystoneadv.com)>  
**Subject:** FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice

---

**From:** "Greer, Leslie" <[Leslie.Greer@ct.gov](mailto:Leslie.Greer@ct.gov)>  
**Date:** Thursday, June 2, 2016 at 11:29 AM  
**To:** Ads Desk <[ads@graystoneadv.com](mailto:ads@graystoneadv.com)>  
**Subject:** DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 6/3/16. For billing purposes, please refer to P.O. 54772. In addition, when the "proof of publication" becomes available, please forward me a copy.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)

Classified Find Buy Sell MARKETPLACE

PLACE YOUR AD ANYTIME AT theday.com/classified

Customer Service: Monday-Friday 8:00AM - 4:30PM class@theday.com 1.860.701.4200

Public Notices

TOWN OF SALEM, CONNECTICUT PATH COMMITTEE SALEM MULTI-USE PATH CROSSING NO. 3 INVITATION TO BID

Sealed Bids for Path Committee Salem Multi-Use Path Crossing No. 3 will be received by the Town of Salem at the Issuing Office until 2:00 PM local time on June 23, 2016...

Bids will be received for a single prime Contract. Bids shall be on a lump sum and unit price basis as indicated in the Bid Form.

The Issuing Office is the Office of the Town Clerk, Salem Town Hall, 270 Hartford Road, Salem, Connecticut 06420-3809.

Printed copies of the Bidding Documents may be obtained from the Issuing Office upon payment of a \$100 non-refundable fee for each set. PDF copies are available upon request after the receipt of the non-refundable fee.

The date that the Bidding Documents are transmitted by the Issuing Office will be considered the Bidder's date of receipt of the Bidding Documents.

A pre-bid conference will be held at 2:00 PM local time on June 13, 2016 at Salem Town Hall, 270 Hartford Road, Salem, Connecticut 06420-3809.

Bids must be accompanied by a Bid Bond or a certified check in the amount of five percent of the Bid.

The successful Bidder will be required to provide Performance and Payment Bonds each in the amount of one hundred percent of the Contract Price.

The Contract Documents require affirmative action of the Contractor and any subcontractors to ensure equal employment opportunity as noted in Governor's Executive Orders 3 and 17.

The Owner is exempt from payment of Sales and Use Taxes on all materials and equipment to be permanently incorporated in the Work.

Unless provided for by the Instructions to Bidders, no Bid may be withdrawn until sixty (60) days after the Bid Opening. The Town reserves the right to reject any or all Bids; make extensions to review Bids; waive informalities or defects in Bids; and accept the Bid that, in the Town's judgment, will be in its best interests.

Owner: Town of Salem, Connecticut Date: June 1, 2016

Notice of Tentative Determination to Approve a Point Source New Source Review Permit Application

Applicant: Thames Shipyard & Repair Company Application Nos: 200801207 & 200801208 City/Town: New London, CT

The Commissioner of the Department of Energy and Environmental Protection (DEEP) hereby gives notice that a tentative determination has been reached to approve the following applications.

Applicant's Name and Address: Thames Shipyard & Repair Company, 2 Ferry Street, New London, CT 06320

Contact Name/Phone/Email: Mr. Adam Wronowski, 860-442-5349, adam@longislandferry.com

Type of Permit: New Source Review permits for Two Floating Dry Docks

Relevant Statute(s)/Regulation: CGS 22a-174, Clean Air Act Amendments of 1990

Facility Location: 50 Farnsworth Street, New London, CT 06320

INFORMATION REQUESTS/PUBLIC COMMENT Interested persons may obtain copies of the application from the applicant at the above address.

Notice of Public Sale of Personal Property Notice is hereby given that Extra Space Storage will sell at public auction, on June 16th, 2016 at 2:30 PM to satisfy the lien of the owner, personal property described below...

PETITIONS FOR HEARING Description below should include the application numbers noted above and also identify a contact person to receive notifications.

ADA PUBLICATION STATEMENT The Department of Energy and Environmental Protection is an Affirmative Action and Equal Opportunity Employer.

Office of Health Care Access Public Hearings

Statute Reference: 19a-638

Applicant(s): Northeast Medical Group, Inc. & M Physician Association, Inc.

Town: Stratford

Docket Number: 15-32032-CON

Proposal: Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group

Applicant(s): Yale New Haven Health Services Corporation & L&M Corporation

Town: New London

Docket Number: 15-32033-CON

Proposal: Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation

Date: June 27, 2016

Time: 3:00 p.m.

Place: New London High School 490 Jefferson Avenue New London, CT 06320

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 22, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies...

PLANNING AND ZONING COMMISSION TOWN OF STONINGTON NOTICE OF PUBLIC HEARING

Pursuant to the General Statutes of the State of Connecticut revision of 1958 and all amendments thereto, and pursuant to the Zoning Regulations for the Town of Stonington, Connecticut, the Planning and Zoning Commission hereby gives notice that it will hold a Public Hearing at the Mystic Middle School, 204 Mistuxet Ave., Mystic, CT, on Tuesday, June 7, 2016 at 7:30 p.m. on the following application(s):

PZ16045UP 30 Extrusion, LLC (Carl Bardy, Jr.) - Special Use Permit application for the construction of a 26,700 square foot mini-warehouse storage facility consisting of 5 one-story buildings (5th building likely build in second phase), and associated parking, landscaping, and drainage.

PZ16099A Andrew Halsey - Regulation Amendment to ZR Section 7.2 Groundwater Protection Overlay District (GPOD) to add conditional uses (Assembly Woodworking) in the GC-60 Zoning District.

AT SUCH HEARING ANY PARTY MAY APPEAR IN PERSON OR BE REPRESENTED BY AN AGENT OR BY AN ATTORNEY.

Any disabled person requiring auxiliary aids or services for effective communication or access at this hearing should contact the Department of Planning at (860) 535-5095 ten days prior to the hearing date.

Dated at Stonington, Connecticut, this 17th day of May, 2016.

John Prue, Chairman

Job searching? Follow THE DAY.jobs for new listings and updates

The Day is looking for industrious, early risers to deliver newspapers for Home Delivery Subscribers in Waterford Area

Call 860-442-2200 Ext 4213

Public Notices

TOWN OF STONINGTON Board of Selectmen Notice of Public Hearing

Notice is hereby given that the Board of Selectmen of the Town of Stonington will conduct a Public Hearing for the Town of Stonington on June 8, 2016 at 7:00 p.m. at the Stonington Police Department to discuss the 2016 Neighborhood Assistance Act Tax Credit Applications.

At this hearing, interested persons may appear and be heard and written communications will be received. If unable to attend, please forward written communications to the Board of Selectmen, 152 Elm Street, Stonington, CT 06378 by June 7, 2016.

Dated at Stonington, Connecticut this 1st day of day of June, 2016.

/s/ Robert R. "Rob" Simmons First Selectman

TOWN OF EAST LYME NOTICE OF PUBLIC AUCTION

The Town of East Lyme will auction all property possessions resulting in an eviction at the following address: Kristin M. O'Shaughnessy and Heather LeClaire AKA Jane Doe 1 of 81 East Pattagansett Road, Unit 42, East Lyme, CT. Auction will take place on June 10, 2016 at 10:00 a.m. at Rent a space at 9 King Arthur Drive, Niantic, CT.

LIQUOR PERMIT Notice of Application

This is to give notice that I, LORENZO A MEJIA 62 FULLER ST NEW LONDON, CT 06320-2728

Have filed an application for a RESTAURANT WINE & BEER PERMIT for the sale of alcoholic liquor on the premises at 725 COLONEL LEDYARD HWY LEDYARD CT 06339-1511

The business will be owned by: MEJIA LLC Entertainment will consist of: None None None None None None None

Objections must be filed by: 06/01/2016

COURT OF PROBATE, Niantic Regional Probate District. NOTICE TO CREDITORS. ESTATE OF Ralph Charles Lanzetti, (d-0180) The Hon. Jeffrey A. McNamara, Judge of the Court of Probate, District of Niantic Regional Probate District, by decree dated, ordered that all claims, orders that be presented to the fiduciary at the address below.

Notice of Public Sale of Personal Property Notice is hereby given that Extra Space Storage will sell at public auction, on June 16th, 2016 at 2:30 PM to satisfy the lien of the owner, personal property described below...

LIQUOR PERMIT Notice of Application

This is to give notice that I, EDUARDO MARTONE 350 BROWNSTONE RD MERIDEN, CT 06451-3624

Have filed an application for a RESTAURANT WINE & BEER PERMIT for the sale of alcoholic liquor on the premises at 11 E PATTAGANSETT RD NIANCTIC CT 06375-2311

The business will be owned by: CASTELLO PIZZA & MARKET LLC Entertainment will consist of: Acoustics (Not Amplified) Disc Jockeys Karaoke Live Bands Comedians

Objections must be filed by: 07/07/2016

EDUARDO MARTONE

COURT OF PROBATE, District of New London. NOTICE TO CREDITORS. ESTATE OF Henry Harry Tessman, Jr. (16-00250) The Hon. Matthew H. Greene, Judge of the Court of Probate, District of New London, by decree dated May 26, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Pamela M. Rowe, Clerk. The fiduciary is: Jonathan N. Tessman, 180R Rope Ferry Rd, Waterford, CT 06385

Merchandise

Antiques/Collectibles/Art LOOK Connecticut Pickers Buying Antiques, Coins and Jewelry Free Estimates - 30+ years Experience Call Mark Pierce 860-729-1069

Reversed painting - on dome glass \$100 txt for pic 860-460-6530

Upright Edison Record Player & Northpole Icebox, Both in Fair Cond. Bureau Draws w/ Mirror \$300 or E/O for ALL... 860-460-9104

Vintage Italian Alabaster Ashtray - Hand Carved. 1970s. 7"L x 5.5"D x 2.5"H. Never Used. \$30. 860.535.0099

WE BUY Old/Antique Oriental RUGS In Almost Any Condition Call 401-900-2758 BILL TREMBLAY Carpet Cleaning Experts

Furniture 87" BEIGE LEATHER RECLINING SOFA, Good Cond. \$195 Call 860-885-1961

bakers rack - Green with butcher block and wine bottle holders, txt for pic 860-460-6530

chair - Lee Industries recliner chair, made in NC, 960-460-6530

chairs - set of six ladder back building to captains, \$100 txt for pic 860-460-6530

drop leaf table - 18 x 42 down 42 x 42 up \$100 txt for pic 860-460-6530

Lane Cedar chest - Excellent condition with bottom drawers \$100 txt for pic 860-460-6530

Pennsylvania Oak Dining Rm Set w/ 6 Chairs, 2 Captain, 42x42x82 \$700 & Sofa 86x24 \$600 or E/O. Call 860-223-3254

Set of (4) - \$100 Excellent condition Wrought iron with faux leather seats 860-785-5177

table & chairs - 42 "Round table that goes to 58" oval w/built in leaf \$125 txt for pic 860-460-6530

tea cart - By Imperial, great condition \$100 txt for pic 860-460-6530

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Household Goods

AC - Kenmore Energy star 50 BTU \$60 860-460-6530

Groton - LARGE 2-Day Yard Sale - 8am - 2pm Fri 6/10 & Sat 6/11. 120 Walker Hill Rd, Groton. MANY household items, furniture, clothing & MORE!

mirror - very nice mahogany mirror \$50, txt for pic 860-460-6530

Lawn / Garden Items

ARBORVITAE SPRING SALE! Dark Green, Emerald S, Green Giant. For Beautiful Privacy Borders, FREE DELIVERY & Planting! Start at \$59 860-712-5359 www.cttrees.com

ARIENS Riding Tractor Lawn Mower w/ Utility Trailer. \$675 or E/O. Call 860-910-0931

Mulch Hay - \$2.50 bail. Call 860-599-2112

PERENNIAL PLANTS - LARGE VARIETIES LOCAL GROWN \$4 EACH 860-464-8500

SHRUBS - BOXWOOD 8" TALL - PRIVET HEDGE 15' TALL \$10 EACH 860-464-8500

COLEMAN 5000 Watt Generator, 9HP, NEW! \$300. Ryobi Table Saw, B13000. Delta Chop Saw \$150 for both. 860-608-9002 Bob

Digital Dual Coastal Cable - Eagle Aspen Brand. 36 Feet. With Connectors. 2.25 Ghz. 18 AWG. \$20. 860.917.6364

LAZY BOY LIBERTY POWER RECLINER. Excellent Cond. Gray. \$600 Call 860-415-9185

Superman DVD Boxed Set - Collector's Edition. Films I-VI. 2001. Hard Slip Case. In-F. C. \$10. 860.535.0099

CD Player 5 Disc Changer - Technics SL-DB61 + Remote Manual & Wires. 1994/ Japan. \$60. 860.535.0099

DVD Player - Toshiba SD-2710. w/Remote, Audio Cables & Manual. 17.1 x 8.5" x 3.1". \$20. 860.917.6364

10X8 SHED: X-Wide, 64in. DBL Doors, 8ft High Roof Peak. 4 Windows. \$600. Brown color. 860-934-6662

Must Pick-up & Take Down. Best Offer! 860-460-9923

Coleman 5000 Watt Generator, 9HP, NEW! \$300. Ryobi Table Saw, B13000. Delta Chop Saw \$150 for both. 860-608-9002 Bob

Digital Dual Coastal Cable - Eagle Aspen Brand. 36 Feet. With Connectors. 2.25 Ghz. 18 AWG. \$20. 860.917.6364

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DVD Player - Toshiba SD-2710. w/Remote, Audio Cables & Manual. 17.1 x 8.5" x 3.1". \$20. 860.917.6364

10X8 SHED: X-Wide, 64in. DBL Doors, 8ft High Roof Peak. 4 Windows. \$600.

## Greer, Leslie

---

**From:** Lazarus, Steven  
**Sent:** Tuesday, June 14, 2016 9:31 AM  
**To:** Nancy Rosenthal (Nancy.Rosenthal@greenwichhospital.org)  
**Cc:** Carney, Brian; Riggott, Kaila; Ciesones, Ron; Greer, Leslie  
**Subject:** Emailing - 15-32032 & 15-32033 Request for Prefile and Issues.pdf  
**Attachments:** 15-32032 & 15-32033 Reqeust for Prefile and Issues.pdf

Good Morning Nancy,

Please see the attached Request for Prefile Testimony and Issues in the upcoming combined hearing in the above referenced matter on June 27<sup>th</sup>. If you have any questions regarding the correspondence, please feel free to contact Brian Carney ([brian.carney@ct.gov](mailto:brian.carney@ct.gov)) or me directly.

Thank you,

Steve

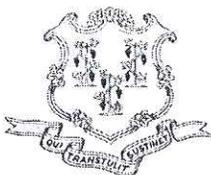
### *Steven W. Lazarus*

Associate Health Care Analyst  
Division of Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, CT 06134  
Phone: 860-418-7012  
Fax: 860-418-7053



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

### Office of Health Care Access

June 14, 2016

Via Email Only

Nancy Rosenthal  
Senior Vice President, Strategy and Regulatory Planning  
Yale-New Haven Health Services Corporation  
5 Perryridge Road  
Greenwich, CT 06360

RE: Certificate of Need Application, Docket Numbers 15-32032-CON and 15-32033  
Transfer of Ownership of Group Practice by merger of L&M Physician Association, Inc. into  
Northeast Medical Group, Inc. and Transfer of ownership of L+M Corporation to Yale New  
Haven Health Services Corporation  
Request for Prefile Testimony and Issues for Combined Public Hearings

Dear Ms. Rosenthal,

The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket numbers on June 27, 2016. The hearing is at 3:00 p.m. at New London High School – Auditorium, 490 Jefferson Avenue, New London, Connecticut. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29(e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. Yale-New Haven Hospital ("Applicant") submit prefiled testimony by 4:00 p.m. on **June 22, 2016**.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.



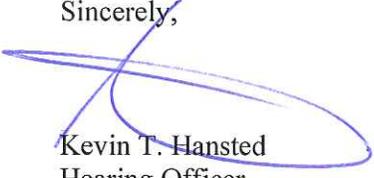
Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

Additionally, please find attached OHCA's Issues. Please respond to the attached Issues in writing to OHCA by 4:00 p.m. on **June 22, 2016**.

Please contact Brian Carney or me at (860) 418-7001 if you have any questions concerning this request.

Sincerely,



Kevin T. Hansted  
Hearing Officer

Attachment

## Office of Health Care Access

### Public Hearing Issues

**Docket Number: 15-32032-CON:** Transfer of Ownership of Group Practice by merger of L&M Physician Association, Inc. into Northeast Medical Group, Inc.; and

**Docket Number: 15-32033-CON:** Transfer of ownership of L+M Corporation ("L+M") to Yale New Haven Health Services Corporation ("YNNHSC")

**The Applicants should be prepared to present and discuss supporting evidence on the following issues:**

- The clear public need for the proposal.
- The effect of the proposed transfer of ownership on the residents of the region with respect to health care services, including how access to services (including specialty care) will be maintained or improved in the area following the acquisition.
- Describe the benefits achieved in the Bridgeport/Greenwich Hospital service areas following the YNNHSC affiliation, in terms of financial stability or enhanced programs or services.
- Please describe how successful the CHNA implementation plan has been in addressing priority health issues in L+M's service area.
- How will the proposal affect community health improvement spending (community benefits) and community building activities in L+M's service area?

## Greer, Leslie

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**From:** Martone, Kim  
**Sent:** Friday, June 17, 2016 1:14 PM  
**To:** Riggott, Kaila; Lazarus, Steven; Carney, Brian; Ciesones, Ron  
**Cc:** Greer, Leslie  
**Subject:** FW: CON Application Dockets 15-32032 and 15-32033  
**Attachments:** 2016 0617 CON APP DOCKET #15-32032 FROM DISTRICT 1199.pdf

### ***Kimberly R. Martone***

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



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**From:** Deborah Chernoff [<mailto:dchernoff@seiu1199ne.org>]  
**Sent:** Friday, June 17, 2016 12:55 PM  
**To:** Martone, Kim; Hansted, Kevin  
**Subject:** CON Application Dockets 15-32032 and 15-32033

Attached please find District 1199's petition for Intervenor status in the above-cited CON applications. Hard copy to follow by mail.

June 17, 2016

Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

### **Cost and Price:**

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.<sup>1</sup> In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.
- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.<sup>2</sup> Consolidation in such markets most often leads to price increases of 20% or more.<sup>3</sup>
- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.<sup>4</sup> YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.<sup>5</sup>
- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.
- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

### **Community Access and Well-being:**

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."<sup>6</sup> Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest \$300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the \$300 million will only come if L+M and other system hospitals hit profit targets.<sup>7</sup> We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."
- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.
- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

**Workforce:**

- L+M is New London's 2<sup>nd</sup> largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

**Community Accountability and Monitoring:**

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local" boards.
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## **The Intervenors: Interests and Evidence**

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In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
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  - Members of the Governor’s Health Care Cabinet
  - Members of the Governor’s Certificate of Need Review Task Force, and;
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The coalition will present first-hand evidence from the entire range of the organizations’ experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, “efficiency” and quality, and; a breakdown of the Applicants’ financial statements to shed light on claims of financial hardship.

### **AFT CONNECTICUT including Locals 5049, 5051, 5123 and 5119**

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AFT Connecticut was previously granted intervenor status by OHCA in a 2004 CON hearing (04-30348-CON) involving the Hospital’s desire to close the Hospital’s OB/GYN clinic. AFT Connecticut will offer testimony on the efficiency of current L+M operations, the impact of aggressive expansion on core missions, and expert testimony on trends in consolidation, cost, prices, access and governance.

### **CONNECTICUT CITIZEN ACTION GROUP**

Connecticut Citizen Action Group is a statewide membership organization dedicated to involving the residents of Connecticut in bringing about a fair and equitable society. For over 40 years, CCAG has been at the forefront of advocating for a high quality, affordable and fully accessible health care system for all Connecticut residents. CCAG has worked effectively to advance health care policies that strengthen consumer access to fair, affordable health care services, coverage and benefits. CCAG's health care reform work includes monitoring hospital consolidation and regulation, expanding and protecting Medicaid coverage and benefits, and strengthening the ACA law.

CCAG has 500 members who live within the L+M catchment region, and will be directly impacted by potential increased costs, loss of local access, and changes in community programming directed toward health and well-being. Our members include a broad, diverse cross-section of the community including health care providers, child care providers, municipal workers, senior citizens, and educators. In addition to presenting testimony on the need for controlling cost and sustaining local community access to health care services, we will offer testimony on previous attempts to impose public accountability conditions on hospital acquisitions, and the need to impose strong community oversight, monitoring and accountability measures on this acquisition to ensure that the terms adequately and appropriately meet community health care needs and priorities, and that any such terms or conditions are actually carried out.

### **UNITE HERE CONNECTICUT**

UNITE HERE Connecticut is a labor organization representing more than 7,000 employees in Connecticut, including 250 in the primary and secondary service areas of L+M Hospital. We bargain health benefits for all of our members in the state, and have a powerful interest in preserving access to affordable, high quality health care. UNITE HERE members cook and serve food in corporate, university and K-12 cafeterias. These are low-wage, seasonal, often part-time jobs. For them, comprehensive, affordable health insurance coverage is essential to achieving any hope of a middle class life. UNITE HERE members at Electric Boat in New London are engaged in bargaining for health benefits. Members currently pay 20% of the cost, which is unaffordable for workers who make \$12 per hour. If regional costs continue to escalate, workers will be forced to drop coverage, or be forced to choose between rent and health care. The price structure of the Greater New London market is vital to our members' future well-being.

UNITE HERE's Taft-Hartley fund, jointly administered by the union and management, has established a national health plan tailored specifically for food service workers. In Connecticut, nearly 1,000 members have enrolled in the past several years. In some cases, the savings compared to commercial plans have been large enough to maintain comprehensive coverage and actually reduce the cost to individual members. But the efficiency of this plan will not ultimately protect members if the state's largest hospital is permitted to grow unchecked.

UNITE HERE will offer evidence of the immediate impact of any pricing changes at L+M on service sector workers struggling at the margins of the health care system. UNITE HERE will also offer testimony based on experience establishing a specially designed Taft-Hartley health plan for food service workers in Connecticut, as market consolidation continues to drive prices up.

### **NATIONAL PHYSICIANS ALLIANCE IN CONNECTICUT (NPA-CT)**

The National Physicians Alliance in Connecticut (NPA-CT) is part of a national 501(c)3 organization, the National Physicians Alliance (NPA), that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a home to physicians across medical specialties who share a commitment to professional integrity and health justice. NPA-CT physicians are members of the staff of the parties involved in the affiliation and primary care physicians in the communities served by the two entities. As such, they have a key interest in assuring that their patients and communities have access to affordable, high-quality hospital care.

NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

### **CONNECTICUT HEALTH POLICY PROJECT**

Since 1999 as a nonprofit consumer advocacy organization, the CT Health Policy Project has labored to expand access to high quality, affordable health care for all Connecticut residents, with a particular focus on ensuring access for people in low-income communities of color. The proposed acquisition of Lawrence and Memorial Hospital/Health System by Yale-New Haven Hospital/Health System will undermine every part of our mission.

Executive Director Ellen Andrews, who sits on the Governor’s Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

### **UNITED ACTION CONNECTICUT**

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT’s New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

### **NEW ENGLAND HEALTH CARE EMPLOYEES UNION, DISTRICT 1199, SEIU**

District 1199 represents approximately 25,000 health care workers in the state of Connecticut, including state employees, hospital employees, nursing home employees, direct care and professional workers at private Mental Health and Developmental Disability agencies and FQHCs, and home care workers providing personal care and support services to Medicaid recipients. Of those, more than 1,000 health care workers live in Lawrence and Memorial’s Primary and Secondary Service Areas.

At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just \$10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut

Connecticut Citizen Action Group

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UNITE HERE Connecticut

Connecticut Health Policy Project

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National Physicians Alliance Connecticut

United Action Connecticut

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New England Health Care Employees Union

District 1199 SEIU



Signature

David W. Pickus

Name

President

Title

77 Huyshope Avenue, First Floor, Hartford, CT 06106

Address

(860) 549-1199

Telephone

dpickus@seiu1199ne.org

Email

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<sup>1</sup> Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHC, p. 868.

<sup>2</sup> CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, December 2015, p. 4.

<sup>3</sup> The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.

<sup>4</sup> Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015.

<http://www.healthcarepricingproject.org/>

<sup>5</sup> Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"

<sup>6</sup> Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.

<sup>7</sup> Docket 15-30233, p.

<sup>8</sup> Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

## Greer, Leslie

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**From:** Martone, Kim  
**Sent:** Friday, June 17, 2016 1:26 PM  
**To:** Riggott, Kaila; Lazarus, Steven; Carney, Brian; Ciesones, Ron  
**Cc:** Greer, Leslie  
**Subject:** FW: Connecticut Citizen Action Group  
**Attachments:** Connecticut Citizen Action Group 6-17-16.pdf

### ***Kimberly R. Martone***

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
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Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



**From:** Ann Pratt [<mailto:ann.prattccag@gmail.com>]  
**Sent:** Friday, June 17, 2016 1:17 PM  
**To:** Martone, Kim; Hansted, Kevin  
**Cc:** Henry F. Murray  
**Subject:** Connecticut Citizen Action Group

**Dear Ms. Martone and Mr. Hansted,**

Please find attached Connecticut Citizen Action Group's signed statement requesting intervenor status in two Certificate of Need Applications, Docket # 15-32032 and Docket # 15-32033.

Please let me know if you need any additional information.

Thank you.

Ann Pratt

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Ann Pratt  
Director of Organizing  
Connecticut Citizen Action Group  
30 Arbor Street  
Hartford, CT 06106

[ann.prattCCAG@gmail.com](mailto:ann.prattCCAG@gmail.com)

860-209-1234

Putting People First

June 17, 2016

Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
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In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut

Connecticut Citizen Action Group

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Signature

  
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Signature

\_\_\_\_\_  
Name

Tom Swan  
\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

Exec. Director  
\_\_\_\_\_  
Title

\_\_\_\_\_  
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06106  
\_\_\_\_\_  
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\_\_\_\_\_  
Telephone

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tswan@igc.org  
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Email

UNITE HERE Connecticut

Connecticut Health Policy Project

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Signature

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Name

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National Physicians Alliance Connecticut

United Action Connecticut

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Signature

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Name

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Name

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Address

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Email

New England Health Care Employees Union  
District 1199 SEIU

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Signature

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Name

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Address

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Telephone

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<sup>1</sup> Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHS, p. 868.

<sup>2</sup> CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, December 2015, p. 4.

<sup>3</sup> The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.

<sup>4</sup> Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015.

<http://www.healthcarepricingproject.org/>

<sup>5</sup> Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"

<sup>6</sup> Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.

<sup>7</sup> Docket 15-30233, p.

<sup>8</sup> Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

## Greer, Leslie

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**From:** Martone, Kim  
**Sent:** Friday, June 17, 2016 3:04 PM  
**To:** Riggott, Kaila; Carney, Brian; Lazarus, Steven; Ciesones, Ron  
**Cc:** Greer, Leslie  
**Subject:** FW: Petition to file for Intervenor status Certificate of Need Application, Docket # 15-32032, Docket # 15-32033  
**Attachments:** Intervenor Petition Final AFT (3).docx

### **Kimberly R. Martone**

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



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**From:** John Brady [<mailto:JBrady@aftct.org>]  
**Sent:** Friday, June 17, 2016 2:34 PM  
**To:** Martone, Kim; Hansted, Kevin  
**Subject:** Petition to file for Intervenor status Certificate of Need Application, Docket # 15-32032, Docket # 15-32033

Ms. Martone and Mr. Hansted,  
Please find the attached petition to file for intervenor status on the Certificate of Need Application, Docket # 15-32032, Docket # 15-32033.  
Please contact me if you have any questions.  
Thank you,  
John

John Brady RN  
AFT Connecticut Executive Vice President  
O (860)257-9782 x107  
F (860)257-8214  
C (860)908-9711

June 17, 2016

Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

### **Cost and Price:**

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.<sup>1</sup> In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.
- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.<sup>2</sup> Consolidation in such markets most often leads to price increases of 20% or more.<sup>3</sup>
- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.<sup>4</sup> YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.<sup>5</sup>
- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.
- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

### **Community Access and Well-being:**

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."<sup>6</sup> Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest \$300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the \$300 million will only come if L+M and other system hospitals hit profit targets.<sup>7</sup> We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."
- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.
- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

**Workforce:**

- L+M is New London's 2<sup>nd</sup> largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

**Community Accountability and Monitoring:**

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local" boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

## **The Intervenors: Interests and Evidence**

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
  - Members of the Governor’s Health Care Cabinet
  - Members of the Governor’s Certificate of Need Review Task Force, and;
  - Members of the steering committee of L+M’s current Community Needs Assessment process.

The coalition will present first-hand evidence from the entire range of the organizations’ experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, “efficiency” and quality, and; a breakdown of the Applicants’ financial statements to shed light on claims of financial hardship.

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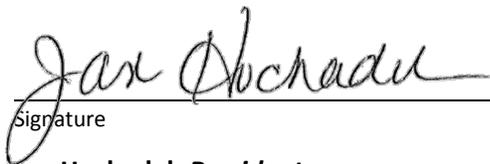
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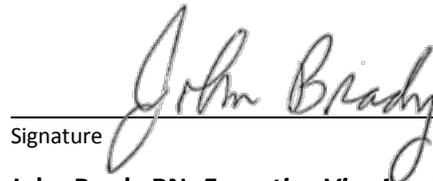
Very truly yours,



Signature

**Jan Hochadel, President**

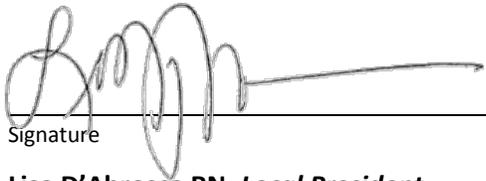
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**Lisa D'Abrosca RN, Local President**

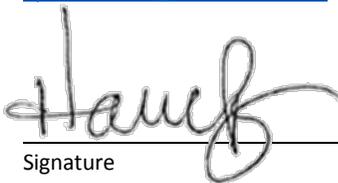
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**Stephanie Johnson, Local President**

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**Harry Rodriguez, Local President**

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**Martha Marx RN, Local President**

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<sup>1</sup> Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHS, p. 868.

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<sup>3</sup> The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.

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<sup>5</sup> Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"

<sup>6</sup> Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.

<sup>7</sup> Docket 15-30233, p.

<sup>8</sup> Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

## Greer, Leslie

---

**From:** Martone, Kim  
**Sent:** Friday, June 17, 2016 3:05 PM  
**To:** Riggott, Kaila; Ciesones, Ron; Carney, Brian; Lazarus, Steven  
**Cc:** Greer, Leslie  
**Subject:** FW: Yale New Haven Health System and Lawrence & Memorial Hospital - CON 15-32033; L & M Physician Association and Northeast Medical Group - CON 15-32032  
**Attachments:** Intervenor Petition Final EMA.docx

### ***Kimberly R. Martone***

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



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**From:** Ellen Andrews [<mailto:andrews@cthealthpolicy.org>]  
**Sent:** Friday, June 17, 2016 2:33 PM  
**To:** Martone, Kim; Hansted, Kevin  
**Subject:** Yale New Haven Health System and Lawrence & Memorial Hospital - CON 15-32033; L & M Physician Association and Northeast Medical Group - CON 15-32032

Attached please find my application for intervenor status.  
Thank you

Ellen Andrews, PhD  
CT Health Policy Project  
[cthealthpolicy.org](http://cthealthpolicy.org)  
[@cthealthnotes](https://twitter.com/cthealthnotes)

June 17, 2016

Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

### **Cost and Price:**

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.<sup>1</sup> In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.
- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.<sup>2</sup> Consolidation in such markets most often leads to price increases of 20% or more.<sup>3</sup>
- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.<sup>4</sup> YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.<sup>5</sup>
- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.
- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

### **Community Access and Well-being:**

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."<sup>6</sup> Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest \$300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the \$300 million will only come if L+M and other system hospitals hit profit targets.<sup>7</sup> We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."
- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.
- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

**Workforce:**

- L+M is New London's 2<sup>nd</sup> largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

**Community Accountability and Monitoring:**

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local" boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

## **The Intervenors: Interests and Evidence**

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
  - Members of the Governor’s Health Care Cabinet
  - Members of the Governor’s Certificate of Need Review Task Force, and;
  - Members of the steering committee of L+M’s current Community Needs Assessment process.

The coalition will present first-hand evidence from the entire range of the organizations’ experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, “efficiency” and quality, and; a breakdown of the Applicants’ financial statements to shed light on claims of financial hardship.

### **AFT CONNECTICUT including Locals 5049, 5051, 5123 and 5119**

AFT Connecticut is a statewide federation of the local unions of the American Federation of Teachers. Our locals have more than 1,800 members who work for Lawrence and Memorial Hospital and its affiliates. They all live in L+M’s primary or secondary service area. They account for more than 50% of the total workforce at L+M, including the Visiting Nurses Association of Southeastern Connecticut. When counting non-L+M employees, altogether AFT Connecticut (State Federation) represents over 5,000 members who live in L+M’s Primary and Secondary Service Areas.<sup>8</sup> . Based on AFT Connecticut’s large concentration of members and their families in L+M services areas, the organization’s interests are directly affected by the acquisition proposal, both as workers and as patients.

AFT Connecticut was previously granted intervenor status by OHCA in a 2004 CON hearing (04-30348-CON) involving the Hospital’s desire to close the Hospital’s OB/GYN clinic. AFT Connecticut will offer testimony on the efficiency of current L+M operations, the impact of aggressive expansion on core missions, and expert testimony on trends in consolidation, cost, prices, access and governance.

### **CONNECTICUT CITIZEN ACTION GROUP**

Connecticut Citizen Action Group is a statewide membership organization dedicated to involving the residents of Connecticut in bringing about a fair and equitable society. For over 40 years, CCAG has been at the forefront of advocating for a high quality, affordable and fully accessible health care system for all Connecticut residents. CCAG has worked effectively to advance health care policies that strengthen consumer access to fair, affordable health care services, coverage and benefits. CCAG’s health care reform work includes monitoring hospital consolidation and regulation, expanding and protecting Medicaid coverage and benefits, and strengthening the ACA law.

CCAG has 500 members who live within the L+M catchment region, and will be directly impacted by potential increased costs, loss of local access, and changes in community programming directed toward health and well-being. Our members include a broad, diverse cross-section of the community including health care providers, child care providers, municipal workers, senior citizens, and educators. In addition to presenting testimony on the need for controlling cost and sustaining local community access to health care services, we will offer testimony on previous attempts to impose public accountability conditions on hospital acquisitions, and the need to impose strong community oversight, monitoring and accountability measures on this acquisition to ensure that the terms adequately and appropriately meet community health care needs and priorities, and that any such terms or conditions are actually carried out.

### **UNITE HERE CONNECTICUT**

UNITE HERE Connecticut is a labor organization representing more than 7,000 employees in Connecticut, including 250 in the primary and secondary service areas of L+M Hospital. We bargain health benefits for all of our members in the state, and have a powerful interest in preserving access to affordable, high quality health care. UNITE HERE members cook and serve food in corporate, university and K-12 cafeterias. These are low-wage, seasonal, often part-time jobs. For them, comprehensive, affordable health insurance coverage is essential to achieving any hope of a middle class life. UNITE HERE members at Electric Boat in New London are engaged in bargaining for health benefits. Members currently pay 20% of the cost, which is unaffordable for workers who make \$12 per hour. If regional costs continue to escalate, workers will be forced to drop coverage, or be forced to choose between rent and health care. The price structure of the Greater New London market is vital to our members' future well-being.

UNITE HERE's Taft-Hartley fund, jointly administered by the union and management, has established a national health plan tailored specifically for food service workers. In Connecticut, nearly 1,000 members have enrolled in the past several years. In some cases, the savings compared to commercial plans have been large enough to maintain comprehensive coverage and actually reduce the cost to individual members. But the efficiency of this plan will not ultimately protect members if the state's largest hospital is permitted to grow unchecked.

UNITE HERE will offer evidence of the immediate impact of any pricing changes at L+M on service sector workers struggling at the margins of the health care system. UNITE HERE will also offer testimony based on experience establishing a specially designed Taft-Hartley health plan for food service workers in Connecticut, as market consolidation continues to drive prices up.

### **NATIONAL PHYSICIANS ALLIANCE IN CONNECTICUT (NPA-CT)**

The National Physicians Alliance in Connecticut (NPA-CT) is part of a national 501(c)3 organization, the National Physicians Alliance (NPA), that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a home to physicians across medical specialties who share a commitment to professional integrity and health justice. NPA-CT physicians are members of the staff of the parties involved in the affiliation and primary care physicians in the communities served by the two entities. As such, they have a key interest in assuring that their patients and communities have access to affordable, high-quality hospital care.

NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

### **CONNECTICUT HEALTH POLICY PROJECT**

Since 1999 as a nonprofit consumer advocacy organization, the CT Health Policy Project has labored to expand access to high quality, affordable health care for all Connecticut residents, with a particular focus on ensuring access for people in low-income communities of color. The proposed acquisition of Lawrence and Memorial Hospital/Health System by Yale-New Haven Hospital/Health System will undermine every part of our mission.

Executive Director Ellen Andrews, who sits on the Governor’s Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

### **UNITED ACTION CONNECTICUT**

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT’s New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

### **NEW ENGLAND HEALTH CARE EMPLOYEES UNION, DISTRICT 1199, SEIU**

District 1199 represents approximately 25,000 health care workers in the state of Connecticut, including state employees, hospital employees, nursing home employees, direct care and professional workers at private Mental Health and Developmental Disability agencies and FQHCs, and home care workers providing personal care and support services to Medicaid recipients. Of those, more than 1,000 health care workers live in Lawrence and Memorial’s Primary and Secondary Service Areas.

At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just \$10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut

Connecticut Citizen Action Group

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Signature

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UNITE HERE Connecticut

Connecticut Health Policy Project



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Signature

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Signature

Ellen Andrews

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Name

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Name

Executive Director

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Title

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Title

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National Physicians Alliance Connecticut

United Action Connecticut

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Signature

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Name

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New England Health Care Employees Union  
District 1199 SEIU

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Signature

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## Greer, Leslie

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**From:** Martone, Kim  
**Sent:** Friday, June 17, 2016 3:07 PM  
**To:** Riggott, Kaila; Carney, Brian; Ciesones, Ron; Lazarus, Steven  
**Cc:** Greer, Leslie  
**Subject:** FW: Yale New Haven Health System and Lawrence & Memorial Hospital - CON 15-32033; L & M Physician Association and Northeast Medical Group - CON 15-32032  
**Attachments:** l&m appearance\_20160617133336508.pdf; l&m ltr ohca\_20160617133304384.pdf; Intervenor Petition Final.pdf  
**Importance:** High

### **Kimberly R. Martone**

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



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**From:** Henry F. Murray [<mailto:hfmurray@lapm.org>]  
**Sent:** Friday, June 17, 2016 2:06 PM  
**To:** Martone, Kim; Hansted, Kevin  
**Subject:** Yale New Haven Health System and Lawrence & Memorial Hospital - CON 15-32033; L & M Physician Association and Northeast Medical Group - CON 15-32032  
**Importance:** High

Dear Ms. Martone and Mr. Hansted:

Attach please find an electronic version of my appearance on behalf of a coalition of organizations that filed an application today for Intervenor status in the above referenced matters. Each organization is signing and sending the application to OCHA today but as a courtesy I have also included an electronic version of that application with this notice of appearance. As I state in my attached cover letter I would like to get a copy of the Service Sheet in these matters so I can forward my appearance to counsel for the Petitioners. Thank you.

Hank Murray

Henry F. Murray, Esq.  
**Livingston, Adler, Pulda, Meiklejohn & Kelly PC**  
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June 17, 2016

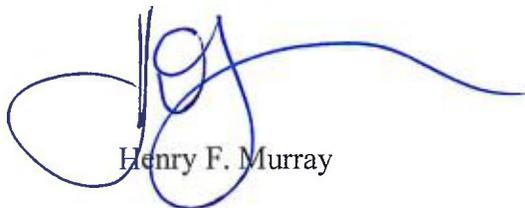
Kimberly Martone, Director of Operations  
Kevin Hansted, Hearing Officer  
Office of Health Care Access  
Department of Public Health  
State of Connecticut  
410 Capitol Avenue  
Hartford, CT 06106

**Re: Certificate of Need Applications,  
OHCA Docket No. 15-32032- CON, Merger of L & M Physicians Association and  
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OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial  
Corporation and Yale New Haven Health Services Corporation**

Dear Ms. Martone and Mr. Hansted:

Attached please find my appearance entered on behalf of a coalition of organizations who have requested intervenor status in the above captioned matters. I have also attached a copy of the intervenor application which the organizations are filing today. Please send me the service sheet for these two matters at your earliest convenience. Thank you.

Very truly yours,

  
Henry F. Murray

HFM:vds  
Enclosure



June 17, 2016

Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

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We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

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When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."<sup>6</sup> Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest \$300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the \$300 million will only come if L+M and other system hospitals hit profit targets.<sup>7</sup> We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."
- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.
- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

**Workforce:**

- L+M is New London's 2<sup>nd</sup> largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

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- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
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At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just \$10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut

Connecticut Citizen Action Group

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UNITE HERE Connecticut

Connecticut Health Policy Project

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National Physicians Alliance Connecticut

United Action Connecticut

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New England Health Care Employees Union  
District 1199 SEIU

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<sup>1</sup> Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHS, p. 868.

<sup>2</sup> CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, December 2015, p. 4.

<sup>3</sup> The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.

<sup>4</sup> Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015.

<http://www.healthcarepricingproject.org/>

<sup>5</sup> Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"

<sup>6</sup> Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.

<sup>7</sup> Docket 15-30233, p.

<sup>8</sup> Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

## Greer, Leslie

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**From:** Martone, Kim  
**Sent:** Monday, June 20, 2016 8:03 AM  
**To:** Hansted, Kevin; Riggott, Kaila  
**Cc:** Greer, Leslie  
**Subject:** FW: L & M intervenor  
**Attachments:** NPA-CT application.pdf

### ***Kimberly R. Martone***

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



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**From:** Henry F. Murray [<mailto:hfmurray@lapm.org>]  
**Sent:** Friday, June 17, 2016 4:24 PM  
**To:** Martone, Kim  
**Subject:** L & M intervenor

Kim, here is the intervenor application for NPA-CT.

Henry F. Murray, Esq.  
**Livingston, Adler, Pulda, Meiklejohn & Kelly PC**  
557 Prospect Avenue  
Hartford, Connecticut 06105  
860.233.9821  
860.570.4635 (direct)  
860.232.7818 (fax)  
[hfmurray@lapm.org](mailto:hfmurray@lapm.org)  
[www.lapm.org](http://www.lapm.org) (website)

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please notify the sender at the telephone numbers and email addresses above and delete the transmittal and any attachments. THANK YOU

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*Please think about the environment before deciding to print this email.*

June 17, 2016

Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

### **Cost and Price:**

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.<sup>1</sup> In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.
- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.<sup>2</sup> Consolidation in such markets most often leads to price increases of 20% or more.<sup>3</sup>
- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.<sup>4</sup> YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.<sup>5</sup>
- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.
- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

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At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just \$10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut

Connecticut Citizen Action Group

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UNITE HERE Connecticut

Connecticut Health Policy Project

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United Action Connecticut

  
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\_\_\_\_\_  
Name

Steering Committee Chair, NPA, CT  
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Title

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New England Health Care Employees Union  
District 1199 SEIU

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<sup>1</sup> Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHC, p. 868.

<sup>2</sup> CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, December 2015, p. 4.

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<sup>6</sup> Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.

<sup>7</sup> Docket 15-30233, p.

<sup>8</sup> Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

## Greer, Leslie

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**From:** Martone, Kim  
**Sent:** Monday, June 20, 2016 8:05 AM  
**To:** Greer, Leslie  
**Subject:** FW: Petition for intervenor status  
**Attachments:** 20160617154950.pdf; ATT00001.htm

Kimberly R. Martone  
Director of Operations, Office of Health Care Access Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)

-----Original Message-----

From: Dodson, Alicia [<mailto:DodsonA@chc1.com>]  
Sent: Friday, June 17, 2016 4:08 PM  
To: Martone, Kim  
Subject: Petition for intervenor status

Hi Ms Martone,

Please see the attached petition from the coalition for intervenor status. Signed by NPA-CT today. Thank you for your review. Sincerely,

Alicia M. Dodson, MD

<http://www.linkedin.com/in/aliciadodsonmedpeddoc>

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This message originates from Community Health Center, Inc.. The information contained in this message may be privileged and confidential. If you are the intended recipient you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and delete all copies of this message. Thank you.

June 17, 2016

Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

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We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

### **Cost and Price:**

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.<sup>1</sup> In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.
- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.<sup>2</sup> Consolidation in such markets most often leads to price increases of 20% or more.<sup>3</sup>
- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.<sup>4</sup> YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.<sup>5</sup>
- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.
- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

### **Community Access and Well-being:**

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."<sup>6</sup> Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest \$300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the \$300 million will only come if L+M and other system hospitals hit profit targets.<sup>7</sup> We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."
- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.
- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

#### **Workforce:**

- L+M is New London's 2<sup>nd</sup> largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

#### **Community Accountability and Monitoring:**

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local" boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

## **The Intervenors: Interests and Evidence**

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
  - Members of the Governor's Health Care Cabinet
  - Members of the Governor's Certificate of Need Review Task Force, and;
  - Members of the steering committee of L+M's current Community Needs Assessment process.

The coalition will present first-hand evidence from the entire range of the organizations' experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, "efficiency" and quality, and; a breakdown of the Applicants' financial statements to shed light on claims of financial hardship.

### **AFT CONNECTICUT including Locals 5049, 5051, 5123 and 5119**

AFT Connecticut is a statewide federation of the local unions of the American Federation of Teachers. Our locals have more than 1,800 members who work for Lawrence and Memorial Hospital and its affiliates. They all live in L+M's primary or secondary service area. They account for more than 50% of the total workforce at L+M, including the Visiting Nurses Association of Southeastern Connecticut. When counting non-L+M employees, altogether AFT Connecticut (State Federation) represents over 5,000 members who live in L+M's Primary and Secondary Service Areas.<sup>8</sup> . Based on AFT Connecticut's large concentration of members and their families in L+M services areas, the organization's interests are directly affected by the acquisition proposal, both as workers and as patients.

AFT Connecticut was previously granted intervenor status by OHCA in a 2004 CON hearing (04-30348-CON) involving the Hospital's desire to close the Hospital's OB/GYN clinic. AFT Connecticut will offer testimony on the efficiency of current L+M operations, the impact of aggressive expansion on core missions, and expert testimony on trends in consolidation, cost, prices, access and governance.

### **CONNECTICUT CITIZEN ACTION GROUP**

Connecticut Citizen Action Group is a statewide membership organization dedicated to involving the residents of Connecticut in bringing about a fair and equitable society. For over 40 years, CCAG has been at the forefront of advocating for a high quality, affordable and fully accessible health care system for all Connecticut residents. CCAG has worked effectively to advance health care policies that strengthen consumer access to fair, affordable health care services, coverage and benefits. CCAG's health care reform work includes monitoring hospital consolidation and regulation, expanding and protecting Medicaid coverage and benefits, and strengthening the ACA law.

CCAG has 500 members who live within the L+M catchment region, and will be directly impacted by potential increased costs, loss of local access, and changes in community programming directed toward health and well-being. Our members include a broad, diverse cross-section of the community including health care providers, child care providers, municipal workers, senior citizens, and educators. In addition to presenting testimony on the need for controlling cost and sustaining local community access to health care services, we will offer testimony on previous attempts to impose public accountability conditions on hospital acquisitions, and the need to impose strong community oversight, monitoring and accountability measures on this acquisition to ensure that the terms adequately and appropriately meet community health care needs and priorities, and that any such terms or conditions are actually carried out.

### **UNITE HERE CONNECTICUT**

UNITE HERE Connecticut is a labor organization representing more than 7,000 employees in Connecticut, including 250 in the primary and secondary service areas of L+M Hospital. We bargain health benefits for all of our members in the state, and have a powerful interest in preserving access to affordable, high quality health care. UNITE HERE members cook and serve food in corporate, university and K-12 cafeterias. These are low-wage, seasonal, often part-time jobs. For them, comprehensive, affordable health insurance coverage is essential to achieving any hope of a middle class life. UNITE HERE members at Electric Boat in New London are engaged in bargaining for health benefits. Members currently pay 20% of the cost, which is unaffordable for workers who make \$12 per hour. If regional costs continue to escalate, workers will be forced to drop coverage, or be forced to choose between rent and health care. The price structure of the Greater New London market is vital to our members' future well-being.

UNITE HERE's Taft-Hartley fund, jointly administered by the union and management, has established a national health plan tailored specifically for food service workers. In Connecticut, nearly 1,000 members have enrolled in the past several years. In some cases, the savings compared to commercial plans have been large enough to maintain comprehensive coverage and actually reduce the cost to individual members. But the efficiency of this plan will not ultimately protect members if the state's largest hospital is permitted to grow unchecked.

UNITE HERE will offer evidence of the immediate impact of any pricing changes at L+M on service sector workers struggling at the margins of the health care system. UNITE HERE will also offer testimony based on experience establishing a specially designed Taft-Hartley health plan for food service workers in Connecticut, as market consolidation continues to drive prices up.

### **NATIONAL PHYSICIANS ALLIANCE IN CONNECTICUT (NPA-CT)**

The National Physicians Alliance in Connecticut (NPA-CT) is part of a national 501(c)3 organization, the National Physicians Alliance (NPA), that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a home to physicians across medical specialties who share a commitment to professional integrity and health justice. NPA-CT physicians are members of the staff of the parties involved in the affiliation and primary care physicians in the communities served by the two entities. As such, they have a key interest in assuring that their patients and communities have access to affordable, high-quality hospital care.

NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

#### **CONNECTICUT HEALTH POLICY PROJECT**

Since 1999 as a nonprofit consumer advocacy organization, the CT Health Policy Project has labored to expand access to high quality, affordable health care for all Connecticut residents, with a particular focus on ensuring access for people in low-income communities of color. The proposed acquisition of Lawrence and Memorial Hospital/Health System by Yale-New Haven Hospital/Health System will undermine every part of our mission.

Executive Director Ellen Andrews, who sits on the Governor’s Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

#### **UNITED ACTION CONNECTICUT**

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT’s New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

#### **NEW ENGLAND HEALTH CARE EMPLOYEES UNION, DISTRICT 1199, SEIU**

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Alicia M. Dodson, MD  
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Steering Committee Chair, NPA, CT  
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New England Health Care Employees Union  
District 1199 SEIU

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## Greer, Leslie

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**Sent:** Monday, June 20, 2016 8:05 AM  
**To:** Greer, Leslie  
**Subject:** FW: Application for intervenor status  
**Attachments:** Intervenor Petition Final UH sigs.pdf

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

### **Kimberly R. Martone**

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



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**From:** John Canham-Clyne [<mailto:jcc@unitehere.org>]  
**Sent:** Friday, June 17, 2016 4:07 PM  
**To:** Martone, Kim; Hansted, Kevin  
**Subject:** Application for intervenor status

Ms. Martone, Mr. Hansted:

Please find attached UNITE HERE Connecticut's signed copy of our application for intervenor status as part of a coalition with Connecticut Citizen Action Group, AFT Connecticut, United Action Connecticut, New England Health Care Employees Union District 1199 SEIU, the National Physicians Alliance, Connecticut, and the Connecticut Health Policy Project, in the matters of Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and; Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*.

Please refer all questions and correspondence to:

John Canham-Clyne  
425 College St.  
New Haven 06511  
203-668-2064  
[jcc@unitehere.org](mailto:jcc@unitehere.org)

Thank you.



June 17, 2016

Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

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- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.<sup>2</sup> Consolidation in such markets most often leads to price increases of 20% or more.<sup>3</sup>
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- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.
- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

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outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest \$300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the \$300 million will only come if L+M and other system hospitals hit profit targets.<sup>7</sup> We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."
- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.
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- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
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- Professors at Brown University and Columbia University Medical schools;
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  - Members of the Governor’s Certificate of Need Review Task Force, and;
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UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

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District 1199 represents approximately 25,000 health care workers in the state of Connecticut, including state employees, hospital employees, nursing home employees, direct care and professional workers at private Mental Health and Developmental Disability agencies and FQHCs, and home care workers providing personal care and support services to Medicaid recipients. Of those, more than 1,000 health care workers live in Lawrence and Memorial’s Primary and Secondary Service Areas.

At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just \$10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,



Laurie Kennington  
President  
UNITE HERE Local 34  
[Kennington@yaleunions.org](mailto:Kennington@yaleunions.org)



Bob Proto  
President  
UNITE HERE Local 35  
[proto@yaleunions.org](mailto:proto@yaleunions.org)



Constance Holt  
Secretary-Treasurer  
UNITE HERE Local 217  
[CHolt@unitehere.org](mailto:CHolt@unitehere.org)

**UNITE HERE CONNECTICUT**

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New Haven CT 06511  
(203) 624-5161

Please direct correspondence to:

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AFT Connecticut

Connecticut Citizen Action Group

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District 1199 SEIU

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<sup>1</sup> Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHS, p. 868.

<sup>2</sup> CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, December 2015, p. 4.

<sup>3</sup> The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.

<sup>4</sup> Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015.  
<http://www.healthcarepricingproject.org/>

<sup>5</sup> Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"

<sup>6</sup> Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.

<sup>7</sup> Docket 15-30233, p.

<sup>8</sup> Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

June 17, 2016



Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

### **Cost and Price:**

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.<sup>1</sup> In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.
- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.<sup>2</sup> Consolidation in such markets most often leads to price increases of 20% or more.<sup>3</sup>
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At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just \$10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut

Connecticut Citizen Action Group

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UNITE HERE Connecticut

Connecticut Health Policy Project

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National Physicians Alliance Connecticut

United Action Connecticut

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*John S. Volpini*

*John S. Volpini*

*President, Board of Directors*

*185 Miller Avenue Meriden, CT 06450*

*(203) 443-3431*

*steverolpini2@gmail.com*

New England Health Care Employees Union  
District 1199 SEIU

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<sup>1</sup> Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHC, p. 868.

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June 17, 2016



Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

### **Cost and Price:**

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.<sup>1</sup> In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.
- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.<sup>2</sup> Consolidation in such markets most often leads to price increases of 20% or more.<sup>3</sup>
- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.<sup>4</sup> YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.<sup>5</sup>
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- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

### **Community Access and Well-being:**

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."<sup>6</sup> Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest \$300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the \$300 million will only come if L+M and other system hospitals hit profit targets.<sup>7</sup> We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."
- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.
- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

**Workforce:**

- L+M is New London's 2<sup>nd</sup> largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

**Community Accountability and Monitoring:**

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local" boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

## **The Intervenor: Interests and Evidence**

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
  - Members of the Governor's Health Care Cabinet
  - Members of the Governor's Certificate of Need Review Task Force, and;
  - Members of the steering committee of L+M's current Community Needs Assessment process.

The coalition will present first-hand evidence from the entire range of the organizations' experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, "efficiency" and quality, and; a breakdown of the Applicants' financial statements to shed light on claims of financial hardship.

### **AFT CONNECTICUT including Locals 5049, 5051, 5123 and 5119**

AFT Connecticut is a statewide federation of the local unions of the American Federation of Teachers. Our locals have more than 1,800 members who work for Lawrence and Memorial Hospital and its affiliates. They all live in L+M's primary or secondary service area. They account for more than 50% of the total workforce at L+M, including the Visiting Nurses Association of Southeastern Connecticut. When counting non-L+M employees, altogether AFT Connecticut (State Federation) represents over 5,000 members who live in L+M's Primary and Secondary Service Areas.<sup>8</sup> . Based on AFT Connecticut's large concentration of members and their families in L+M services areas, the organization's interests are directly affected by the acquisition proposal, both as workers and as patients.

AFT Connecticut was previously granted intervenor status by OHCA in a 2004 CON hearing (04-30348-CON) involving the Hospital's desire to close the Hospital's OB/GYN clinic. AFT Connecticut will offer testimony on the efficiency of current L+M operations, the impact of aggressive expansion on core missions, and expert testimony on trends in consolidation, cost, prices, access and governance.

### **CONNECTICUT CITIZEN ACTION GROUP**

Connecticut Citizen Action Group is a statewide membership organization dedicated to involving the residents of Connecticut in bringing about a fair and equitable society. For over 40 years, CCAG has been at the forefront of advocating for a high quality, affordable and fully accessible health care system for all Connecticut residents. CCAG has worked effectively to advance health care policies that strengthen consumer access to fair, affordable health care services, coverage and benefits. CCAG's health care reform work includes monitoring hospital consolidation and regulation, expanding and protecting Medicaid coverage and benefits, and strengthening the ACA law.

CCAG has 500 members who live within the L+M catchment region, and will be directly impacted by potential increased costs, loss of local access, and changes in community programming directed toward health and well-being. Our members include a broad, diverse cross-section of the community including health care providers, child care providers, municipal workers, senior citizens, and educators. In addition to presenting testimony on the need for controlling cost and sustaining local community access to health care services, we will offer testimony on previous attempts to impose public accountability conditions on hospital acquisitions, and the need to impose strong community oversight, monitoring and accountability measures on this acquisition to ensure that the terms adequately and appropriately meet community health care needs and priorities, and that any such terms or conditions are actually carried out.

### **UNITE HERE CONNECTICUT**

UNITE HERE Connecticut is a labor organization representing more than 7,000 employees in Connecticut, including 250 in the primary and secondary service areas of L+M Hospital. We bargain health benefits for all of our members in the state, and have a powerful interest in preserving access to affordable, high quality health care. UNITE HERE members cook and serve food in corporate, university and K-12 cafeterias. These are low-wage, seasonal, often part-time jobs. For them, comprehensive, affordable health insurance coverage is essential to achieving any hope of a middle class life. UNITE HERE members at Electric Boat in New London are engaged in bargaining for health benefits. Members currently pay 20% of the cost, which is unaffordable for workers who make \$12 per hour. If regional costs continue to escalate, workers will be forced to drop coverage, or be forced to choose between rent and health care. The price structure of the Greater New London market is vital to our members' future well-being.

UNITE HERE's Taft-Hartley fund, jointly administered by the union and management, has established a national health plan tailored specifically for food service workers. In Connecticut, nearly 1,000 members have enrolled in the past several years. In some cases, the savings compared to commercial plans have been large enough to maintain comprehensive coverage and actually reduce the cost to individual members. But the efficiency of this plan will not ultimately protect members if the state's largest hospital is permitted to grow unchecked.

UNITE HERE will offer evidence of the immediate impact of any pricing changes at L+M on service sector workers struggling at the margins of the health care system. UNITE HERE will also offer testimony based on experience establishing a specially designed Taft-Hartley health plan for food service workers in Connecticut, as market consolidation continues to drive prices up.

### **NATIONAL PHYSICIANS ALLIANCE IN CONNECTICUT (NPA-CT)**

The National Physicians Alliance in Connecticut (NPA-CT) is part of a national 501(c)3 organization, the National Physicians Alliance (NPA), that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a home to physicians across medical specialties who share a commitment to professional integrity and health justice. NPA-CT physicians are members of the staff of the parties involved in the affiliation and primary care physicians in the communities served by the two entities. As such, they have a key interest in assuring that their patients and communities have access to affordable, high-quality hospital care.

NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

#### **CONNECTICUT HEALTH POLICY PROJECT**

Since 1999 as a nonprofit consumer advocacy organization, the CT Health Policy Project has labored to expand access to high quality, affordable health care for all Connecticut residents, with a particular focus on ensuring access for people in low-income communities of color. The proposed acquisition of Lawrence and Memorial Hospital/Health System by Yale-New Haven Hospital/Health System will undermine every part of our mission.

Executive Director Ellen Andrews, who sits on the Governor's Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

#### **UNITED ACTION CONNECTICUT**

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT's New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

#### **NEW ENGLAND HEALTH CARE EMPLOYEES UNION, DISTRICT 1199, SEIU**

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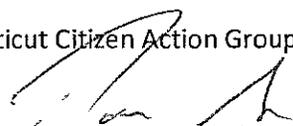
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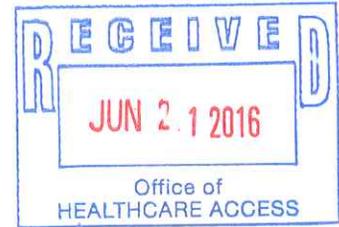
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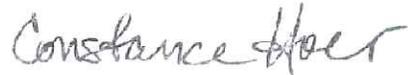
Very truly yours,



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AFT Connecticut

Connecticut Citizen Action Group

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<sup>7</sup> Docket 15-30233, p.

<sup>8</sup> Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

June 17, 2016



Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

### **Cost and Price:**

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.<sup>1</sup> In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.
- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.<sup>2</sup> Consolidation in such markets most often leads to price increases of 20% or more.<sup>3</sup>
- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.<sup>4</sup> YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.<sup>5</sup>
- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.
- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

### **Community Access and Well-being:**

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."<sup>6</sup> Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest \$300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the \$300 million will only come if L+M and other system hospitals hit profit targets.<sup>7</sup> We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."
- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.
- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

#### **Workforce:**

- L+M is New London's 2<sup>nd</sup> largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

#### **Community Accountability and Monitoring:**

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local" boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

## **The Intervenors: Interests and Evidence**

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<sup>6</sup> Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.

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<sup>8</sup> Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

June 17, 2016



Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

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We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

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outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest \$300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the \$300 million will only come if L+M and other system hospitals hit profit targets.<sup>7</sup> We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."
- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.
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### **CONNECTICUT CITIZEN ACTION GROUP**

Connecticut Citizen Action Group is a statewide membership organization dedicated to involving the residents of Connecticut in bringing about a fair and equitable society. For over 40 years, CCAG has been at the forefront of advocating for a high quality, affordable and fully accessible health care system for all Connecticut residents. CCAG has worked effectively to advance health care policies that strengthen consumer access to fair, affordable health care services, coverage and benefits. CCAG's health care reform work includes monitoring hospital consolidation and regulation, expanding and protecting Medicaid coverage and benefits, and strengthening the ACA law.

CCAG has 500 members who live within the L+M catchment region, and will be directly impacted by potential increased costs, loss of local access, and changes in community programming directed toward health and well-being. Our members include a broad, diverse cross-section of the community including health care providers, child care providers, municipal workers, senior citizens, and educators. In addition to presenting testimony on the need for controlling cost and sustaining local community access to health care services, we will offer testimony on previous attempts to impose public accountability conditions on hospital acquisitions, and the need to impose strong community oversight, monitoring and accountability measures on this acquisition to ensure that the terms adequately and appropriately meet community health care needs and priorities, and that any such terms or conditions are actually carried out.

### **UNITE HERE CONNECTICUT**

UNITE HERE Connecticut is a labor organization representing more than 7,000 employees in Connecticut, including 250 in the primary and secondary service areas of L+M Hospital. We bargain health benefits for all of our members in the state, and have a powerful interest in preserving access to affordable, high quality health care. UNITE HERE members cook and serve food in corporate, university and K-12 cafeterias. These are low-wage, seasonal, often part-time jobs. For them, comprehensive, affordable health insurance coverage is essential to achieving any hope of a middle class life. UNITE HERE members at Electric Boat in New London are engaged in bargaining for health benefits. Members currently pay 20% of the cost, which is unaffordable for workers who make \$12 per hour. If regional costs continue to escalate, workers will be forced to drop coverage, or be forced to choose between rent and health care. The price structure of the Greater New London market is vital to our members' future well-being.

UNITE HERE's Taft-Hartley fund, jointly administered by the union and management, has established a national health plan tailored specifically for food service workers. In Connecticut, nearly 1,000 members have enrolled in the past several years. In some cases, the savings compared to commercial plans have been large enough to maintain comprehensive coverage and actually reduce the cost to individual members. But the efficiency of this plan will not ultimately protect members if the state's largest hospital is permitted to grow unchecked.

UNITE HERE will offer evidence of the immediate impact of any pricing changes at L+M on service sector workers struggling at the margins of the health care system. UNITE HERE will also offer testimony based on experience establishing a specially designed Taft-Hartley health plan for food service workers in Connecticut, as market consolidation continues to drive prices up.

### **NATIONAL PHYSICIANS ALLIANCE IN CONNECTICUT (NPA-CT)**

The National Physicians Alliance in Connecticut (NPA-CT) is part of a national 501(c)3 organization, the National Physicians Alliance (NPA), that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a home to physicians across medical specialties who share a commitment to professional integrity and health justice. NPA-CT physicians are members of the staff of the parties involved in the affiliation and primary care physicians in the communities served by the two entities. As such, they have a key interest in assuring that their patients and communities have access to affordable, high-quality hospital care.

NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

### **CONNECTICUT HEALTH POLICY PROJECT**

Since 1999 as a nonprofit consumer advocacy organization, the CT Health Policy Project has labored to expand access to high quality, affordable health care for all Connecticut residents, with a particular focus on ensuring access for people in low-income communities of color. The proposed acquisition of Lawrence and Memorial Hospital/Health System by Yale-New Haven Hospital/Health System will undermine every part of our mission.

Executive Director Ellen Andrews, who sits on the Governor’s Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

### **UNITED ACTION CONNECTICUT**

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT’s New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

### **NEW ENGLAND HEALTH CARE EMPLOYEES UNION, DISTRICT 1199, SEIU**

District 1199 represents approximately 25,000 health care workers in the state of Connecticut, including state employees, hospital employees, nursing home employees, direct care and professional workers at private Mental Health and Developmental Disability agencies and FQHCs, and home care workers providing personal care and support services to Medicaid recipients. Of those, more than 1,000 health care workers live in Lawrence and Memorial’s Primary and Secondary Service Areas.

At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just \$10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut

Connecticut Citizen Action Group

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UNITE HERE Connecticut

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New England Health Care Employees Union  
District 1199 SEIU



Signature

David W. Pickus

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President

Title

77 Huyshope Avenue, First Floor, Hartford, CT 06106

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<sup>1</sup> Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHC, p. 868.

<sup>2</sup> CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, December 2015, p. 4.

<sup>3</sup> The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.

<sup>4</sup> Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015.

<http://www.healthcarepricingproject.org/>

<sup>5</sup> Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"

<sup>6</sup> Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.

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LAW OFFICES

**LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.**

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June 17, 2016

Kimberly Martone, Director of Operations  
Kevin Hansted, Hearing Officer  
Office of Health Care Access  
Department of Public Health  
State of Connecticut  
410 Capitol Avenue  
Hartford, CT 06106

**Re: Certificate of Need Applications,  
OHCA Docket No. 15-32032- CON, Merger of L & M Physicians Association and  
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OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial  
Corporation and Yale New Haven Health Services Corporation**

Dear Ms. Martone and Mr. Hansted:

Attached please find my appearance entered on behalf of a coalition of organizations who have requested intervenor status in the above captioned matters. I have also attached a copy of the intervenor application which the organizations are filing today. Please send me the service sheet for these two matters at your earliest convenience. Thank you.

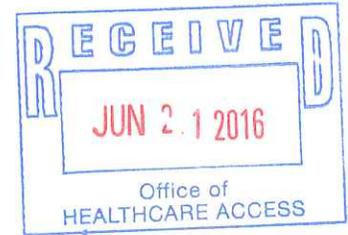
Very truly yours,

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HFM:vds  
Enclosure



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Executive Director Ellen Andrews, who sits on the Governor's Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

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Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut

Connecticut Citizen Action Group

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UNITE HERE Connecticut

Connecticut Health Policy Project

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National Physicians Alliance Connecticut

United Action Connecticut

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New England Health Care Employees Union  
District 1199 SEIU

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Signature

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<sup>1</sup> Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHSC, p. 868.

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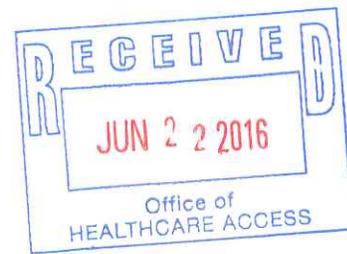
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June 17, 2016



Ms Kimberly Martone, Director  
Mr. Kevin Hansted, Hearing Officer  
Office of Health Care Access  
410 Capitol Ave.  
Hartford CT 06106

**REFERENCE:** Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

### **Cost and Price:**

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.<sup>1</sup> In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.
- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.<sup>2</sup> Consolidation in such markets most often leads to price increases of 20% or more.<sup>3</sup>
- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.<sup>4</sup> YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.<sup>5</sup>
- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.
- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

### **Community Access and Well-being:**

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."<sup>6</sup> Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest \$300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the \$300 million will only come if L+M and other system hospitals hit profit targets.<sup>7</sup> We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."
- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.
- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

#### **Workforce:**

- L+M is New London's 2<sup>nd</sup> largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

#### **Community Accountability and Monitoring:**

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local" boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

## **The Intervenors: Interests and Evidence**

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
  - Members of the Governor's Health Care Cabinet
  - Members of the Governor's Certificate of Need Review Task Force, and;
  - Members of the steering committee of L+M's current Community Needs Assessment process.

The coalition will present first-hand evidence from the entire range of the organizations' experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, "efficiency" and quality, and; a breakdown of the Applicants' financial statements to shed light on claims of financial hardship.

### **AFT CONNECTICUT including Locals 5049, 5051, 5123 and 5119**

AFT Connecticut is a statewide federation of the local unions of the American Federation of Teachers. Our locals have more than 1,800 members who work for Lawrence and Memorial Hospital and its affiliates. They all live in L+M's primary or secondary service area. They account for more than 50% of the total workforce at L+M, including the Visiting Nurses Association of Southeastern Connecticut. When counting non-L+M employees, altogether AFT Connecticut (State Federation) represents over 5,000 members who live in L+M's Primary and Secondary Service Areas.<sup>8</sup>. Based on AFT Connecticut's large concentration of members and their families in L+M services areas, the organization's interests are directly affected by the acquisition proposal, both as workers and as patients.

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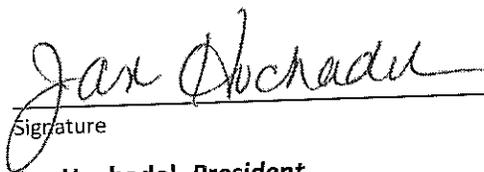
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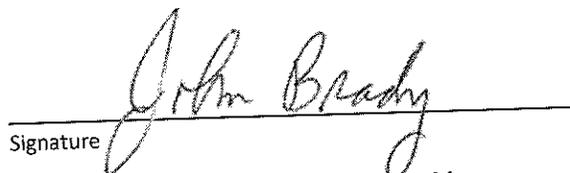
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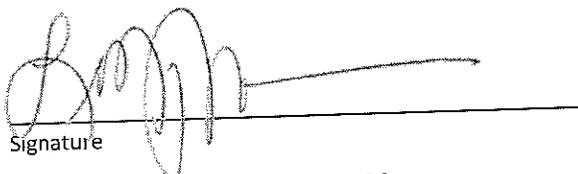
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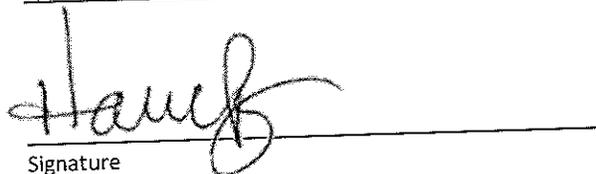
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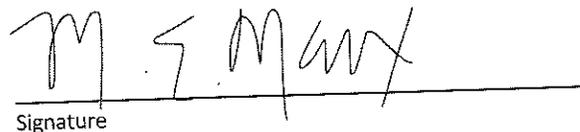
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<sup>1</sup> Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHSC, p. 868.

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## Greer, Leslie

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**From:** Greer, Leslie  
**Sent:** Wednesday, June 22, 2016 3:26 PM  
**To:** 'nancy.rosenthal@ynhh.org'  
**Cc:** Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara  
**Subject:** Yale-New Haven Health Services Hearing Notice  
**Attachments:** 32032\_201606221507.pdf

Tracking:	Recipient	Delivery	Read
	'nancy.rosenthal@ynhh.org'		
	Lazarus, Steven	Delivered: 6/22/2016 3:26 PM	Read: 6/22/2016 3:47 PM
	Carney, Brian	Delivered: 6/22/2016 3:26 PM	Read: 6/22/2016 3:31 PM
	Riggott, Kaila	Delivered: 6/22/2016 3:26 PM	
	Hansted, Kevin	Delivered: 6/22/2016 3:26 PM	
	Martone, Kim	Delivered: 6/22/2016 3:26 PM	Read: 6/22/2016 3:26 PM
	Olejarz, Barbara	Delivered: 6/22/2016 3:26 PM	

Ms. Rosenthal,  
Attached are the rescheduled hearing notices for Yale-New Haven Health Services Corporation.

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Raul Pino, M.D., M.P.H.  
Commissioner

### Office of Health Care Access

June 22, 2016

Nancy Rosenthal  
SVP, Strategy and Regulatory Planning  
Yale-New Haven Health System  
5 Perryridge Road  
Greenwich, CT 06830

RE: Certificate of Need Application, Docket Number 15-32032-CON and 15-32033-CON  
**Docket Number: 15-32032-CON**

Northeast Medical Group ("NMG") and L&M Physician Association  
("L&MPA")

Transfer of Ownership of a Group Practice by Merger of L&MPA into NMG

**Docket Number: 15-32033-CON**

Yale New Haven Health Services Corporation ("YNHHSC") and Lawrence +  
Memorial Corporation ("L+M")

Acquisition of L+M by YNHHSC

Dear Ms. Rosenthal,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Northeast Medical Group, Inc., L&M Physician Association, Inc., Yale New Haven Health Services Corporation and L&M Corporation ("Applicants") on April 29, 2016, the Office of Health Care Access ("OHCA") has initiated its review of the CON applications identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

Applicant(s): Northeast Medical Group, Inc.  
L&M Physician Association, Inc.

Docket Number: 15-32032-CON

Proposal: Transfer of Ownership of a Group Practice by Merger of L&M Physicians  
Association into Northeast Medical Group

Applicant(s): Yale New Haven Health Services Corporation  
L&M Corporation

Docket Number: 15-32033-CON

Proposal: Acquisition of L+M by YNHHSC

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: July 11, 2016

Time: 3:00 p.m.,

Place: Holiday Inn New London – Mystic Area  
35 Governor Winthrop Boulevard – Ballroom  
New London, CT 06320

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in *The Day* pursuant to General Statutes § 19a-639a (f) and 19a-486 (f).

Sincerely,



Kimberly R. Martone  
Director of Operations  
Enclosure

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

cc: Henry Salton, Esq., Office of the Attorney General  
Antony Casagrande, Department of Public Health  
Kevin Hansted, Department of Public Health  
Wendy Furniss, Department of Public Health  
Maura Downes, Department of Public Health  
Jill Kennedy, Department of Public Health  
Chris Stan, Department of Public Health  
Brie Wolf, Department of Public Health  
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC:img

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Raul Pino, M.D., M.P.H.  
Commissioner

Office of Health Care Access

June 22, 2016

P.O. #54772

The Day  
47 Eugene O'Neil Drive  
New London, CT 06320

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, June 24, 2016**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

A handwritten signature in black ink, appearing to read "Kimberly R. Martone".

Kimberly R. Martone  
Director of Operations

Attachment

cc: Danielle Pare, DPH  
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC;lmg



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

Statute Reference: 19a-638

Applicant(s): Northeast Medical Group, Inc.  
L&M Physician Association, Inc.

Town: Stratford

Docket Number: 15-32032-CON

Proposal: Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group

Applicant(s): Yale New Haven Health Services Corporation  
L&M Corporation

Town: New London

Docket Number: 15-32033-CON

Proposal: Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation

Date: July 11, 2016

Time: 3:00 p.m.

Place: Holiday Inn New London – Mystic Area  
35 Governor Winthrop Boulevard – Ballroom  
New London, CT 06320

Any person who wishes to request status in the above listed public hearing may file a written petition no later than July 6, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at [www.ct.gov/ohca](http://www.ct.gov/ohca) for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

## Greer, Leslie

---

**From:** ADS <ADS@graystoneadv.com>  
**Sent:** Wednesday, June 22, 2016 2:26 PM  
**To:** Greer, Leslie  
**Subject:** Re: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Good day!

Thanks so much for your ad request.  
We will be in touch shortly and look forward to serving you.

***If you would like to add diversity to this or future requests don't hesitate to ask. Remember, "Quotes are Free". You only pay for the placements you approve.***

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for \$115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,  
Graystone Group Advertising

2710 North Avenue  
Bridgeport, CT 06604  
Phone: 800-544-0005  
Fax: 203-549-0061

**E-mail new ad requests to:** [ads@graystoneadv.com](mailto:ads@graystoneadv.com)  
<http://www.graystoneadv.com/>

---

**From:** "Greer, Leslie" <[Leslie.Greer@ct.gov](mailto:Leslie.Greer@ct.gov)>  
**Date:** Wednesday, June 22, 2016 at 2:13 PM  
**To:** Ads Desk <[ads@graystoneadv.com](mailto:ads@graystoneadv.com)>  
**Cc:** "Olejarz, Barbara" <[Barbara.Olejarz@ct.gov](mailto:Barbara.Olejarz@ct.gov)>  
**Subject:** DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 6/24/16. For billing purposes, please refer to P.O. 54772. In addition, when the "proof of publication" becomes available, please forward me a copy.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
**Website:** [www.ct.gov/ohca](http://www.ct.gov/ohca)

## Greer, Leslie

---

**From:** Robert Taylor <RTaylor@graystoneadv.com>  
**Sent:** Thursday, June 23, 2016 5:05 PM  
**To:** Greer, Leslie  
**Cc:** Olejarz, Barbara  
**Subject:** Re: DN's 15-32032-CON & 15-32033-CON Hearing Notice  
**Attachments:** 15-32032 and 15-32033 The Day 2nd REVISION.docx

Good afternoon,

This notice is set to publish tomorrow.  
\$471.21

Thanks,

Robert Taylor  
Graystone Group Advertising  
[www.graystoneadv.com](http://www.graystoneadv.com)  
2710 North Avenue, Suite 200  
Bridgeport, CT 06604  
Phone: 203-549-0060  
Toll Free: 800-544-0005  
Fax: 203-549-0061

---

**From:** "Greer, Leslie" <[Leslie.Greer@ct.gov](mailto:Leslie.Greer@ct.gov)>  
**Date:** Wed, 22 Jun 2016 18:45:26 +0000  
**To:** RTaylor <[rtaylor@graystoneadv.com](mailto:rtaylor@graystoneadv.com)>  
**Cc:** "Olejarz, Barbara" <[Barbara.Olejarz@ct.gov](mailto:Barbara.Olejarz@ct.gov)>  
**Subject:** RE: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Thank you! I've attached the correct version.

---

**From:** Robert Taylor [<mailto:RTaylor@graystoneadv.com>]  
**Sent:** Wednesday, June 22, 2016 2:44 PM  
**To:** Greer, Leslie  
**Cc:** Olejarz, Barbara  
**Subject:** FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice  
**Importance:** High

Hi Leslie,

Is this correct version (for us) to publish?

Thanks,

Robert Taylor  
Graystone Group Advertising  
[www.graystoneadv.com](http://www.graystoneadv.com)

2710 North Avenue, Suite 200  
Bridgeport, CT 06604  
Phone: 203-549-0060  
Toll Free: 800-544-0005  
Fax: 203-549-0061

---

**From:** ADS <[ADS@graystoneadv.com](mailto:ADS@graystoneadv.com)>  
**Date:** Wed, 22 Jun 2016 14:26:09 -0400  
**To:** RTaylor <[rtaylor@graystoneadv.com](mailto:rtaylor@graystoneadv.com)>  
**Subject:** FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice

---

**From:** "Greer, Leslie" <[Leslie.Greer@ct.gov](mailto:Leslie.Greer@ct.gov)>  
**Date:** Wednesday, June 22, 2016 at 2:13 PM  
**To:** Ads Desk <[ads@graystoneadv.com](mailto:ads@graystoneadv.com)>  
**Cc:** "Olejarz, Barbara" <[Barbara.Olejarz@ct.gov](mailto:Barbara.Olejarz@ct.gov)>  
**Subject:** DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 6/24/16. For billing purposes, please refer to P.O. 54772. In addition, when the "proof of publication" becomes available, please forward me a copy.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)



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Public Notices 21327 Office of Health Care Access Public Hearings Statute Reference: 19a-638 Applicant(s): Northeast Medical Group, Inc. L&M Physician Association, Inc. Town: Stratford Docket Number: 15-32032-CO...

Any person who wishes to request status in the above listed public hearing may file a written petition no later than July 6, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies...

TOWN OF GROTON 21324 WATER POLLUTION CONTROL AUTHORITY Sanitary Sewer Use Rate Schedule 2016/2017 The Town of Groton Water Pollution Control Authority hereby adopts the following revised Sanitary Sewer Use Rate Schedule:

David Williams Chairman TOWN OF GROTON WATER POLLUTION CONTROL AUTHORITY 21321 TOWN OF SALEM ATTENTION SALEM TAXPAYERS FIRST INSTALLMENT NOTICE Notice is hereby given to the taxpayers of the Town of Salem that I have a warrant to collect a tax of 31.7 mills on a dollar on the levy of October 1, 2015 which is due and payable as follows:

- 1) Real Estate and Personal Property bills over \$100.00 may be paid in full, or in two equal installments: first installment due on July 1, 2016 and the second installment on January 1, 2017. 2) Real Estate and Personal Property tax bills under \$100.00 are due in full on July 1, 2016. 3) Motor Vehicle taxes are due in full July 1, 2016, regardless of the amount.

You have one month from the due date to pay taxes/installment without interest or penalty. Failure to make payment within the prescribed time will invoke a penalty of 1 1/2 % per month (18% per year) with a \$2.00 minimum on each tax bill.

Taxpayers who do not have a bill for the Oct. 1, 2015 list should contact the Salem Tax Collector's office for a duplicate bill. CT State Statute 12-130 Failure to receive a bill does not invalidate the taxes or respective penalties should the account become delinquent.

Taxes may be paid at the Salem Town Office building with cash or check Monday thru Thursday from 8:00 a.m. to 5:00 p.m. (Thursday from 8:00 a.m. to 6:00 p.m. for the months of July and January only.) The town hall is closed on Friday. Payment can also be made online using a checking account, credit or debit card at Salemct.gov.

Dated at Salem Connecticut the 24th day of June 2015.

Cheryl A. Philomena C.C.M.C. Tax Collector Town of Salem

21185 TOWN OF MONTVILLE ZONING BOARD OF APPEALS NOTICE OF PUBLIC HEARING The Montville Zoning Board of Appeals will hold a regular meeting and public hearing on Wednesday, July 6, 2016 commencing at 7:00 p.m. in Council Chambers at Montville Town Hall for the following application: #2162B-02-189 Connecticut Blvd (M92 L186), Oakdale, CT-Roseanne C. Marks for variance of Zoning Regulations Sections 9.6 (R-20 Min. Side Yard Setback) to construct a detached garage 5.26' from the north side boundary line.

21333 TOWN OF GROTON ZONING BOARD OF APPEALS NOTICE OF DECISION The Town of Groton Zoning Board of Appeals, at its meeting on June 22, 2016, took the following action: ZBA#16-07 - 49 Watrous Avenue, Brian Barbour/Owner for a variance to Section 5.2 to allow a 29 foot front yard setback in lieu of the required 50 feet. PIN#270014435910, RU-40 Zone - Approved with modifications. Additional information concerning the above decision may be obtained from the Planning Department, 134 Groton Long Point Road. Dated this 24th day of June, 2016, at Groton, Connecticut. Ed Stebbins, Chairman

Do you want to expand your coverage and reach every household in the area? Call us and we'll tell you how! theday Classified Department 860-701-4200

21325 DECISION NOTICE PLANNING AND ZONING COMMISSION TOWN OF STONINGTON, CONNECTICUT 06378 Pursuant to the Connecticut General Statutes and the Subdivision and Zoning Regulations of the Town of Stonington, revision of 1958 and all amendments thereto, the Planning and Zoning Commission at their regular meeting held on June 21, 2016, at Mystic Middle School, 204 Mistuxet Avenue, Mystic, CT, voted on the following application(s) as indicated: PZ1613BR Denison Pequotsesop Nature Center - Bond Reduction/Release application for release of a \$25,078.30 Erosion and Sedimentation control bond posted to satisfy requirements of approved Special Use Permit application PZ1418SUP & CAM. Property located at 162 Greenmanville Ave., Mystic. Assessor's Map 172 Block 2 Lot 5. Zones RM-15 & RA-40. Approved.

PZ1608SUP Goran & Desiree Subotic - Special Use Permit application to extend the current permitted hours of operation to Monday thru Saturday, 9:00 AM to 9:30PM, and Sunday, no later than 8:00 PM. Property located at 325 Mistuxet Ave., Mystic. Assessor's Map 133 Block 6 Lot 5B. Zone RA-40. Approved with Stipulations.

PZ1611RA Suzanne R. Moore - Regulation Amendment to ZR Section 4.3.4 Buffer Requirements to change the buffer requirements in the LS-5 Zone to fifteen (15) feet of screening for a commercial use adjoining a residential zone, and eliminating the screening requirements of ZR Sections 4.3.4.2 and 4.3.4.3. Denied.

PZ1614SUP McQuade's Mystic, LLC (S & K Wilson) - Special Use Permit application for a recreational facility (escape room adventure), in an existing multi tenant building. Property located at 14 Clara Drive, Mystic. Assessor's Map 164 Block 4 Lot 3. Zone TC-80. Approved.

Dated at Stonington, Connecticut, this 22nd day of June, 2016

David Rathbun, Acting Chairman

21226 TOWN OF STONINGTON & FIRE DISTRICTS, ASSOCIATIONS & BOROUGHS STONINGTON, MYSTIC, QUIAMBAUG, OLD MYSTIC, LORDS POINT, WAMPHASSUC PT & STONINGTON BOROUGHS OFFICE OF THE TAX COLLECTOR LEVY OF 2015 All property owners in the Town of Stonington & Fire Districts, Associations & Boroughs are hereby notified that taxes on land, buildings, personal property and motor vehicle taxes where applicable, are due and payable July 1 through August 1, 2016. Taxes not paid within one month of due date will be delinquent and subject to 1-1/2 % interest per month from original date due, e.g., if paid on August 2, 2016 there will be a 3% charge. Minimum interest is \$2 per tax bill. (Sec. 12-146 of the Connecticut General Statutes)

COLLECTIONS - STONINGTON TOWN HALL 152 Elm St., Stonington 8:30 am to 4:00 pm - Monday thru Friday Linda Camello Stonington Tax Collector

21326 THE UNIVERSITY OF CONNECTICUT REQUEST FOR STATEMENTS OF QUALIFICATIONS FOR TRADE LABOR CONTRACTOR FOR ACADEMIC RENOVATIONS PROJECT NUMBER 060116JP RELEASED June 24, 2016 PROPOSALS DUE: July 21, 2016 by 2:00 PM THE UNIVERSITY OF CONNECTICUT IS AUTHORIZED TO SOLICIT EXPERIENCED GENERAL CONTRACTING FIRMS TO PROVIDE TRADE LABOR SERVICES FOR ACADEMIC RENOVATIONS ON THE STORRS AND REGIONAL CAMPUSES.

TO FIND OUT MORE ABOUT THIS RFP AND THE REQUIREMENTS FOR SUBMISSION, PLEASE VISIT OUR WEBSITE: http://cpca.uconn.edu; OR www.das.ct.gov/cr1.aspx?page=12

21264 Town of Groton, Fire Districts, Subdivisions and Special Tax Districts located in the Town of Groton Tax Collector's Notice of Taxes Due

All property owners in the Town of Groton are hereby notified that taxes on land, buildings, personal property including motor vehicles will be due and payable July 1, 2016, based on the Town of Groton abstract of October 1, 2015.

The Town of Groton and the Groton Sewer District real estate and personal property tax bills over \$100 may be paid in full or in two installments. The first installment will become due July 1, 2016. The second installment will become due January 1, 2017. Real estate and personal property taxes under \$100, motor vehicle taxes, and all other fire district/political subdivision taxes will become due in full July 1, 2016.

These taxes shall be payable without penalty on or before August 1, 2016. All taxes paid after that date will become delinquent and due immediately and subject to interest at the rate of one and one-half percent (1.5%) per month or fraction thereof from the due date. Failure to send out or receive any such bill or statement shall not invalidate the tax or interest.

PAYABLE AT: GROTON TOWN HALL, TAX DIVISION 45 FORT HILL ROAD, GROTON, CT 8:30 AM TO 4:30 PM MONDAY - FRIDAY For other payment options and information, visit the town website at www.groton-ct.gov. Cynthia L. Small, CCMC, Tax Collector

FOLLOW THE DAY JOBS FOR NEW JOBS AND UPDATES TheDay.Jobs @THEDAYjobsCT

21319 TAX COLLECTOR'S NOTICE TOWN OF LEDYARD All persons liable to pay property taxes in the Town of Ledyard on the October 1, 2015 Grand List are hereby notified that any Real Estate or Personal Property Tax of 100.00 dollars and under is due and payable in full on July 01, 2016. If the tax is more than 100.00 dollars, it may be paid in two installments. The first installment is due and payable July 01, 2016, and the second installment is due and payable on January 01, 2017. All Motor Vehicle Taxes are due and payable in full on July 01, 2016. If payment is not made by August 1, 2016, the amount due will become delinquent and subject to interest at the rate of eighteen per annum (one and one-half percent per month) from July 1, 2016. The minimum interest is 2.00 dollars. Failure to receive a tax bill does not invalidate the taxes or the interest that accrues. For collecting said tax, the Tax Collector will maintain the following office hours in the Town Hall: Monday - Friday 8:30 A.M. to 4:00 P.M. Current taxes may also be paid at the Dime Savings Bank - Ledyard branch, during the month of July. Joan L. Carroll, CCMC Tax Collector

21236 TOWN OF GROTON ZONING COMMISSION NOTICE OF PUBLIC HEARING Notice is hereby given that the following public hearing will be held on July 6, 2016 at 6:30 p.m. In Community Room 2, Town Hall Annex, 134 Groton Long Point Road, in said Town, to consider the following: Special Permit #349, 10 Water Street, PIN 261918306539, WDD Zone. Proposal is to convert 750 square feet of retail to a standard restaurant with up to 200 square feet of seating area. Review is per Sections 6.3 and 8.3 of the Zoning Regulations. (The Mystic Group at Mystic LLC Owner; Melody Pere, Applicant) Application is on file and available for public inspection during normal business hours at the Planning Department, 134 Groton Long Point Road. Dated this 24th day of June 2016 at Groton, Connecticut. Susan Sutherland, Chairperson

21228 TOWN OF GROTON PLANNING COMMISSION NOTICE OF PUBLIC HEARING Notice is hereby given that a public hearing, at which parties of interest and citizens will have an opportunity to be heard, will be held on June 29, 2016 at 6:30 p.m. in Community Room 1, Town Hall Annex, 134 Groton Long Point Road, in said Town, to consider the draft 2016 Groton Plan of Conservation and Development. A copy of the plan is on file and available at the office of the Town Clerk, Town of Groton, for public inspection. Copies are also available on the Town's Website and in the Office of Planning and Development Services. For more information, contact the Office of Planning and Development Services at 860-446-5970. Dated this 24th day of June, 2016 at Groton, Connecticut. James Sherrard, Chairman

1989 Chevy Camaro RS - 305 engine, auto, \$1,500. 860-941-7600 Hyundai XG350 2004 Sedan - 71K One owner Excellent \$4700 860-739-7512 Toyota RAV4 - 2.0L I4 Engine, no accidents or damages, 82K miles, runs very good, \$3300 Please call me at 2489528138

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1976 BMW Classic 900 CC - \$3,200. 860-912-7706. In Mystic

2001 Jeep Wrangler Sport - 6 Cty, 5spd, hard top, lifted, many extras, good cond. \$7,800. 080 860-428-5400

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Publication Date: 06/24/2016 This E-Sheet(R) confirms that the ad appeared in The Day on the date and page indicated. You may not create derivative works, or in any way exploit or repurpose any content displayed, or contained, on the electronic tearsheet.

The Day Classified Department 860-701-4200



**SHIPMAN & GOODWIN** LLP®  
COUNSELORS AT LAW

Joan W. Feldman, Esq.  
Phone: (860) 251-5104  
Fax: (860) 251-5211  
[jfeldman@goodwin.com](mailto:jfeldman@goodwin.com)



June 22, 2016

VIA HAND DELIVERY & EMAIL

Kevin Hansted, Esq.  
Hearing Officer  
Department of Public Health  
Office of Health Care Access  
410 Capitol Avenue, MS #13HCA  
P.O. Box 34048  
Hartford, Connecticut 06134-0308  
[Kevin.Hansted@ct.gov](mailto:Kevin.Hansted@ct.gov)

**Re: IN THE MATTERS OF: DOCKET NOs. 15--32032-CON and  
15--32033-CON**

Dear Attorney Hansted:

On behalf of the Applicants in the above-referenced matters, enclosed please find:

1. Shipman & Goodwin's Notice of Appearance Forms;
2. The Applicants' Objection to the Coalition's request for full intervenor status; and
3. Shipman & Goodwin's Certification that the above-referenced documents have been provided to the Coalition's attorney.

If you have any questions, please do not hesitate to contact me.

Sincerely yours,

  
Joan W. Feldman

Jwf/tja  
Enclosure

Cc: Kimberly Martone  
Director of Operations  
[Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov)

**STATE OF CONNECTICUT**

**OFFICE OF HEALTH CARE ACCESS**

IN THE MATTER OF THE : Docket No. 15-32032-CON  
PROPOSAL FOR MERGER OF :  
L&M PHYSICIAN ASSOCIATION, INC. :  
AND NORTHEAST MEDICAL GROUP, INC. : June 22, 2016

**NOTICE OF APPEARANCE**

Please enter the appearance of Shipman & Goodwin LLP on behalf of L&M Physician Association, Inc. and Northeast Medical Group, Inc. in the above entitled proceeding.

Respectfully Submitted,

**L&M PHYSICIAN ASSOCIATION, INC.**

**NORTHEAST MEDICAL GROUP, INC.**

By:   
Joan W. Feldman, Esq.  
[jfeldman@goodwin.com](mailto:jfeldman@goodwin.com)  
Shipman & Goodwin LLP  
One Constitution Plaza  
Hartford, CT 06103-1919  
Tel: 860-251-5104  
Fax: 860-251-5211  
Its Attorneys



**SHIPMAN & GOODWIN** LLP®  
COUNSELORS AT LAW

Joan W. Feldman  
Phone: (860) 251-5104  
Fax: (860) 251-5211  
[jfeldman@goodwin.com](mailto:jfeldman@goodwin.com)

June 22, 2016

VIA HAND DELIVERY & EMAIL

Kevin Hansted, Esq.  
Hearing Officer  
Department of Public Health  
Office of Health Care Access  
410 Capitol Avenue, MS #13HCA  
P.O. Box 34048  
Hartford, Connecticut 06134-0308  
[Kevin.Hansted@ct.gov](mailto:Kevin.Hansted@ct.gov)

**Re: Objection to the Coalition's Petition for Full Intervenor Status in the  
Matters of Docket NOs. 15-32032-CON and 15-32033-CON**

Dear Attorney Hansted:

On behalf of the Applicants in the above-referenced Applications, I respectfully object to AFT Connecticut's, Connecticut Citizen Action Group's, UNITE HERE Connecticut's, National Physicians Alliance in Connecticut's, Connecticut Health Policy Project's, United Action Connecticut's, and New England Health Care Employees, 1199, SEIU's (collectively the "Coalition") petition for full intervenor status (the "Petition").

The Applicants share some of the same concerns set forth in the Coalition's Petition regarding healthcare costs, retaining services in the community and maintaining a commitment to local governance. Thus, we do not object to the Coalition's participation in the hearings for the above-referenced Applications as an intervenor. For the reasons described herein, however, we object to the Coalition's request to cross-examine the Applicants' witnesses, and to the scope of the testimony that the Coalition seeks to introduce.

While we do not object to the Coalition's ability to participate in the hearings as an intervenor, we object to their Petition for "full" intervenor status. More specifically, and in the interests of an orderly hearing and facilitating OHCA's fact-finding and application of the statutorily mandated criteria by which OHCA approves or denies applications, the Applicants believe that the Coalition's participation should be limited solely to submitting

Kevin Hansted, Esq.  
June 22, 2016  
Page Two

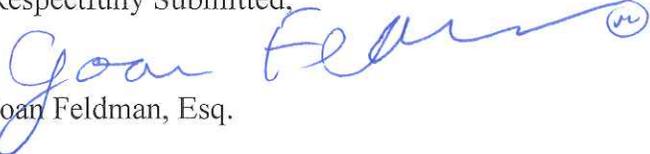
pre-file testimony and presenting witness testimony at the hearing(s). The Coalition should not be allowed to make opening statements or cross-examine witnesses. The Applicants are concerned that if the Coalition were granted the right to cross-examine the Applicants' witnesses, it would provide a forum and an opportunity for the Coalition to address issues and grievances that are not relevant to the Applications at hand. Moreover, and as you know, OHCA has the right to ask the Applicants and their witnesses questions that can address any of the concerns set forth by the Coalition in its pre-filed testimony. By proceeding in this manner, OHCA will ensure that the hearings proceed in an orderly manner and focus only on the relevant issues within OHCA's jurisdiction.

Accordingly, we respectfully request that the Coalition's Petition for full intervenor status be denied and that said Petition be approved on a very limited basis as described herein. The Applicants believe that a more appropriate avenue for many of the Coalition's statements or grievances is through the public portion of the upcoming hearing(s) at which time OHCA may permit any member of the Coalition's views to be heard or outside these proceedings directly between the Applicants and the Coalition's members.

The Applicants request that should the Coalition be granted intervenor status, that OHCA limits the Coalition's testimony to a list of issues specified by OHCA prior to the hearings on the aforementioned Applications.

Finally, the Coalition states that Executive Order 51 requires OHCA to deny the Applications. While the Applicants recognize that OHCA is not in a position to decide the lawfulness of that Executive Order, we want OHCA to be aware that the Applicants disagree with the Coalition's statements regarding Executive Order 51. We are of the opinion that Executive Order 51 should not be enforced and/or adhered to by OHCA in the aforementioned proceedings.

Respectfully Submitted,

  
Joan Feldman, Esq.

Cc: Kimberly Martone  
Director of Operations  
[Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov)

## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Notice of Appearances and the Applicants' Objection to the Coalition's petition for intervenor status were sent via e-mail the 22nd day of June, 2016 to:

Henry F. Murray, Esq.  
Livingston, Adler, Pulda, Meiklejohn & Kelly PC  
557 Prospect Avenue  
Hartford, CT 06105  
[hfmurray@lapm.org](mailto:hfmurray@lapm.org)



---

Joan W. Feldman

## Greer, Leslie

---

**From:** Greer, Leslie  
**Sent:** Thursday, June 23, 2016 10:33 AM  
**To:** jfeldman@goodwin.com  
**Cc:** 'nancy.rosenthal@ynhh.org'; Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim  
**Subject:** Ruling on Petition for Intervenor Status  
**Attachments:** 32032 Ruling.pdf

Tracking:	Recipient	Delivery	Read
	jfeldman@goodwin.com		
	'nancy.rosenthal@ynhh.org'		
	Lazarus, Steven	Delivered: 6/23/2016 10:33 AM	
	Carney, Brian	Delivered: 6/23/2016 10:33 AM	Read: 6/23/2016 10:34 AM
	Riggott, Kaila	Delivered: 6/23/2016 10:33 AM	
	Hansted, Kevin	Delivered: 6/23/2016 10:33 AM	
	Martone, Kim	Delivered: 6/23/2016 10:33 AM	

Attorney Feldman,  
Attached is the Ruling on Petition for Intervenor Status.

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)



## Greer, Leslie

---

**From:** Greer, Leslie  
**Sent:** Thursday, June 23, 2016 11:00 AM  
**To:** 'delivingston@lapm.org'  
**Cc:** 'nancy.rosenthal@ynhh.org'; Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim  
**Subject:** OHCA Ruling on Petition for Intervenor Status  
**Attachments:** 32032 Ruling.pdf

<b>Tracking:</b>	<b>Recipient</b>	<b>Delivery</b>
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	'nancy.rosenthal@ynhh.org'	
	Lazarus, Steven	Delivered: 6/23/2016 11:01 AM
	Carney, Brian	Delivered: 6/23/2016 11:01 AM
	Riggott, Kaila	Delivered: 6/23/2016 11:01 AM
	Hansted, Kevin	Delivered: 6/23/2016 11:01 AM
	Martone, Kim	Delivered: 6/23/2016 11:01 AM

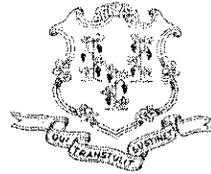
Attorney Murray,  
Attached is the Ruling on Petition for Intervenor Status.

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

### IN THE MATTER OF:

Certificate of Need Applications by  
Lawrence + Memorial Corporation;  
Yale New Haven Health Services Corporation;  
L+M Physicians Association; and  
Northeast Medical Group, Inc.

Docket Numbers: 15-32032-CON  
15-32033-CON

### RULING ON PETITION FOR INTERVENOR STATUS

By petition dated June 17, 2016, AFT Connecticut, Connecticut Citizen Action Group, UNITE HERE Connecticut, National Physicians Alliance in Connecticut, Connecticut Health policy Project, United Action Connecticut, and New England Health Care Employees, District 1199, SEIU ("Petitioners") requested Intervenor status in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") applications filed under Docket Numbers: 15-32032-CON and 15-32033-CON. The Applicants filed an objection thereto on June 22, 2016.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioners are hereby designated as Intervenors with full rights of at the hearing scheduled for July 11, 2016 at Holiday Inn, 35 Governor Winthrop Blvd., New London, Connecticut. As Intervenors with full rights, the Petitioners may participate as indicated below.

The Petitioners are granted the right to inspect and copy records on file with OHCA related to the CONs filed under Docket Numbers 15-32032-CON and 15-32033-CON and shall be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicants until the issuance of a final decision by OHCA. As Intervenors with full rights of, the Petitioners may be cross-examined by the Applicants and the Petitioners have the right to cross-examine the Applicants. **The Petitioners shall file their pre-file testimony by the close of business on July 1, 2016.**

OHCA's jurisdiction in this matter is limited to the guidelines and principles set forth in Connecticut General Statutes § 19a-639. Therefore, with respect to pre-filed testimony, direct testimony, and any cross-examination at the hearing, the Petitioners are limited to those guidelines and principles as set forth below.



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Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

- (1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;
- (2) The relationship of the proposed project to the state-wide health care facilities and services plan;
- (3) Whether there is a clear public need for the health care facility or services proposed by the applicant;
- (4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;
- (5) Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons;
- (6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;
- (7) Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;
- (8) The utilization of existing health care facilities and health care services in the service area of the applicant;
- (9) Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;
- (10) Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;
- (11) Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region; and
- (12) Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioners throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

Date

6/23/16

Kevin T. Hansted  
Hearing Officer

## Greer, Leslie

---

**From:** Greer, Leslie  
**Sent:** Thursday, June 23, 2016 2:31 PM  
**To:** jfeldman@goodwin.com  
**Cc:** 'nancy.rosenthal@ynhh.org'; Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim  
**Subject:** OHCA Order Regarding DN's 15-32032-CON & 15-32033-CON  
**Attachments:** 32032 Order.pdf

Attorney Feldman,

Please see the attached Order regarding docket numbers 15-32032-CON & 15-32033-CON.

Sincerely,

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)



## Greer, Leslie

---

**From:** Greer, Leslie  
**Sent:** Thursday, June 23, 2016 2:16 PM  
**To:** 'hfmurray@lapm.org'  
**Cc:** Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim  
**Subject:** OHCA Ruling on Petition for Intervenor Status & Order  
**Attachments:** 32032 Ruling.pdf; 32032 Order.pdf

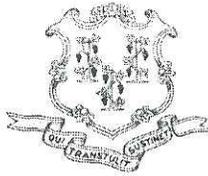
<b>Tracking:</b>	<b>Recipient</b>	<b>Delivery</b>	<b>Read</b>
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	Lazarus, Steven	Delivered: 6/23/2016 2:16 PM	
	Carney, Brian	Delivered: 6/23/2016 2:16 PM	Read: 6/23/2016 2:17 PM
	Riggott, Kaila	Delivered: 6/23/2016 2:16 PM	
	Hansted, Kevin	Delivered: 6/23/2016 2:16 PM	
	Martone, Kim	Delivered: 6/23/2016 2:16 PM	

Attorney Murray,  
Attached is the Ruling on Petition for Intervenor Status and Order regarding hearing.

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Raul Pino, M.D., M.P.H.  
Commissioner

Office of Health Care Access

**IN THE MATTER OF:**

Certificate of Need Applications by  
Lawrence + Memorial Corporation;  
Yale New Haven Health Services Corporation;  
L+M Physicians Association; and  
Northeast Medical Group, Inc.

Docket Numbers: 15-32032-CON  
15-32033-CON

**ORDER**

The Applicants in the above-referenced matters shall file their pre-file testimony on or before the close of business on July 1, 2016.

6/23/16  
\_\_\_\_\_  
Date

\_\_\_\_\_  
Kevin T. Hansted  
Hearing Officer



Phone: (860) 418-7001 • Fax: (860) 418-7053  
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Hartford, Connecticut 06134-0308  
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# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

TO: Kevin Hansted, Hearing Officer

FROM: Raul Pino MD/MPH, Commissioner 

DATE: June 24, 2016

RE: Certificate of Need Application; Docket Number: 15-32032-CON  
Northeast Medical Group, Inc. and L&M Physician Association, Inc.  
Transfer of Ownership of a Group Practice by Merger of L&M Physicians  
Association into Northeast Medical Group

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I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.



Phone: (860) 509-8000 • Fax: (860) 509-7184  
410 Capitol Avenue, P.O. Box 340308  
Hartford, Connecticut 06134-0308  
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*Affirmative Action/Equal Opportunity Employer*

Joan W. Feldman  
Phone: 860-251-5104  
Fax: 860-251-5211  
[jfeldman@goodwin.com](mailto:jfeldman@goodwin.com)

July 1, 2016



**Via E-Mail & Hand Delivery**

Kevin T. Hansted  
Staff Attorney/Hearing Officer  
Department of Public Health  
Office of Health Care Access  
410 Capitol Ave., MS #13HCA  
P.O. Box 340308  
Hartford, CT 06134  
Phone: 860-418-7044  
[Kevin.Hansted@ct.gov](mailto:Kevin.Hansted@ct.gov)

**RE: DOCKET NO. 15-32032-CON - MERGER OF L&M PHYSICIAN  
ASSOCIATION, INC. AND NORTHEAST MEDICAL GROUP, INC.**

Dear Mr. Hansted:

On behalf of the Applicants in the above referenced matter, enclosed please find the following:

1. The Applicants' responses to OHCA's "Public Hearing Issues" request dated June 14, 2016; and
2. Pre-filed Testimony for:
  - a) Christopher Lehrach;
  - b) Prathibha Varkey; and
  - c) Bruce Cummings.

Please do not hesitate to contact me at 860-251-5104 if you have any questions.

Sincerely,

  
Joan W. Feldman

Enclosures

## CERTIFICATE OF SERVICE

I hereby certify that true and correct copies of the foregoing documents were sent via electronic mail the 1<sup>st</sup> day of July, 2016 to:

Henry F. Murray, Esq.  
Livingston, Adler, Pulda, Meiklejohn & Kelly PC  
557 Prospect Avenue  
Hartford, CT 06105  
[hfmurray@lapm.org](mailto:hfmurray@lapm.org)

  
\_\_\_\_\_  
Joan W. Feldman

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS**

<b>AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE-NEW HAVEN HEALTH SERVICES CORPORATION</b>	<b>:</b>	<b>DOCKET NO. 15-32033-CON</b>
	<b>:</b>	
	<b>:</b>	
	<b>:</b>	<b>July 11, 2016</b>
	<b>:</b>	
<b>MERGER OF L&amp;M PHYSICIAN ASSOCIATION, INC. AND NORTHEAST MEDICAL GROUP, INC.</b>	<b>:</b>	<b>DOCKET NO. 15-32032-CON</b>
	<b>:</b>	
	<b>:</b>	<b>July 11, 2016</b>

---

**OHCA PUBLIC HEARING ISSUES**

**1. The clear public need for proposal.**

The Applicants are of the opinion and belief that there is a clear public need for the services it provides to the residents of the Eastern Connecticut region. More specifically, L+M is a vital resource to the community because it provides everyone with the healthcare they need, regardless of their ability to pay and regardless of the fact that the cost of efficiently providing such health care to those in need significantly exceeds government sponsored healthcare reimbursement (e.g., Medicaid). As stated in the Application and pre-filed testimony, L+M provides essential access and services to those individuals in the community that other providers are unwilling to accept because of their payer or socioeconomic status. Declining revenue from governmental payers coupled with increasing Connecticut hospital taxes have put enormous financial pressure on L+M's ability to continue to subsidize the level of services and access for which there is a clear public need. Given these realities and the associated demands of health care reform (discussed in greater detail in the Application), L+M's financial stability is considerably less certain. In order to responsibly address this financial instability and ensure that patients located in the Eastern Connecticut Region continue to have access to quality healthcare services, L+M is of the belief that it must affiliate with Yale New Haven Health to gain needed access to the operational and clinical infrastructure and expertise that Yale New Haven Health offers. Without this proposed affiliation, L+M believes that the quality of and access to the services that L+M provides will be reduced, all to the detriment of the residents of Eastern Connecticut.

**2. The effect of the proposed transfer of ownership on the residents of the region with respect to health care services, including how access to services (including specialty care) will be maintained or improved in the area following the acquisition.**

If OHCA approves the subject Applications, the Applicants are of the firm belief and opinion that the residents of the Eastern Connecticut will benefit from L+M being a more financially stable hospital. Financial stability for L+M means: more improvements in L+M's facilities, more investment in needed infrastructure, greater access to needed medical equipment and technology, expanded clinical service offerings, and job stability. The more investments that L+M can make in clinical service offerings and clinical programming for the community, the more financially stable L+M will become and the more L+M can promote the overall health and wellness of its community. In addition, access to capital for the infrastructure needed to improve and manage care, such as data analytics, will ultimately inure and contribute to the well-being of our residents in the Eastern Connecticut region. Denial of the Applications will force L+M to reduce scope, hours and type of clinical service offerings. As a direct consequence, the most vulnerable of our residents will have no choice but to go elsewhere for their healthcare. However, given the limited public transportation in the Eastern Connecticut region, this may not be a viable option for many of our patients.

The L+M Board of Directors will continue as a fiduciary board and as such, will have the right to approve any major new programs and clinical services, or the discontinuation or consolidation of any such clinical programs. L+M and Yale New Haven Health also expect that many of the clinical specialty services that were introduced by Yale New Haven Health at Greenwich Hospital and Bridgeport Hospital will also be offered in the L+M community, including bariatric surgery, endocrinology and vascular surgery to name a few.

**3. Describe the benefits achieved in the Bridgeport/Greenwich Hospital service areas following the YNHHSC affiliation, in terms of financial stability or enhanced programs or services.**

Greenwich and Bridgeport Hospitals have enhanced clinical service offerings to their communities as a result of the Yale New Haven Health affiliation. By way of example, the development of cancer, pediatric and cardiovascular surgical programs has increased the scope and level of acuity of clinical services provided by both Greenwich and Bridgeport Hospitals. As a result, both hospitals have been able to offer more advanced and sophisticated clinical offerings on a local basis with patient access to some of the best and brightest physicians in the nation. Each hospital has also benefitted from the sharing of evidence-based best practices, enhanced patient satisfaction, employee engagement and physician growth and engagement. Bridgeport Hospital and Greenwich Hospital have also achieved significant cost savings in areas such as, supply chain, information technology, and

insurance to name a few. Most importantly, since affiliating with Yale New Haven Health both hospitals are in stronger financial positions with consistent positive operating and net incomes.

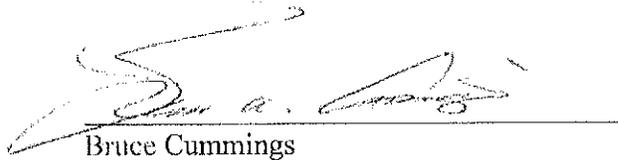
**4. Please describe how successful the CHNA implementation plan has been in addressing priority health issues in L+M's service area.**

L+M's last community needs assessment was performed in 2013 and implementation has been ongoing by L+M on its own and through collaborative efforts among community stakeholders to ensure strategies are implemented and outcomes measured. Socioeconomic factors, physical environment, health behaviors and clinical care are all factors in the assessment and the plan. Areas of focus have been chronic conditions such as heart disease, obesity, diabetes, cancer, sexual health, asthma and behavioral health and is more particularly described in our Applications. L+M has been successful in implementing strategies to address the prioritized identified needs following our 2013 CHNA in partnership with a multi-sector community collaborative. L+M has measured process outcomes, but going forward, we believe that Yale New Haven Health will enhance L+M's analytical capabilities and support more robust program evaluation and tracking of outcome measures. L+M's challenge is to identify metrics on which it can obtain the data to measure whether it is moving the needle at all. A new CHNA will be completed shortly with the implementation plan completed and approved by the L+M board in August of 2016. Please see <http://www.lmhealthcare.org/> for current information.

**5. How will the proposal affect community health improvement spending (community benefits) and community building activities in L+M's service area?**

Pursuant to the Affiliation Agreement between the Applicants, there is a mutual commitment to maintain (at a minimum) the current level of spending on L+M community benefit programming. If the proposed affiliation is approved, the parties will share resources and knowledge in collaboration with other community organizations to achieve and offer the best and most effective community programs with the best outcomes. L+M will continue to perform its local community health needs assessment every three (3) years. If the proposed affiliation is not approved, it is very likely that L+M will need to reduce its community programming.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Bruce Cummings", is written over a horizontal line. The signature is stylized and cursive.

Bruce Cummings  
President & CEO, Lawrence + Memorial Corporation

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS**

**MERGER OF L&M PHYSICIAN ASSOCIATION, INC. AND NORTHEAST MEDICAL GROUP, INC.** : **DOCKET NO. 15-32032-CON**  
: **July 11, 2016**  
:  
:

**PRE-FILED TESTIMONY OF CHRISTOPHER LEHRACH,  
PRESIDENT, L&M PHYSICIAN ASSOCIATION, INC.**

**I. Introduction.**

Good afternoon, Attorney Hansted, Ms. Martone and staff of the Office of Health Care Access (“OHCA”). My name is Christopher Lehrach and I am President of L&M Physician Association, Inc. (“L&MPA”). I am a Board Certified Family Medicine physician with more than 20 years of experience in medicine and medical practice management. My complete curriculum vitae is included as Exhibit A. I want to thank you for the opportunity to speak about this Certificate of Need (“CON”) application which would allow L&MPA to merge into Northeast Medical Group (“NEMG”).

This CON application has been submitted in conjunction with a separate CON application for the affiliation of Lawrence + Memorial Corporation (“L+M”) with Yale New Haven Health Services Corporation (“YNHHSC”). L&MPA and NEMG are both Connecticut medical foundations established pursuant to Connecticut General Statutes § 33-182aa. L&MPA, a subsidiary of L+M, is a multispecialty group practice of approximately 70 physicians with locations throughout southeastern Connecticut and southwestern Rhode Island. NEMG, a subsidiary of YNHHSC, is a multispecialty physician group with more than 100 practice locations and 600 physicians, located in Fairfield and New Haven counties.

I would like to focus my testimony on why L&MPA's merger with NEMG is essential to L&MPA's long term mission and viability. As a group practice of approximately 70 physicians affiliated with two small community hospitals, L&MPA does not have the resources to adequately respond to the challenges associated with health care reform. Specifically, it is difficult for L&MPA to: (i) recruit and retain high-quality primary care and subspecialist physicians; (ii) participate in accountable care and risk-based contracts which require sophisticated information technology to support care coordination and data analytics; (iii) manage risk across a patient population because of its small scale; and (iv) obtain the practice infrastructure necessary to enhance patient services.

## **II. Benefits to L&MPA.**

A. Recruitment and Retention: As the practice of medicine has become increasingly more challenging and demanding, many physicians are looking for the administrative support to assist them in meeting data reporting requirements, and responding to the various requirements of commercial and governmental payers. While the solution for many physicians is to join a large physician group affiliated with a hospital or health system, L&MPA has encountered many challenges recruiting both primary care and specialty physicians. A merger with NEMG will significantly improve our ability to recruit and retain the best physicians to provide care to our local community, as many physicians prefer to be affiliated with an academic health system, such as YNHHS. In addition, there are certain subspecialties that, due to the size of the service area population, would not have a sufficient patient base to support a full-time practice. L+M and L&MPA are committed to being able to offer our community the highest quality medical and hospital care locally. I want to stress that we have already seen a significant increase in interest among the medical community to join our practice with just the announcement of our plans to affiliate with YNHHS and merge with NEMG.

In addition, becoming part of NEMG will allow L&MPA to ensure Medicaid beneficiaries in the New London area have continued access to necessary primary and specialty care services. Given the declining reimbursement from Medicaid, many private physicians are declining to participate or are refusing to accept new Medicaid patients. Specialists in particular are dropping out of the Medicaid program, heightening the need for non-profit

medical foundations that are integrated with local hospitals and provide care to all patients, regardless of payment source. L&MPA currently fills that need in the New London area, and becoming part of NEMG will provide the resources and scale necessary to operate more efficiently and thus, maintain access and care for the most vulnerable patient populations.

B. Accountable Care and Risk Based Contracts: As our health care system rapidly shifts from fee-for-service to risk-based and/or value-based reimbursement, all health care providers must commit and invest in new infrastructure and data analytics to assist them in managing the wellness of their patients. To be successful in a risk-based arrangement, a large patient base is necessary in order to spread the financial risk and the costs of the required infrastructure. Medicare's Accountable Care Organizations ("ACOs") for example, require a minimum of 5,000 Medicare beneficiaries. Given the size of our practice and our local population, we are not large enough to assume this risk on our own.

C. Information Technology: A robust, highly integrated electronic medical record ("EMR") is essential for physicians to provide comprehensive, high quality and cost-effective care. Our current EMR is not adequate. The Epic EMR, available only to academic medical centers and their affiliates and which YNHHS has purchased, is the leading EMR in the country. It is able to integrate patient information in the physician practice setting, hospital and other outpatient settings. As part of the merger, L&MPA physicians will utilize the Epic EMR in our practice settings, but will be fully integrated with our two local hospitals as well as Yale-New Haven Hospital where some of our patients will seek tertiary and quaternary care. A sophisticated system like Epic is not inexpensive and we would never be able to afford its purchase and implementation without the merger with NEMG. We recently implemented the Community Connect option of Epic that we purchased from Yale New Haven Health. As part of Yale New Haven Health's license arrangement with Epic it is allowed to offer a basic version of the EMR to local hospitals and physician groups, but the costs of that system are much higher (almost \$14 million) than they would be if we were part of Yale New Haven Health, and the functionality of the Community Connect product is much more limited.

D. Data Analytics: NEMG has invested in tools and systems to provide its physicians with the necessary data needed to improve practice and patient outcomes. Regular dashboard reports regarding adherence to a number of quality indicators such as screenings, preventative care and medication adherence are routinely produced for physicians. NEMG also prepares regular reports that capture the utilization of hospital services, emergency room visits, primary care visits, and post-acute care across a physician's patient panel. These reports enable physicians to view the entirety of an episode of care, and collaborate with others at NEMG to identify the most efficient and effective way to manage a patient population. This type of data analytics will be available to L&MPA and play a significant role in the way we practice medicine so that we can provide greater value at a lower cost.

E. Care Management: NEMG has developed a number of clinical pathways and protocols that help guide physicians in selecting the appropriate tests and interventions. These protocols help ensure that evidence-based best practices are disseminated, and will be available to L&MPA physicians if the merger is approved. L&MPA physicians, as part of NEMG, also will have opportunities to participate in the development of additional pathways and protocols in the future, an area of interest for many of our physicians. NEMG currently offers care management services through care coordinators who follow common clinical pathways, address post-acute care needs and have a major focus on disease management and reducing unnecessary emergency room visits and 30-day readmissions. The care coordinators have a major role in ensuring patients understand their care plan, have access to services needed and receive timely, appropriate follow-up. L&MPA does not currently have the resources to provide these services on its own.

### **III. Financial Losses.**

As OHCA noted in its completeness questions, both L&MPA and NEMG currently operate at a financial loss. These losses which would have previously been absorbed by the respective hospitals are largely associated with serving an increasing number of Medicaid, uninsured and other governmental payers. L&MPA's financial losses, however, have become a significant stressor on L+M's overall financial condition, which makes the merger with NEMG all the more imperative as a means of reducing overhead costs and improving

efficiencies. To the extent that both L&MPA and NEMG can allocate fixed overhead expenses over a larger number of providers and avoid duplicate infrastructure expenses, the better off each will be from a fiscal perspective.

#### **IV. Executive Order.**

As Bruce Cummings has pointed out in his testimony, we believe that Executive Order 51 imposing a moratorium on the approval of the Yale New Haven Health and L+M Certificate of Need is unlawful. I would like to further note that the Executive Order does not, on its face, affect the L&MPA and NEMG Certificate of Need application, and denying this Certificate of Need based solely on Executive Order 51 would be inconsistent with OHCA's legislative mandate in this matter. L&MPA and NEMG urge OHCA to carefully consider this application on its own merits.

#### **V. Conclusion.**

I would like to close with an emphasis on the following few key points:

- The proposed merger of NEMG and L&MPA is vital to the continued access to high quality physicians for L+M service area residents;
- Motivated by the Affordable Care Act and market pressures, health care providers must manage the health of patient populations and be held financially accountable for meeting greater value at a lower cost. This move cannot be accomplished by L+M and L&MPA alone. Our ability to remain viable and succeed in offering patients the best access to quality care requires this merger be approved; and
- L&MPA and L+M's rapidly declining financial condition make the need for action imperative, in order to preserve access and prevent future cuts to services.

Thank you for this opportunity to share with you the challenges we face and the benefits NEMG will bring to L&MPA. Approval of the CON application is vital to ensure continued access to essential health care services for L&MPA's service area residents

I adopt the pre-filed testimony as my own.

A handwritten signature in black ink, appearing to read 'C. Lehrach, M.D.', with a stylized flourish at the end.

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Christopher Lehrach, M.D., MBA  
President, L&M Physician Association, Inc.

**EXHIBIT A**

# Christopher M. Lehrach, MD, MBA

34 Sea View Dr., Charlestown, RI 02813 Tel: 401-315-5030 Cell: 401-749-7911 crlehrach@msn.com  
L+M Healthcare, 365 Montauk Ave., New London, CT 06320 Tel. 860-442-0711 clehrach@lmhosp.org

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## Profile:

I am a seasoned, results-oriented clinical leader with a proven record of accomplishment in fast-paced environments. My medical and administrative leadership background, complemented by top-tier business training, allows me to approach complex issues with a value-driven and highly analytical orientation, in the dynamic high-stakes and high-energy health care industry. With a disciplined yet flexible style, I consistently achieve decision quality.

## Professional Experience:

### President, L+M Medical Group

Multispecialty, multisite, medical group serving SE CT and Southern RI.

7/14-Present

### VP, Division of Care Transformation, Chief Transformation Officer

L+M Healthcare, Inc., New London, CT

7/13-Present

- Goal of reducing cost while improving quality and patient experience across organization

### Chief Transformation Officer-Interim Operations

The Westerly Hospital, Westerly, RI

11/12-6/13

- Chief Executive of a 125 bed community Hospital undergoing voluntary receivership

### CEO, The Atlantic Medical Group

Multispecialty, multisite, medical group serving SE CT and Southern RI.

4/10-10/12

### Chair, Department of Emergency Services

The Westerly Hospital, Westerly, RI

1/05-10/12

### Emergency Department Physician/EMP

The Westerly Hospital, Westerly, RI

1998-Present

### Medical Director-P/T

Watch Hill Walk-In, Watch Hill, RI

2006-2012

### Emergency Medicine Physician-P/T

Landmark Medical Center, Woonsocket, RI

1999-2002

### Co-Director, Family Practice/Emergency Medicine

Block Island Medical Center, Block Island, RI

1998-2001

### Emergency Medicine Physician-P/T

Pegasus Group, Emergency Medicine, Flemington, NJ

1996-1998

### Urgent Care/Family Practice-P/T

The Doctor-is-In, Clinton, NJ

1996-1998

### Financial Information Technician

Bloomberg L.P., London, England

1990-1991

## Education:

<u>Yale University, School of Management</u> New Haven, CT <i>Masters of Business Administration Degree, with distinction</i> <ul style="list-style-type: none"><li>• Leadership in Healthcare Management</li></ul>	2008-2010
<u>University of Medicine and Dentistry of New Jersey</u> Flemington, NJ <i>Residency Program, PGY I-III</i> Hunterdon Medical Center, Family Practice Residency <ul style="list-style-type: none"><li>• Chief Resident</li></ul>	1995-1998 1997-1998
<u>University of Connecticut, School of Medicine</u> Farmington, CT <i>Doctor of Medicine Degree</i>	1991-1995
<u>The University of Pennsylvania, College of Arts and Sciences</u> Philadelphia, PA <i>Bachelor of Arts Degree, cum laude</i> <ul style="list-style-type: none"><li>• Biological Basis of Behavior, Neurobiology tract</li><li>• Psychology</li></ul>	1986-1990
<u>The Hartford Hospital</u> Hartford, CT <i>Summer Student Fellowship Program</i> <ul style="list-style-type: none"><li>• Senior Fellow</li></ul>	1988-1989 Summer 1989

## Board Positions:

<u>Hospital Association of Rhode Island-Chairman</u> Providence, RI	2012-Present
<u>Rhode Island Blood Center</u> Providence, RI	2012-Present
<u>Regional Policy Board/American Hospital Association</u> District 1	2015-Present
<u>Board of Trustees-The Westerly Hospital</u> Westerly, RI	2007-2011

## Certification:

<u>Diplomat, American Board of Family Medicine</u> Recertified 2005, 2015	1998-Present
<u>Clinical Instructor in Emergency Medicine</u> Quinnipiac University, Physician Assistant Program, Hamden, CT	2001-Present
<u>Clinical Instructor in Family Medicine</u> Brown University, School of Medicine, Providence, RI	1998-2001
ACLS, ATLS, Neonatal Resuscitation certification	1996-Present
Rhode Island Allopathic Medical License	1997-Present
Connecticut Allopathic Medical License	2014-Present
New York Allopathic Medical License	2014-Present
New Jersey Allopathic Medical License	1996-1998

Federal DEA Registration/CDS Certificate

1996-Present

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS**

**MERGER OF L&M PHYSICIAN ASSOCIATION, INC. AND NORTHEAST MEDICAL GROUP, INC.** : **DOCKET NO. 15-32032-CON**  
:   
:   
: **July 11, 2016**

**PRE-FILED TESTIMONY OF PRATHIBHA VARKEY, MBBS, MPH, MHPE, MBA  
CHIEF EXECUTIVE OFFICER, NORTHEAST MEDICAL GROUP, INC.**

Good afternoon Attorney Hansted and staff of the Office of Health Care Access (“OHCA”). My name is Prathibha Varkey. I am a board certified internal medicine and preventive medicine physician and the newly appointed Chief Executive Officer (“CEO”) of NEMG. Prior to my current position, I served as President and CEO of the Seton Clinical Enterprise, a multispecialty group at Seton Family Healthcare, the largest health system in Austin, Texas and I held several leadership positions at the Mayo Clinic for twelve years. In addition to my medical degree, I have master’s degrees in public health, health professions education and business administration. I have included my full curriculum vitae as *Attachment I* for your information.

Thank you for the opportunity to speak about the Certificate of Need (“CON”) application before you for the L&M Physician Association, Inc. (“L&MPA”) to merge into Northeast Medical Group (“NEMG”). Given my short tenure at NEMG, Mr. Christopher O’Connor, Chief Operating Officer of Yale New Haven Health (which includes NEMG), is also present today and available to answer questions.

Dr. Lehrach has outlined the specific reasons why L&MPA desires this merger, therefore, I would like to focus my testimony on the capabilities of NEMG and the benefits it brings to

L&MPA, as well as the importance of the physician enterprise to Yale New Haven Health Services Corporation and its affiliated delivery networks, which I will hereby refer to as Yale New Haven Health.

NEMG and Yale New Haven Health believe that proactive population health management by healthcare providers is essential to enhancing the health of the communities we serve. Therefore, we have made significant investments in information technology, data management, and care coordination. I would like to briefly highlight NEMG's capabilities that will be shared by L&MPA physicians should this CON be approved by OHCA and which are currently unavailable to L&MPA.

**Population Health:**

In 2014, NEMG was selected as one of 89 new Medicare Shared Savings Program ACOs to provide Medicare beneficiaries with access to high-quality, coordinated care. The infrastructure, number of patients, and financial resources required to become an ACO are substantial and typically cannot be met by small physician organizations, such as L&MPA. Once merged, however, L&MPA physicians will be able to participate in the NEMG Medicare ACO and avail itself of its' population health capabilities described below.

Information Technology.

A critical need for managing and coordinating the health of any population is having access to current and historical patient health information across care settings. If the subject CON is approved, L&MPA, will gain access to patient information for all providers on the care team. Easy access to shared medical records, with information about previous hospitalizations, physician office visits or ancillary testing, facilitates the delivery of efficient care that avoids unnecessary duplication of services.

Data Management.

Within NEMG, clinical and utilization data is shared across locations through a unified EMR allowing for greater clinical integration, information

sharing between physicians and physician collaboration while minimizing wasteful, duplicative utilization of scarce resources. Physicians at NEMG currently receive regular dashboard reports regarding their adherence to a number of quality indicators such as screenings, preventative care and medication adherence allowing for discussion and analysis between and among providers. Moreover, NEMG also prepares regular reports that capture the utilization of hospital services, emergency room visits, primary care visits, and post-acute care across a physician's patient panel. These reports enable physicians to view the entirety of an episode of patient care, and collaborate with other providers within NEMG to identify the most efficient and effective way to manage a patient population.

#### Care Coordination.

L&MPA physicians will gain access to clinical pathways and protocols to provide evidence-based practice information to providers to help guide them in selecting the most appropriate tests and clinical interventions for the patient. NEMG currently offers care management services through care coordinators who follow common clinical pathways, address post-acute care needs and have a major focus on reducing unnecessary emergency room visits and 30-day readmissions. These services will be provided to L&MPA practices once part of NEMG and are critical for coordinating care across the region. The care coordinators have a major role in ensuring patients understand their care plan, have access to services needed and receive timely, appropriate follow-up.

#### Efficiency, Quality and Patient Safety.

NEMG has implemented a wide array of systems, standards and tools to ensure success for the physician practice that will be advantageous to the L&MPA physician practices once merged. NEMG has a strong culture of continuous improvement and patient centered care which is led by a Quality Process Improvement Committee and draws upon several practices and tools to ensure the delivery of efficient, safe, and high quality patient care. Our most recent patient

satisfaction scores are upward of the 95<sup>th</sup> percentile compared to national trends for most of our clinic practices. The Quality Process Improvement Committee is a physician constituted committee focused on determining measures and processes to enhance care delivery and quality across the continuum of care. The group establishes metrics and works collaboratively to ensure improvements are achieved across the NEMG.

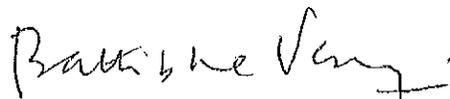
NEMG has also initiated the Lean methodology as one of the key drivers for process improvement. Lean is an approach that supports continuous improvement by achieving changes in processes to improve efficiency and quality. The early successes from this approach have increased physician engagement, patient satisfaction, and patient access. There is a multi-disciplinary oversight group engaged in this cultural and process change effort across NEMG. The medical Chief Experience Officer at NEMG works with providers and office staff to develop, implement and monitor the success of improvement plans related to patient experience. NEMG also offers training and coaching opportunities that have been essential for the cultural shift to improve the patient experience within NEMG offices. NEMG conducts physician practice assessments to ensure standard processes and workflows that allow for optimal patient and provider experience. Additionally, NEMG has developed standard operational dashboards distributed monthly to support process improvement efforts. Primary care practices offer “after-hour” office hours to help minimize the need to access hospital emergency departments and NEMG staff ensure that office visits are scheduled within 7-10 days following the hospitalization to help minimize visits to the emergency department or hospital readmission.

NEMG is critical to Yale New Haven Health’s strategy to address changes in health care delivery and payment, including innovative care models. NEMG, working in concert with other components of the health care system, is essential to achieve superior patient outcomes, efficient operations and ultimately overall financial success. Yale New Haven Health has demonstrated its ongoing commitment to support NEMG, while NEMG supports Yale New Haven Health’s

mission and offers critical access points for patients. We all work together to best serve our communities in this rapidly changing health care environment.

Thank you for your time and attention today and I request your approval of the CON application for the merger of L&MPA and NEMG.

I adopt this prefiled testimony as my own.



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Prathibha Varkey, MBBS, MPH, MHPE, MBA  
CEO  
Northeast Medical Group, Inc.

Attachment I

## CURRICULUM VITAE

**Date of Revision:** 5/11/2016

**Name:** Prathibha Varkey M.B.B.S, M.P.H, M.H.P.E, M.B.A

**Proposed for Appointment to:** Professor, Clinician Educator Track, Department of Internal Medicine

**Term:** on a continuing basis beginning July 1, 2016

**School:** Yale University School of Medicine

**Reason for Appointment:**

**Education:**

M.B.B.S Christian Medical College, Vellore, Tamil Nadu, India 1995  
M.P.H Harvard School of Public Health, Boston, MA 2001  
M.H.P.E University of Illinois Chicago 2007  
M.B.A Carlson School of Management, University of MN 2013

### Career/Academic Appointments

1996-1997 Rotating Intern, Christian Medical College Hospital, Vellore, India  
1997-1998 Resident, Internal Medicine, Hospital of St Raphael, New Haven, CT  
1998-2000 Resident, Internal Medicine, Hospital of St Raphael, New Haven, CT  
2001-2002 Fellow, Preventive Medicine, Mayo Clinic, Rochester, MN  
2002-2003 Instructor of Preventive Medicine Mayo Clinic, Rochester, MN  
2003-2008 Assistant Professor of Preventive Medicine, Mayo Clinic, Rochester, MN  
2004-2008 Assistant Professor of Medicine, Mayo Clinic, Rochester, MN  
2008-2012 Associate Professor of Preventive Medicine, Mayo Clinic, Rochester, MN  
2008-2012 Associate Professor of Medicine, Mayo Clinic, Rochester, MN  
2012-2013 Professor of Preventive Medicine, Mayo Clinic, Rochester, MN  
2012-2013 Professor of Medicine, Mayo Clinic, Rochester, MN  
2013-present Adjunct Professor of Preventive Medicine, Mayo Clinic, Rochester, MN  
2013-present Adjunct Professor of Medicine, Mayo Clinic, Rochester, MN

### Administrative Positions:

2016-present Senior Vice President, Yale New Haven Health System, New Haven, CT  
2016-present Chief Executive Officer, Yale New Haven Health Northeast Medical Group, Stratford, CT  
  
2013-2016 President and CEO of Clinical Enterprise, Seton healthcare family, Austin, TX

**Prathibha Varkey, MBBS, MPH, MHPE, MBA**

- 2013-2016 Interim Chief, Department of Internal Medicine, Seton healthcare family, Austin, TX
- 2014-2016 President, Seton-University of Texas Southwestern University Physicians Group
- 2007-2013 Associate Chair, Department of Medicine, Mayo Clinic, Rochester, MN  
2012-2013 Medical Director, *Better*, Mayo Clinic Global Business Ventures, Rochester, MN  
2013 Medical Director, Value Creation Program, Center for Science of Healthcare Delivery, Mayo Clinic, Rochester, MN
- 2011-2013 Vice Chair, Mayo Clinic Outpatient Practice committee, Rochester, MN  
2011-2013 Senior Medical Editor, Mayo Clinic Global Products and Services, Rochester, MN
- 2011-2013 Associate Chair, Division of Preventive, Occupational and Aerospace Medicine, Mayo Clinic, Rochester, MN
- 2007-2013 Medical Director, Ask Mayo Clinic, Mayo Clinic Global Business Ventures, Rochester, MN
- 2007-2010 Curriculum Director, Quality Improvement, Mayo School of Graduate Medical Education
- 2005-2009 Program Director, Preventive Medicine Fellowship, Mayo Clinic, Rochester, MN  
2005-2008 Director - Quality/Safety/Innovation Program, Division of Preventive Medicine, Mayo Clinic, Rochester, MN
- 2003-2009 Curriculum Director, Quality Improvement, Mayo Medical School, Rochester, MN
- 2002-2003 Founding Member and Associate Director, SPARC Innovation Program, Rochester, MN
- 2002-2005 Associate Program Director, Preventive Medicine Fellowship, Mayo Clinic, Rochester, MN

**Board Certification:**

American Board of Internal Medicine, Internal Medicine, 2000, 2010  
American Board of Preventive Medicine, General Preventive Medicine and Public Health, 2003, 2013

**Professional Honors & Recognition**

**International / National / Regional**

- 2011: Thought leader session: Cooper lecture  
American Association of Medical Colleges, Annual Meeting, Denver, CO
- 2011: Karl Shurson Quality Award - Rochester Area Quality Council, MN
- 2011: Honorable Mention Book Award: American Medical Writers' Association  
"Mayo Clinic Preventive Medicine and Public Health Board Review";
- 2010: Parker Palmer "Courage to Teach" Award - Accreditation Council for Graduate Medical  
Education
- 2009: President's Service Award - American College of Medical Quality
- 2009: William Kane Rising Star Award - American College of Preventive Medicine
- 2009: Physician Leadership in Quality - Minnesota Medical Association
- 2008: Congress Physician Mentor Recognition Award - Women Physicians Congress,  
American Medical Association
- 2004: American Medical Association Foundation Leadership Award

**Institutional**

- 2008: Individual award for excellence - Mayo Clinic, Rochester, Minnesota
- 2005: Excellence through teamwork award - SPARC Team, Center for Innovation, Mayo Clinic

**Grants History**

**Past Grants**

Agency:	Macy Foundation
Title:	"Patient Care through Education: The Mayo Clinic Quality and Safety Curriculum Initiative"
Principal Investigator	Prathibha Varkey, MBBS
Percent effort	20% Year 1, 10% Years 2-3
Total costs for project period:	\$350,000
Project period:	07/2009 - 07/2012

**Prathibha Varkey, MBBS, MPH, MHPE, MBA**

Agency: Robert Wood Johnson Foundation:  
Achieving Competence Today II (ACT II).  
Title: "Enhancing medication reconciliation through  
interprofessional education"

Principal  
Investigator: Prathibha Varkey  
Percent effort: 0%  
Total costs for  
project period: \$25,000  
Project period: 10/2004 - 06/2005

Agency: Association of American Medical Colleges,  
I.D.# Centers for Disease Control  
Regional medicine-public health education center  
and Graduate medical education  
Title: "Mayo Clinic GME--Public Health Education  
Initiative: A pilot project integrating a preventive  
medicine-public health curriculum into a pediatric  
residency"

Principal  
Investigator: Prathibha Varkey  
Percent effort: 0%  
Total costs for  
project period: 15K (estimate)  
Project period 01/2008 - 09/2010

**Invited Speaking Engagements Not Affiliated With Yale**

- 2014: The Innovation Conundrum: Practical Strategies for Transforming Healthcare, Thomas Jefferson School of Public Health, Philadelphia, PA
- 2012: Integrating Quality Improvement and Patient Safety into Medical Education, Stony Brook University
- 2011: Faculty Development and Quality Improvement, Atlantic Health System Morristown, New Jersey
- 2011: TQM, CQI, PDSA: What do all these mean? Enhancing Patient Care Through Quality Improvement, St. Vincent's Hospital, Department of Internal Medicine Grand Rounds
- 2010: Practical Tips for Quality Improvement and Patient Safety Grand Rounds Albert Lea Medical Center, Albert Lea, Minnesota
- 2010: Mentoring Model and Faculty Development Marshfield Clinic Marshfield, Wisconsin

**Prathibha Varkey, MBBS, MPH, MHPE, MBA**

- 2009: Basics of Quality Improvement and Patient Safety Bharateeya Vidhyapeeth Medical College, Pune, India
- 2009: Basics of Quality Improvement and Patient Safety, Trivandrum Medical College, Kerala, India
- 2008: Harvard Medical School Geriatric Fellowship: Practical Tips to Implement Quality Improvement, Massachusetts General Hospital, Boston, Massachusetts
- 2008: Medication Reconciliation and Dissemination of Best Practices, Atlantic Health Residency Programs, Morristown, New Jersey
- 2008: Medication Reconciliation and Dissemination of Best Practices Atlantic Health Residency Programs, Morristown, New Jersey
- 2008: Medication Reconciliation Implementation In All Residency Programs Atlantic Health Residency Programs, Morristown, New Jersey
- 2007: Quality Improvement & Medication Reconciliation Atlantic Health Residency Programs, Morristown, New Jersey

**Peer Reviewed Presentations and Symposia Given at Meetings Not Affiliated with Yale**

**International**

- 2015: Quality Improvement Overview, Quality Improvement workshop, Transforming Quality and patient safety through innovation, education and leadership, Abu Dhabi, UAE
- 2015: Science of Improvement, Transforming Quality and patient safety through innovation, education and leadership, Abu Dhabi, UAE
- 2015: Integrating Quality into training, Transforming Quality and patient safety through innovation, education and leadership, Abu Dhabi, UAE
- 2011: A Frame work for Healthcare Quality Improvement in Brazil, Brazilian Congress of Internal Medicine Annual Meeting, Curitiba, Brazil
- 2011: An Innovative Faculty Development Program Using a Multi-pronged Systems Approach, Association of Medical Education in Europe, Vienna, Austria
- 2008: An Objective Structured Clinical Examination For Assessing Competency in Teamwork, Association of Medical Education in Europe Annual Meeting, Prague, Czech Republic

**Prathibha Varkey, MBBS, MPH, MHPE, MBA**

- 2008: Validity Evidence for an Objective Structured Clinical Examination to Assess Competency in Quality Improvement, 13th Annual Ottawa International Conference on Clinical Competence, Melbourne, Australia
- 2004: Enhancing Patient Care: The Principles of Quality Improvement International Anesthesia and Pain Conference, St. John's Medical College, Bangalore, India
- 2004: Integrating a Quality Improvement Curriculum to Undergraduate Medical Education International Society of Quality Improvement, Amsterdam, Netherlands
- 2003: Empowerment of Women and its Influence on the Health of the Community, Women's Health Review, Quito, Ecuador
- 2003: Depression and Women, Women's Health Review, Quito, Ecuador
- 2003: Epidemiology of Tuberculosis in Primary Refugee Arrivals to MN, International Society of Travel Medicine, New York, New York
- 2002: Epidemiology of Intestinal Parasite Infection in Primary Refugee Arrivals to MN, Asia-Pacific Travel Health Conference Shanghai, People's Republic of China

**National**

- 2016: The role of the board in enhancing quality, American College of Medical Quality institute, Medical Quality 16, Washington, DC
- 2015: Quality and Safety in the Post Graduate Curriculum, Panel Discussion, Medical Quality 2015, Washington, DC
- 2012: Transforming Healthcare through Quality Improvement and Innovation: The Time is Now! 1st Annual California Healthcare Quality and Innovation Colloquium, Oakland, CA
- 2012: Adventures in SBP and PBLI: Integrating Quality Improvement into Graduate Medical Education, Workshop, ACGME Annual Meeting Orlando, FL
- 2011: Thought leader session: Cooper Lecture, Transforming Healthcare Through Systems and Quality Improvement Education: The Time is Now!, American Association of Medical Colleges, Annual Meeting, Denver, Colorado
- 2011: Publishing QI Activities, Teaching Quality Improvement and Patient Safety in Medical Education, Rochester, Minnesota
- 2011: Teaching Quality Improvement: A Collaboration Project between Medicine and Engineering, Medical Education Innovations Conferences, Pasadena, California

**Prathibha Varkey, MBBS, MPH, MHPE, MBA**

- 2010: Quality Improvement, Graduate Medical Education, and Research, Alliance of Independent Academic Medical Centers, New Orleans, Louisiana
- 2009: Training the Physicians of the Future: Integrating Quality and Patient Safety into Our Educational Curriculum, American Association of Medical Colleges Annual meeting Boston, Massachusetts
- 2008: Medication Reconciliation Medication Safety Learning Session, Atlantic Health Residency Programs Meeting, Morristown, New Jersey
- 2007: Designing Patient Safety Learning Experiences in Medical Education "Mayo Medical School Patient Safety Curriculum", American Medical Association, Chicago, Illinois
- 2007: Medication Reconciliation Medication Safety Learning Session, Atlantic Health Residency Programs Meeting, Morristown, New Jersey
- 2007: Changing Culture through Medical Curriculum. Human Factors In Healthcare: Practical Applications to Improve Patient Safety, Mayo Clinic, Rochester, Minnesota
- 2006: Changing the Culture of Quality and Safety through Experiential Education 7th Annual Healthcare Quality Improvement Workshop, American College of Medical Quality, Miami, Florida
- 2005: Behavioral Health Planning For Terrorism and Other Disasters, College of Preventive Medicine, Washington, District of Columbia
- 2005: Educating To Improve Care: Introducing a Quality Improvement Curriculum Mayo Program Directors' Workshop Amelia Island, Florida
- 2005: Medication Reconciliation Annual Forum Of The Institute For Healthcare Improvement, Orlando, Florida
- 2004: TQM, CQI, PDSA, DMAIC: What Do These Mean? Understanding the Concepts of Quality Measurements and Improvements, Christian Medical College Alumni Conference, Charleston, South Carolina
- 2004: Infusing Patient Safety In to The Next Generation Annual Minnesota Alliance Patient Safety Conference, Minneapolis, Minnesota
- 1996: Induced Abortion as a Mode of Spacing, Fortieth All India Congress of Obstetrics and Gynecology, Pune, India

**Professional Service for Professional Organizations**

**Journal Service:**

Associate Editor

2009-2014, *BMC Medical Education*

Editorial Board and reviewer

2008-present, *American Journal of Medical Quality*

*American College of Medical Quality*

2015-present	President
2013-2015	President-elect
2011-2013	Vice President
2009-2011	Secretary
2007-2013	Chair, Professional Development Committee
2007-present	Member, Board of Trustees

*American College of Preventive Medicine*

2009-2013:	Business Committee, member
2009-2013:	Finance Committee, member
2011-2012:	2012 Annual Meeting Program Planning Committee, Chair

**Yale University and Yale New Haven Health System Service**

5/2016 – Present	Member, System Operating Committee
5/2016 – Present	Chief Executive Officer, Board of Trustees, Northeast Medical Group
5/2016 – Present	Member, Nominating and Governance Committee, Northeast Medical Group
5/2016 – Present	Member, Hospitalist Committee, Northeast Medical Group
5/2016 – Present	Member, Network Development / Physician Compensation and Contracts Committee, Northeast Medical Group
5/2016 – Present	Member, Quality and Performance Improvement Committee, Northeast Medical Group
5/2016 – Present	Member, MD LIVE Steering Committee, Yale New Haven Health System
5/2016 – Present	Member, Compliance Committee, Yale New Haven Health System
5/2016 – Present	Member, Institute for Excellence (IFE) Council, Yale New Haven Health System
5/2016 – Present	Member, System Leadership Group, Yale New Haven Health System
5/2016 – Present	Member, System Cabinet, Yale New Haven Health System

**Seton Healthcare Family**

## Prathibha Varkey, MBBS, MPH, MHPE, MBA

2014-2016 President, Seton-UTSW University Physicians group  
2013-2016 President and CEO of Seton Clinical Enterprise  
2013-2016 Interim Chief, Department of Internal Medicine  
2013-2015 Member, Seton CEO Council  
2013-2016 Member, Clinical Enterprise Board  
2013-2015 Member, Ascension Clinical Council  
2013-2015 Member, Ascension Clinical Integration Committee

### Mayo Clinic

2007 – 2008 Member, Mayo Clinic Quality Academy, Quality Academy Council  
2004 – 2008 Member, Department of Education Services, College of Medicine, Mayo Clinic, Mayo Medical School Education Committee  
2002 – 2008 Member, Medical Education Research Group

### Mayo Clinic Rochester Committees

2012 – 2013 Mayo Leadership and Organization Development Advisory Panel  
2010 – 2013 Co-Vice Chair, Outpatient Practice Committee  
2009 – 2013 Member, Facilities Committee – Rochester  
2009 – 2013 Member, Diversity Subcommittee – Physician/Scientist  
2008 – 2010 Member, Continuing Education Committee – Rochester  
2011 Chair, Kasson Family Medicine Clinic Master Planning Task Force  
2008 – 2011 Member, Rochester Clinical Practice Space and Remodeling Committee  
2010 Chair, Mayo 7 and 4 Ophthalmology Master Planning Task Force  
2009 – 2010 Member, Rochester Career and Leadership Development Council  
2006 – 2009 Member, Clinical Practice Quality Oversight Committee  
2003 – 2008 Team Leader, Institute for Healthcare Improvement  
2004 – 2008 Member, Foundation Medical School Education Committee

### Bibliography

#### Peer-reviewed Original Research

1. **Varkey P**, Balakris PP, PrasadJH, Abraham S, Joseph A. The reality of unsafe abortion in a rural community in South India. *Reproductive Health Matters*. 2000 Nov;83-91.
2. Lim L, **Varkey P**, Giesen P, Edmonson L. Cryptosporidiosis outbreak in a recreational swimming pool in Minnesota. *J Environ Health*. 2004; 67(1):16-20.
3. **Varkey P**, Chutka DS, Lesnick TG. The Aging Game: improving medical students' attitudes toward caring for the elderly. *J Am Med Dir Assoc*. 2006 May; 7(4):224-9.
4. **Varkey P**, Reller MK, Smith A, Ponto J, Osborn M. An experiential interdisciplinary quality improvement education initiative. *Am J Med Qual*. 2006 Sep-Oct; 21(5):317-22.

**Prathibha Varkey, MBBS, MPH, MHPE, MBA**

5. **Varkey P**, Hagen PT, Wimsett W, Buchta W. Telemedicine applications in occupational medicine. *Minn Med*. 2006 Nov; 89(11):46-8.
6. **Varkey P**, Jerath AU, Bagniewski SM, Lesnick TG. The epidemiology of tuberculosis among primary refugee arrivals in Minnesota between 1997 and 2001. *J Travel Med*. 2007 Jan-Feb; 14(1):1-8.
7. **Varkey P**, Natt N. The Objective Structured Clinical Examination as an educational tool in patient safety. *Jt Comm J Qual Patient Saf*. 2007 Jan; 33(1):48-53.
8. **Varkey P**, Aponte P, Swanton C, Fischer D, Johnson SF, Brennan MD. The effect of computerized physician-order entry on outpatient prescription errors. *Manag Care Interface*. 2007 Mar; 20(3):53-7.
9. **Varkey P**, Cunningham J, O'Meara J, Bonacci R, Desai N, Sheeler R. Multidisciplinary approach to inpatient medication reconciliation in an academic setting. *Am J Health Syst Pharm*. 2007 Apr 15; 64(8):850-4.
10. **Varkey P**, Cunningham J, Bisping DS. Improving medication reconciliation in the outpatient setting. *Jt Comm J Qual Patient Saf*. 2007 May; 33(5):286-92.
11. **Varkey P**, Jerath AU, Bagniewski S, Lesnick T. Intestinal parasitic infection among new refugees to Minnesota, 1996-2001. *Travel Med Infect Dis*. 2007 Jul; 5(4):223-9.
12. **Varkey P**. Educating to improve patient care: integrating quality improvement into a medical school curriculum. *Am J Med Qual*. 2007 Mar-Apr; 22(2):112-6.
13. **Varkey P**, Schumacher K, Swanton C, Timm B, Hagen PT. Telemedicine in the work site: a study of feasibility, and patient and provider satisfaction. *J Telemed Telecare*. 2008; 14(6):322-5.
14. Irungu TK, **Varkey P**, Cha S, Patterson JM. HIV voluntary counselling and testing in Nakuru, Kenya: findings from a community survey. *HIV Med*. 2008 Feb; 9(2):111-7.
15. **Varkey P**, Karlapudi SP, Hensrud DD. The impact of a quality improvement program on employee satisfaction in an academic microsystem. *Am J Med Qual*. 2008 May-Jun; 23(3):215-21.
16. **Varkey P**, Karlapudi SP, Bennet KE. Teaching quality improvement: a collaboration project between medicine and engineering. *Am J Med Qual*. 2008 Jul-Aug; 23(4):296-301.
17. **Varkey P**, Natt N, Lesnick T, Downing S, Yudkowsky R. Validity evidence for an OSCE to assess competency in systems-based practice and practice-based learning and improvement: a preliminary investigation. *Acad Med*. 2008 Aug; 83(8):775-80.

18. **Varkey P**, Gupta P, Bennet KE. An innovative method to assess negotiation skills necessary for quality improvement. *Am J Med Qual.* 2008 Sep-Oct; 23(5):350-5.
19. Ugwu C, **Varkey P**, Bagniewski S, Lesnick T. Sero-epidemiology of hepatitis B among new refugees to Minnesota. *J Immigr Minor Health.* 2008 Oct; 10(5):469-74.
20. **Varkey P**, Karlapudi SP. A systems approach to teach core topics across graduate medical education programs. *Ann Acad Med Singapore.* 2008 Dec; 37(12):1044-5.
21. North F, **Varkey P**. A retrospective study of adult telephone triage calls in a US call centre. *J Telemed Telecare.* 2009; 15(4):165-70.
22. **Varkey P**, Sathananthan A, Scheifer A, Bhagra S, Fujiyoshi A, Tom A, Murad MH. Using quality-improvement techniques to enhance patient education and counselling of diagnosis and management. *Qual Prim Care.* 2009; 17(3):205-13.
23. Gupta P, **Varkey P**. Developing a tool for assessing competency in root cause analysis. *Jt Comm J Qual Patient Saf.* 2009 Jan; 35(1):36-42.
24. **Varkey P**, Gupta P, Arnold JJ, Torsher LC. An innovative team collaboration assessment tool for a quality improvement curriculum. *Am J Med Qual.* 2009 Jan-Feb; 24(1):6-11.
25. **Varkey P**, Karlapudi S. Lessons learned from a 5-year experience with a four-week experiential Quality Improvement Curriculum in a preventive medicine fellowship. *J of Graduate Medical Education* Sept. 2009, 1; 1(1):93-99.
26. **Varkey P**, Karlapudi S, Rose S, Nelson R, Warner M. A systems approach for implementing practice-based learning and improvement and systems-based practice in graduate medical education. *Acad Med.* 2009 Mar; 84(3):335-9.
27. **Varkey P**, Peloquin J, Reed D, Lindor K, Harris I. Leadership curriculum in undergraduate medical education: a study of student and faculty perspectives. *Med Teach.* 2009 Mar; 31(3):244-50.
28. **Varkey P**, Karlapudi S, Rose S, Swensen S. A patient safety curriculum for graduate medical education: results from a needs assessment of educators and patient safety experts. *Am J Med Qual.* 2009 May-Jun; 24(3):214-21.
29. Daniel DM, Casey DE Jr, Levine JL, Kaye ST, Dardik RB, **Varkey P**, Pierce-Boggs K. Taking a unified approach to teaching and implementing quality improvements across multiple residency programs: The Atlantic Health experience. *Acad Med.* 2009 Dec; 84(12):1788-95.

**Prathibha Varkey, MBBS, MPH, MHPE, MBA**

30. North F, **Varkey P**. How serious are the symptoms of callers to a telephone triage call centre? *J Telemed Telecare*. 2010; 16(7):383-8.
31. **Varkey P**, Kureshi S, Lesnick T. Empowerment of women and its association with the health of the community. *J Womens Health (Larchmt)* 2010 Jan; 19(1):71-6.
32. Hernandez JS, Dale JC, Bennet KE, **Varkey P**. Challenges and opportunities for medical directors in pathology and laboratory medicine: standardization, integration, and innovation. *Am J Clin Pathol*. 2010 Jan; 133(1):8-13.
33. Wittich CM, Reed DA, McDonald FS, **Varkey P**, Beckman TJ. Transformative learning: a framework to link the improvement competencies in graduate medical education. *Acad Med*. 2010 Nov; 85(11):1790-3
34. Burton MC, Kashiwagi DT, Kirkland LL, Manning D, **Varkey P**. Gaining efficiency and satisfaction in the handoff process. *J Hosp Med*. 2010 Nov-Dec; 5(9):547-52.
35. North F, **Varkey P**. Use of the prioritization matrix to enhance triage algorithms in clinical decision support software. *Am J Med Qual*. 2010 Nov-Dec; 25(6):468-73.
36. North F, **Varkey P**, Bartel GA, Cox DL, Jensen PL, Stroebel RJ. Can an office practice telephonic response meet the needs of a pandemic? *Telemed J E Health*. 2010 Dec; 16(10):1012-6.
37. North F, Odunukan O, **Varkey P**. The value of telephone triage for patients with appendicitis. *J Telemed Telecare*. 2011;17(8):417-20.
38. North F, Muthu A, **Varkey P**. Differences between surrogate telephone triage calls in an adult population and self calls. *J Telemed Telecare*. 2011; 17(3):118-22.
39. North F, **Varkey P**, Laing B, Cha SS, Tullidge-Scheitel S. Are e-health web users looking for different symptom information than callers to triage centers? *Telemed J E Health*. 2011 Jan-Feb; 17(1):19-24.
40. Kirkland LL, Kashiwagi DT, Burton MC, Cha S, **Varkey P**. The Charlson Comorbidity Index Score as a Predictor of 30-Day Mortality After Hip Fracture Surgery. *Am J Med Qual*. 2011 Mar 30.
41. **Varkey P**. Practice-based Improvement Curricula: A critical opportunity to educate future physicians and leaders. *Journal of Graduate Medical Education*. 2011 March; 3:12-13
42. Sood A, Prasad K, Schroeder D, **Varkey P**. Stress management and resilience training among department of medicine faculty: a pilot randomized clinical trial. *J Gen Intern Med*. 2011 Aug; 26(8):858-61.

**Prathibha Varkey, MBBS, MPH, MHPE, MBA**

43. **Varkey P**, Billings M, Mathews G, Voigt R. Integrating a preventive medicine-public health curriculum into a pediatric residency. *Am J Prev Med.* 2011 Oct;41(4 Suppl 3):S314-6.
44. Kashiwagi DT, Burton MC, Kirkland LL, Cha S, **Varkey P**. Do Timely Outpatient Follow-up Visits Decrease Hospital Readmission Rates? *Am J Med Qual.* 2012 Jan;27(1):11-5.
45. Morgenthaler TI, Lovely JK, Cima RR, Berardinelli CF, Fedraw LA, Wallerich TJ, Hinrichs DJ, **Varkey P**. Using a Framework for Spread of Best Practices to Implement Successful Venous Thromboembolism Prophylaxis Throughout a Large Hospital System. *Am J Med Qual.* 2012 Jan;27(1):30-8.
46. North F, Ward W, **Varkey P**, Tullidge-Scheitel S. Should you search the Internet for information about your acute symptom? *Telemed J E Health.* 2012 Apr;18(3):213-8.
47. Newcomb R, Buchta W, Molella R, Sturchio G, Hagen P, **Varkey P**. Is an Occupational Examination superior to an Occupational Health History Alone for Pre-placement Screening in Health Care Settings? *J Occup Environ Med.* 2012 Mar;54(3):276-9
48. **Varkey P**, Jatoi A, Williams A et al. The impact of a facilitated peer mentoring program on academic skills and networking for women faculty. *BMC Med Educ.* 2012 Mar 23;12:14.
49. Kirkland L, Malinchoc M, O'Byrne M, Benson J, Kashiwagi D, Burton C, **Varkey P**, Morgenthaler, T. A Clinical Deterioration Prediction Tool for Internal Medicine Patients. *Am J Med Qu* 2013 Mar;28(2):135-42.
50. Dyrbye LN, **Varkey P**, Boone SL, Satele DV, Sloan JA, Shanafelt TD. Physician Satisfaction and Burnout at Different Career Stages. *Mayo Clin Proc.* 2013 Dec; 88(12):1358-67
51. Sturchio GM, Newcomb RD, Molella R, **Varkey P**, Hagen PT, Schueler BA. Protective Eyewear Selection for Interventional Fluoroscopy. *Health Phys.* 2013 Feb;104 (2 Suppl 1):S11-6.
52. North F, Richards DD, Bremseth KA, Lee MR, Cox DL, **Varkey P** and Stroebel RJ. Clinical decision support improves quality of telephone triage documentation - an analysis of triage documentation before and after computerized clinical decision support. *BMC Medical Informatics and Decision Making* 2014, 14:20.
53. Kashiwagi DT, Burton MC, Hakim FA, Manning DM, Klocke DL, Caine NA, Hembre KM, **Varkey P**. Reflective Practice: A Tool for Readmission Reduction. *Am J Med Qual.* 2015 Feb; 1-6

**Chapters, Books and Reviews**

## Chapters

54. **Varkey P**, Hagen PT. Principles of biostatistics and epidemiology in clinical preventive medicine. In: Lang RS, Hensrud DD, editors. Clinical preventive medicine. 2nd Edition. Chicago: American Medical Association; 2004. p. 11-22.
55. **Varkey P**, Millman MP. Preventive Medicine. In: Ghosh AK. Mayo Clinic Internal Medicine Review. 8th ed. Rochester: Mayo Clinic Scientific Press; 2008. p. 839-60.
56. Kollengode A, **Varkey P**. Chapter 2. In: Implementation and use of approaches to quality. 1st ed. 2010.
57. Majka A, **Varkey P**. Ch 18: Medical Quality Management. In Varkey P, editor. In: Mayo Clinic Preventive Medicine Concise review. Mayo Clinic Scientific Press and Oxford Press; 2010. p. 287-297.
58. Majka A, **Varkey P**. Medical quality management. In: Varkey P editor. Mayo Clinic preventive medicine and public health board review. Rochester: Mayo Clinic Scientific Press; 2010. p. 287-97.
59. Millman MP, **Varkey P**. Preventive medicine. In: In: Ghosh AK; et al, editor.. Mayo Clinic internal medicine board review. 9th ed. Rochester: Mayo Clinic Scientific Press; 2010. p. 749-70.
60. **Varkey P**. Basics of quality improvement. In: Varkey P, editor. Medical quality management: theory and practice. Rev Edition. Sudbury: Jones and Bartlett Publishers; 2010. p. 1-28.
61. **Varkey P**, Kollengode A. A Framework for Healthcare Quality Improvement in India: The Time is here and now! Postgrad Med. 2011 Jul-Sep;57(3):237-41.

## Books

62. **Varkey P**. Medical quality management: theory and practice. Varkey P, editor. Rev ed. Sudbury: Jones and Bartlett Publishers; 2010.
63. **Varkey P**. Mayo Clinic preventive medicine and public health board review. Rochester: Mayo Clinic Scientific Press; 2010.
64. **Varkey P** (Section Editor). "Common Problems" in Mayo Clinic Guide to Self-Care. Millman M. 6 ed. 2010.

## Reviews

65. **Varkey P**, Poland GA, Cockerill FR, Smith TF, Hagen PT. Confronting bioterrorism: Physicians on the front line. Mayo Clin Proc. 2002 Jul; 77(7):661-72.

**Prathibha Varkey, MBBS, MPH, MHPE, MBA**

66. **Varkey P**, Athyal VP. Service delivery innovations at Mayo Clinic. *Minn Med*. 2005 Dec; 88(12):39-42.
67. Patel AM, Sundt TM 3rd, **Varkey P**. Complexity science: core concepts and applications for medical practice. *Minn Med*. 2008 Feb; 91(2):40-2.
68. **Varkey P**, Horne A, Bennet KE. Innovation in health care: a primer. *Am J Med Qual*. 2008 Sep-Oct; 23(5):382-8
69. Hernandez JS, **Varkey P**. Vertical versus lateral thinking. *Physician Exec*. 2008 May-Jun; 34(3):26-8.
70. **Varkey P**, Hernandez JS, Schwenk N. 6 techniques for creative problem solving. *Physician Exec*. 2009 May-Jun; 35(3):50-3.
71. **Varkey P**, Hernandez JS, Schwenk N. 6 techniques for creative problem solving. *Physician Exec*. 2009 May-Jun; 35(3):50-3.
72. **Varkey P**. Practical tips and strategies for designing and implementing interprofessional curricula. *Educ Prim Care*. 2010 Jan; 21(1):41-4.
73. **Varkey P**, Bennet KE. Practical techniques for strategic planning in health care organizations. *Physician Exec*. 2010 Mar-Apr; 36(2):46-8.
74. **Varkey P**, Antonio K. Change management for effective quality improvement: a primer. *Am J Med Qual*. 2010 Jul-Aug; 25(4):268-73.
75. Murad MH, Coto-Yglesias F, **Varkey P**, Prokop LJ, Murad AL. The effectiveness of self-directed learning in health professions education: a systematic review. *Med Educ*. 2010 Nov; 44(11):1057-68.
76. **Varkey P**, Murad MH, Braun C, Grall KJ, Saoji V. A review of cost-effectiveness, cost-containment and economics curricula in graduate medical education. *J Eval Clin Pract*. 2010 Dec; 16(6):1055-62.
77. Roeber-Rice H, **Varkey P**. A Review of Recommendations for Adult Immunizations. *J Assoc Physicians India*. 2011 Sep;59:568-72.
78. Kirkland LL, Kashiwagi DT, Brantley S, Scheurer D, **Varkey P**. Nutrition in the hospitalized patient. *J Hosp Med*. 2013 Jan;8(1):52-8.
79. Kashiwagi DT, **Varkey P**, Cook DA. Mentoring programs for physicians in academic medicine: a systematic review. *Acad Med*. 2013 Jul;88(7):1029-37.
80. Mohammed K, Nolan MB, Rajjo T, Shah ND, Prokop LJ, **Varkey P**, Murad MH.

**Prathibha Varkey, MBBS, MPH, MHPE, MBA**

Creating a Patient-centered Healthcare Delivery System: A Systematic Review of Healthcare Quality from the Patient Perspective. *Am J Med Qual.* 2016 Jan;31(1):12-21

**Invited Editorials and Commentaries**

81. **Varkey P**, Resar RK. Medication reconciliation implementation in an academic center. *Am J Med Qual.* 2006 Sep-Oct; 21(5):293-5.
82. **Varkey P**, Diamond LH. ACMQ launches its new comprehensive textbook on medical quality management. *Am J Med Qual.* 2009 Jan-Feb; 24(1):77-8.

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS**

**MERGER OF L&M PHYSICIAN ASSOCIATE, INC. AND NORTHEAST MEDICAL GROUP, INC.** : **DOCKET NO. 15-32032-CON**  
:   
:   
: **July 11, 2016**

**PRE-FILED TESTIMONY OF BRUCE D. CUMMINGS, PRESIDENT AND  
CHIEF EXECUTIVE OFFICER OF LAWRENCE + MEMORIAL  
CORPORATION**

Good afternoon, Attorney Hansted, and staff of the Office of Health Care Access (“OHCA”). My name is Bruce D. Cummings and I am the President & Chief Executive Officer of Lawrence + Memorial Corporation (“L+M”), the parent corporation of Lawrence + Memorial Hospital, Westerly Hospital, L&M Physician Association, Inc., and the Visiting Nurse Association of Southeastern Connecticut Inc., otherwise and collectively known as the L+M Healthcare System. I am grateful to have this opportunity to speak with you and convey the many reasons for recommending to OHCA that it approve the above-referenced application (the “Application”) which will allow L&MPA to merge with Northeast Medical Group, Inc. (“NEMG”) (collectively, the “Applicants”).

By now, you have heard the testimony of representatives of both L+M and Yale New Haven Health System (“YNHHS”) who in earnest have tried to convey to OHCA the importance that this application and the application set forth in Docket No. 15-32033 have with respect to the future wellbeing of L+M. In particular, you have heard from Dr. Lehrach who spoke of the financial challenges that L&MPA faces and more importantly, the access that L&MPA provides to the most vulnerable patients in our

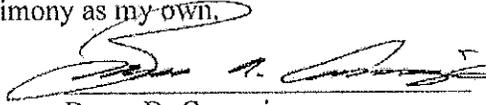
community. More specifically, you have heard that if L&MPA physicians were not providing services to these patients that these patients may lose access to services. You have also heard from me that declining revenue and increasing hospital taxes have made it nearly impossible for L+M Hospital to continue to subsidize L&MPA to provide these needed and valuable services to the community. You have heard how difficult it has been for L+M to recruit and retain physicians and how L&MPA does not have the scale or the capital to create the necessary infrastructure to participate in risk-based contracts. The proposed merger of L&MPA with NEMG makes tremendous sense both from the perspective of achieving greater efficiencies and allocating costs across a larger group of physicians. The proposed merger also promotes greater clinical integration, collaboration and care management among providers and allows for more seamless transitions of care and avoidance of duplicative or medically unnecessary care.

We have heard that some in the community are concerned about losing jobs in the L+M Eastern Connecticut region. We share this same concern and that is the very reason why we propose this affiliation as a solution to L+M's current financial instability. We want to preserve jobs in the community and we can only do so if we have the financial stability to enhance our clinical offerings remain a vibrant provider.

We understand that the application for the proposed merger of L&MPA is integrally tied to the affiliation between L + M and YNHHS, but we believe that OHCA should decide this application on its own merits and not be persuaded by the obstacles that have been imposed by Executive Order No. 51. Notwithstanding, the proposed affiliation between L+M and YNHHS is clearly beneficial and essential to our

community and without approval or delay of approval from OHCA, it is my sincere belief and opinion that irreversible harm will result for L&MPA and L+M as a system. If we are going to maintain diversity in the providers in the Eastern region of Connecticut, maintain access for the most vulnerable patients, and maintain and enhance service offerings, I urge OHCA to approve both applications without any delay.

I hereby adopt this pre-filed testimony as my own.

A handwritten signature in black ink, appearing to read "Bruce D. Cummings", written over a horizontal line.

Bruce D. Cummings  
President & CEO  
Lawrence + Memorial Corporation

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July 1, 2016

Via Email and Hand Delivery

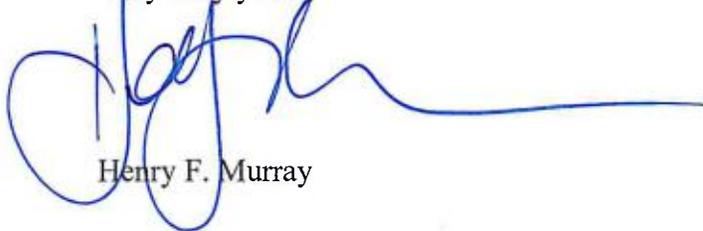
Kimberly Martone, Director of Operations  
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Department of Public Health  
State of Connecticut  
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**Re: Certificate of Need Applications,  
OHCA Docket No. 15-32032-CON, Merger of L & M Physicians Association and  
Northeast Medical Group, Inc. and,  
OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial  
Corporation and Yale New Haven Health Services Corporation**

Dear Ms. Martone and Mr. Hansted:

Attached please find originals and two copies of pre-file testimony submitted by the  
Intervenors in the above captioned matters. Thank you.

Very truly yours,



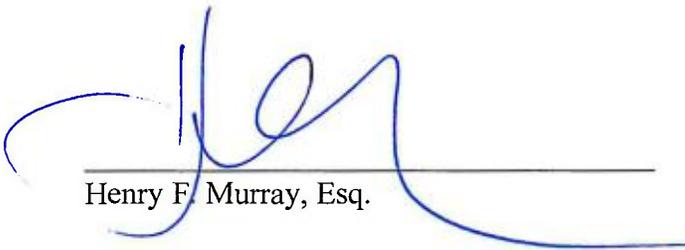
Henry F. Murray

HFM:vds  
Enclosure

## CERTIFICATION

This certifies that the Intervenor's pre-file testimony was sent via email and First Class Mail, pre-paid on July 1, 2016, to the following counsel of record:

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TESTIMONY to the Office of Health Care Access  
July 1, 2016

**Re: CON application regarding acquisition of Lawrence & Memorial Hospital and its physicians' group by Yale-New Haven Health System**

Ellen Andrews, PhD, Executive Director

My name is Ellen Andrews. I reside at 49 Wilkins St., Hamden Connecticut. I am Executive Director of the Connecticut Health Policy Project. I'm here today to urge OHCA not to approve the application of Yale-New Haven Health System to take over Lawrence and Memorial Health.

We are in the midst of enormous transition in our health care system. The Affordable Care Act has enabled 16 million Americans to gain health insurance coverage, and covered thousands of Connecticut's previously uninsured residents. The ACA offers ongoing incentives and supports to help our state get coverage for the remaining 250,000 uninsured that live in Connecticut.

But not all the news is good. The continued consolidation of providers and insurers is driving an ongoing cost spiral that threatens to undo much of the positive change that we've seen in the past few years. . Dr. Hyde has described the overwhelming body of research demonstrating that as competition is drained from our health care system, costs inevitably go up, and consumers lose choice.

The Connecticut Health Policy Project is particularly concerned about the impact of these trends on low income and underserved communities, the state budget and the growing trend of underinsurance among those with private coverage.

Connecticut has received national recognition for its work reining in Medicaid costs.<sup>1</sup> We are the only state to take back Medicaid recipients from private managed care plans and negotiate provider rates ourselves. That decision and resulting reforms has reduced per member costs, increased the number of physicians participating in the Medicaid program, and reduced emergency room visits. More people covered for less money seen by more providers and better quality care in the appropriate setting. Sounds like a win.

But it hasn't been enough. Underlying provider prices are destroying access to care for many in our state. Due to budget constraints, 11,677 working parents are losing HUSKY coverage at the end of this month. Medicaid beneficiaries in high cost areas like New Haven still struggle to get appointments. HUSKY families "transitioning" to coverage in AccessHealthCT insurance plans, our state's health insurance exchange, are expected to meet a \$500 deductible and spend 10-12% of their income on health care. Enrollees in AccessHealthCT plans face enormous

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<sup>1</sup> Melinda Beck, "Connecticut Moves Away From Private Insurers to Administer Medicaid Program," *Wall Street Journal*, March 18, 2016. <http://www.wsj.com/articles/connecticut-moves-away-from-private-insurers-to-administer-medicaid-program-1458325696>

deductibles as subsidies decrease up the income scale. Even workers with decent jobs are increasingly stuck in cost-prohibitive plans. Nearly a quarter of workers are in high deductible plans, up from just 4% in 2006. According to the Kaiser Family Foundation deductibles have increased at nearly seven times the rate of workers' earnings.

Some policymakers insist that high cost sharing is necessary to reduce excess utilization. But utilization isn't really our main problem. Despite progress, Medicaid members, the remaining uninsured and the growing ranks of underinsured state residents still struggle to access recommended care. The US has the highest health care costs by far in the world – we spend twice as much per person on average as the rest of the world, and nobody spends even three quarters as much as we do. Except for Switzerland, we already have the highest out of pocket costs. So if out of pocket costs are the solution, why isn't the problem solved?

As Dr. Hyde's literature review shows, our problem is price, not utilization, and monopoly creates a disaster for prices. Jason Pelletier's testimony contains a shocking fact – workers at a corporate cafeteria run by a global food service company serving food to workers at one of the most profitable companies in the world are forced to go without health insurance or be covered by state assistance programs because their premium share is too high. Shame on those employers, but let's not kid ourselves. Employers are fighting with workers over premiums because underlying provider prices are forcing them to.

And when you lose your coverage, or your deductible goes up to five thousand dollars, what happens? You go to the doctor, and, now that the hospitals are buying up all the doctors, you get charged a facility fee for the privilege of seeing a new sign on your doctor's office door. You find yourself choosing between rent, food, and the electric bill for your family or going to the doctor for yourself.

To approve this CON, OHCA must look the public in the eye and say "Yale is different." Unlike all the other giant monopolies, Yale will throw away its monopoly bargaining advantage and keep prices low. Or you must say "New London County is different." For some reason Yale won't buy up all the doctors the way they have in the New Haven area.

No one can take those arguments seriously. One of the few things that Yale's proposed \$300 million investment clearly identifies as a specific priority is physician recruitment. To most of us, that suggests recruiting neurologists to move to New London so that telemedicine visits or an hour's drive to New Haven aren't patients' only options. But Yale's past behavior in the New Haven area suggests that money is earmarked for physician practice acquisitions – which means more market power, more facility fees, higher prices and people skipping needed care because of cost.

Perhaps the most telling passage in the CON can be found on page 34. Asked how "low income persons, racial and ethnic minorities, disabled persons and other underserved groups" will benefit from the proposal, YNHHS replies that L+M and YNHHS provide services to the uninsured, underinsured and all patients regardless of race, ethnicity, income or ability to pay. "That will not change as a result of this proposal."

The proposal offers no visions for improvement of services to underserved populations save for the general clinical benefits presumed to accrue to all patients. One must assume that this, like so many other specifics, would be left to the post-acquisition strategic planning process to decide. The rest of us are supposed to wait and hope.

As a member of the Governor's Health Care Cabinet, I view this proposal as the leading example of one of the most dangerous trends in health care, and one of the few key issues we must grapple with to set Connecticut on course

for an accountable 21<sup>st</sup> Century health care system. I urge you not to rule on this application until my colleagues and I, and our counterparts on the Certificate of Need Task Force have completed our recommendations. If you must rule before that, you must deny the application. Without dramatic changes to address the issues of access, price and quality within a framework of true accountability to the community and protections for underserved and at-risk residents, you must deny it whenever it ripens for decision. There is no public need for this deal and very great risk to state residents and the state's budget.

Pre-file testimony from Stephen R. Smith, M.D., M.P.H.

My name is Stephen R. Smith, M.D. I am a professor emeritus of family medicine at the Warren Alpert Medical School of Brown University. I live in New London.

I am a family physician working at the Community Health Center of New London. I also speak on behalf of the National Physicians Alliance in Connecticut. This group includes physicians from a variety of different specialties who serve on the medical staff and/or work as community-based physicians who refer their patients to either Yale/New Haven Hospital or Lawrence and Memorial (L+M) Hospital.

I am also speaking on behalf of the Universal Health Care Foundation of Connecticut in my capacity as a member of the board of directors of the Connecticut Health Advancement and Research Trust (CHART), the parent organization of the foundation.

I am a lifelong resident of New London residing at 899 Montauk Avenue and have served on the medical staff at Lawrence and Memorial Hospital in the past.

The initial position that the Office of Health Care Access should take when considering any hospital merger or acquisition is that such mergers are not in the best interest of the public and should be denied. As our testimony has previously shown, hospital mergers are, by their very nature, anti-competitive and generally lead to higher prices without concomitant improvements in efficiency, quality, accessibility, or accountability. Mergers and acquisitions should be permitted *only* when convincing evidence has been presented demonstrating that no other means is available to achieve the purported goals of the merger that would serve the community's interests in preserving high-quality, affordable, and accessible health services.

The proposed acquisition of L+M by Yale/New Haven Health Services Corporation does not demonstrate any compelling public interest, or evidence suggesting a public good.

Close clinical coordination and cooperation is already achieved between the two institutions and with health care providers in the community without the benefit of formal acquisition.

As a family physician working in an independent community health center in New London, I already have instant access to the L+M computers to obtain laboratory data, x-ray reports, emergency room reports, and hospital discharge summaries on my patients. If a patient of our health center is seen in the emergency room at L+M, procedures already exist that allow the emergency physician to schedule a visit for the patient with us within 24 hours. Yet our community health center and L+M are separate, independent entities.

I already have excellent relationships with the specialists at Yale/New Haven, many of whom have office hours at L+M for the convenience of our patients. Yale/New Haven specialists have often called me on the telephone to discuss mutual patients with serious vascular problems and pulmonary conditions. At their behest, I have seen the patients and ordered tests and managed their conditions in between visits to the specialists in New Haven. All of this is done without the need for one hospital to “own” the other, especially given all of the bad results from such ownership.

The neonatal intensive care unit at L+M is already staffed by Yale/New Haven neonatologists. The NICU staff already arrange for babies to be seen within 24 hours at our community health center following their discharge. This occurs without the necessity of L+M being owned by Yale/New Haven.

This and other evidence demonstrates that close clinical coordination and cooperation already exists between L+M and Yale/New Haven. This clinical coordination already exists between Yale/New Haven personnel and community health providers in the New London area. The formal acquisition of L+M by Yale/New Haven is neither required nor justified to achieve clinical goals—that is, to serve our patients.

Should the Office of Health Care Access nevertheless consider approval of such an acquisition, it must condition such an acquisition on agreement by both parties to stipulations that would safeguard health care services in Southeastern Connecticut. These stipulations should be in force for at least 10 years and would include:

- Retaining existing health services in the New London community and not outsourcing them to other Yale hospitals or relocating them to more affluent communities in the L+M service area
- Freezing the prices charged and negotiated by L+M to existing levels with annual increases no greater than the Consumer Price Index
- Ensuring help with any transportation for health care that has to be delivered at another hospital
- Expanding health services to Southeastern Connecticut by fully funding and implementing all the recommendations emanating from the 2016 Community Health Needs Assessment conducted by L+M and the Ledge Light Health District
- Requiring that L+M and Yale/New Haven negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs
- Assuring that L+M Hospital remains under the control of a locally controlled and locally elected Board of Directors with decision making authority and accountability to the community.

The Office of Health Care Access must consider this proposed acquisition in the context of the entire state's health care system. Consolidation of the health care system is not in the best interests of patients or communities. Consolidation weakens accountability to the communities these hospitals serve. Consolidation erodes competition and innovation, increase costs, and provides little or no additional benefits in terms of quality, safety, or accessibility.

I urge the Office of Health Care Access to deny the proposals to transfer ownership of L+M to Yale/New Haven Health Services Corporation and the merger of L&M Physician Association, Inc. into Northeast Medical Group, Inc.

Stephanie Johnson, RPSGT  
President, AFTCT Local 5051 LPN/Technologists  
43 Converse Pl.  
New London CT  
(c) 860-961-1635

Pre-filed Testimony  
July 1, 2016  
Office of Health Care Access

My name is Stephanie Johnson and I am the president of AFTCT Local 5051 which represents more than 270 LPN's and Technologists at Lawrence Memorial Hospital. I am a 15 year employee, the last 13 years being in my current position as a polysomnographic technologist and a resident of East Lyme. Today I am here to ask you, Office of Health Care Access, to follow Governor Malloy's directive to hold off on this takeover of Lawrence Memorial Hospital by Yale New Haven Hospital.

As a caregiver in the hospital and as president of the union, I have seen many changes and understand that sometimes change is necessary. In this instance I would say that not only is this change for the sake of change but also the changes that are made can be devastating to our community. I have reservations about many things but primarily I am concerned about access to the quality care that we provide. I think it is irresponsible for a community hospital to not be there for the region we are supposed to be here to care for. The story has already played out in Windham, how long before it reaches New London and Westerly?

I was at a meeting held jointly by L&M and Yale recently and heard for myself from Bruce Cummings, CEO of L&M Hospital that Westerly Hospital does not have the physical footprint that the hospital needs to do inpatient and outpatient services. As an employee of the New London hospital, which is also land locked and has constraints that might prevent future growth, how long until we are told that the services we provide are not going to continue. How far will our patients have to travel to receive care? I am not just a care giver but I also utilize the hospital for my care. I was born at Lawrence and Memorial Hospital, gave birth to my son there and have said final good byes to close relatives who died there. I cannot imagine having to drive to Yale to visit a sick family member and more importantly, I cannot imagine how our patients who may not have the benefit of transportation and rely on public transportation will get there.

Decisions about which services will be kept at both campuses will be made by Yale. We are asking for assurances that services for our patients will not be made by a board that seeks to fatten the already large pocket of Yale New Haven's system, as there will no longer be any viable competition which. That means reduced patient's choice to seek care at a lower cost. I have personally read the bylaws changes in the Certificate of Need and have seen the handover of control to Yale. When I asked about it, I was not taken seriously and told "Oh those are just words written in the contract." Luckily, I know how to read contracts.

We were surprised to see Yale and L+M say that L+M lacks the financial and clinical resources to run the programs necessary to take care of our community. We've watched management spend \$17 million dollars that could have gone to take care of people in Greater New London on strikebreakers, lawyers

and other expenses to lock their workers out of their jobs. We've watched management spend \$35 million dollars to buy an unprofitable hospital out of bankruptcy. We've watched management spend more \$78 million of our hospital's profits subsidizing the growth of its physician practice, and now Yale-New Haven says the combined NEMG/LMPA practice will run \$70 million a year in losses.

All of that money could have, and should have gone to strengthening our hospital's clinical programs. Instead, we see staffing cuts, the first of what may be many. In the CON, Yale-New Haven says it doesn't have any planned service cuts, but it may reduce "duplicate" services in the future. We are concerned that the duplicate services may simply be the profitable services, which will be extracted from the hospital and placed far from New London, where poorer patients and those who need help with transportation will struggle with access.

When you look at this proposal, make sure you ask what Yale's goals will be. We've already lived under management that thought they were building a small empire. Now the biggest empire in the state wants to take over.

We are asking that services be made available to this community in this community. We are asking that the community be made aware of who will be in control of these services. We are asking that any promises be guaranteed, in writing, with enforcement and oversight by the community. We are asking for you, Office of Healthcare Access to slow down this process. If, after all is said and done, and the bodies that Governor Malloy put in place to look into the laws that govern deals like this find that our concerns are not necessary, we can start a new conversation about the future of L+M, Yale and our health care system. Please allow the process to be followed, and give us time so that all questions can be asked and answered—truthfully.

Pre-filed testimony of Jason Pelletier

Office of Health Care Access

Docket #s 15-30233 CON and 15-30233, Acquisition of L+M Health Care by Yale-New Haven Health Services Corporation and Merger of Lawrence and Memorial Physicians Association into Northeast Medical Group

June 30, 2016

My name is Jason Pelletier. I live at 28 E Street, Groton Connecticut. I am a cook in the cafeteria at Pfizer in Groton, and a shop steward for UNITE HERE Local 217.

I am now almost 49 years old and have always been in great health until last year, when I contracted Lyme disease. After a run of antibiotics, all was well until symptoms started to recur this year.

My health care coverage is very important in order to cover costs of recurring doctor visits and prescriptions. I am also concerned about having adequate health coverage as I get older and have more health issues.

We are in in contract negotiations with our employers. So are 7 other corporate cafeterias in Connecticut that are operated by Compass, including our brothers and sisters at Electric Boat. We pay 20% of our premiums now, and are trying to reduce that percentage at the bargaining table.

The cost of employees' share of the premiums went up by 10% last October. That means that everyone who had coverage had a big bite taken out of the raises that we negotiated with our employer. We have a really good health plan and have fought to keep costs down, but I have coworkers who are uninsured or on state assistance because they can't afford the premiums.

Before I talk about Yale taking over our hospital, I want to tell you how hard our union works on health care costs. Our health plan, UNITE HERE Health, is run jointly by our union and employers in our industries. Workers in our union take leave from their jobs for several weeks to educate their coworkers and help them sign up for a primary care doctor and get their biometric tests so that they can work with our health plan to improve their health and avoid going the hospital. We have run a union-wide education program to educate our coworkers on how to tell the difference between a health care problem and a real emergency, and to use Urgent Care or see their doctors instead of the Emergency Room, unless they really need to go. As a steward, I'm trained to help my coworkers use health care the right way, and to help them connect with our health plan if they have problems.

But that won't matter if prices for hospitals and doctors go up because Yale takes over our hospital. Even if we convince our employer to lower the percentage of the premiums that we pay, if the care itself gets more expensive, premiums will go up and we'll be paying what we paid before. Please stop this takeover, or, if it is approved, make Yale-New Haven guarantee in writing that they won't raise prices.

We don't make a lot of money. As a cook, I make \$16.44 an hour, and I'm one of the better paid people in our workplace. I'm fortunate to have full-time hours and a steady paycheck. But none of us can afford

to pay more for health care. Affordable health insurance has always been important to me, but where I'm at in my life now, I can't do without it. Thank you.

**Pre-filed Testimony  
July 1, 2016**

Fred Hyde, M.D.  
57 Main Street  
Ridgefield, CT 06877

**A. General Background**

- (1) The proposed acquisition of L+M Health Corporation (L+M) by Yale-New Haven Health Services Corporation (YNHHSC) comes at an important moment in the American and Connecticut health care systems.
- (2) The Patient Protection and Affordable Care Act (PPACA) has failed to control the ongoing growth of health care costs.
- (3) In the five years since passage of the PPACA, private sector health care insurance premiums grew at three times the rate of general inflation, faster in relation to inflation than during the five years prior to passage.
- (4) A portion of this increase in health and hospital expense can be *directly attributable to the consolidation of hospitals and health systems*. These consolidations result in:
  - (a) Higher prices through monopoly market position;
  - (b) Inflated expenses resulting from more complex and more generously compensated management, with hospital administration now accounting for 1.43% of the nation's Gross Domestic Product; and
  - (c) Compromise to the integrity of physician judgment when such hospital and health system consolidations include physician practices.
- (5) The burden of these costs falls on the patient, the patients' families, and society, through higher health insurance premiums, higher out-of-pocket payments and compromises to choice and freedom. The Kaiser Family Foundation reports that insurance deductibles grew nearly seven times faster than worker earnings in the five years following PPACA passage.
- (6) This is the background against which OHCA is called upon to evaluate yet another attempt at monopoly acquisition (another hospital by a health system) and consolidation of institutional control over professional judgment through hospital-sponsored medical groups.
- (7) *OHCA's task is non-delegable*. Legal redress opposing or attempting to remedy hospital monopolies has proven to be unreliable: even when "after-the-merger" remedies or checks are in place, inevitable cost increase occurs.

The FTC has allowed the Hart-Scott-Rodino review period to lapse, and the federal government continues to struggle to win cases under antitrust laws.

- (8) OHCA awards a Certificate of Need "franchise" to private corporations which are engaged in publicly funded services: *the award must be based on the public good, not on private gain.*

One state with challenges parallel to those of Connecticut is Massachusetts. Testimony is offered on the applicability of findings from that state to the challenge facing OHCA in this and similar Certificate of Need applications.

B. The Applicants assert these arguments in support of Docket No. 15-32033-CON (**affiliation of Lawrence + Memorial Corporation with Yale-New Haven Health Services Corporation**), and Docket No 15-32032, (**merger of L&M Physician Association and Northeast Medical Group**):

(1) Lawrence + Memorial as a system *does “not have the clinical and financial resources” to “integrate service delivery and assume responsibility for achieving specific quality, cost and service outcomes.”*<sup>1</sup>;

a. Lawrence + Memorial only lacks financial resources as a result of empire building and other imprudent management decisions, including:

(i) Expensive attempts to outsource services, and to “lock out” unionized employees performing those services, about which other members of the coalition will provide more detailed testimony;

(ii) The acquisition of the bankrupt Westerly Hospital for a reported price of \$35 million; and

(iii) The extraordinary subsidy of physician practices. The **first attachment** to this document shows the extent to which hospital revenues are generating adequate margins to support operations and maintenance, but are subsidizing physician practice and other “system” losses. Those losses amount to \$78 million over the past five years. The combined new NEMG practice is expected to lose \$70 million per year.

b. In general, not-for-profit hospitals are doing well financially.<sup>2</sup> In fiscal year 2015 Moody’s reports that not-for-profit hospitals had median annual growth rate of 7.4% and median three-year revenue compounded annual growth rate of 5.6%.

(2) If acquired by Yale-New Haven Health Services Corporation, Lawrence + Memorial as a system would *achieve efficiencies through economies of scale*, and patients will receive *“the right care at the right time and in the most cost effective setting.”*

a. However, evidence provided here (the **second attachment**, a list of peer-reviewed journal articles provided electronically) shows that such economies have not been achieved in similar health system acquisitions in the past, and that consolidation leads to significant price increases and resulting systemic cost growth. Consider these critical examples from a body of literature that grows daily:

i. A comprehensive study by the Massachusetts Health Policy Commission found that market power is the primary determinant of prices in the state,

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<sup>1</sup> OHCA Docket 15-32033-CON, p. 25

<sup>2</sup> Health Care Policies and Trends, *Healthcare Financial Management*, June 2016, Page 18

and that community hospitals provide the same care at much lower price as the dominant system.

- ii. Cooper<sup>3</sup> et al studied nearly 4 billion private sector claims nationwide and found that the primary determinant of health care costs is the price of provider services, and that the most powerful determinant of provider price is market power – not quality, not size, not academic status or reputation. Parenthetically, these authors noted that one area of the country with *both* high Medicare and high private commercial health insurance costs is New Haven, CT.
- iii. Gowrisankaran<sup>4</sup> et al studied data on post-merger pricing and found that separately negotiated prices do not negate the impact of a system's market power. Newly purchased hospitals still gain a price premium.

A new study of leverage in California hospitals<sup>5</sup> indicates that monopolist health systems took active advantage of their status, leading to steadily increasing price differentials, separating them from non-monopolist hospitals by as much as \$4,000 per discharge.

- iv. The Applicant's own evidence makes this point. The Health Care Cost Institute's report submitted with the application notes that the primary driver of health care cost increases is provider and pharmaceutical pricing.
- b. Despite OHCA's request and the urging of legislators, the Applicants flatly refuse to provide comparative price data between L+M and the YNHHS hospitals. However, original analysis of Medicare payments submitted as part of this testimony shows that, almost uniformly, payments for services at Yale-New Haven (including low acuity services) are significantly higher than those at Lawrence + Memorial and much higher than other currently independent hospitals.

The **third attachment** to this testimony is excerpted from 2013 CMS records of billing and payment by DRG by hospital for the top 100 DRGs in Connecticut hospitals.

No evidence has been offered by applicants to demonstrate that past acquisitions or affiliations (Bridgeport, Greenwich) have produced economies similar to those predicted in the current application. To the contrary, these hospitals remain among the most expensive in Connecticut;

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<sup>3</sup> Cooper, Z. et al, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," NBER Health Care Pricing Project, December 2015

<sup>4</sup> Gowrisankaran, G., et al, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *The American Economic Review*, March 2013

<sup>5</sup> Melnick, G. and K. Fonkych, "Hospital Price Increases in California, Especially Among Hospitals in the Largest Multi-hospital Systems," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, Volume 53: 1-7, 2016

- c. A report by members of the intervenor coalition from December of last year, submitted as the **fourth attachment**, demonstrates that this acquisition will lead to extreme market concentration in the L+M service area, and intensify Yale-New Haven's market power from New York to the Rhode Island border. If this acquisition is consummated, Yale-New Haven Health Systems will account for 83% of discharges in L+M's primary service area, and nearly 60% of all inpatient discharges in the southern half of the state. Using the federal government's standard measure, the growth in market concentration in each of those areas would be presumed to create excessive market power.
- d. Consolidation can alter financial and referral relationships to create a "death spiral" for community hospitals. The Massachusetts Health Policy Commission, in its comprehensive study of community hospitals and the effect of monopolist systems, has concluded that the provision of *routine* hospital care at academic medical centers and teaching hospitals leads to lower total and commercial inpatient volume at community hospitals.

This sequence of events, in turn, leads to lower prices at community hospitals, poor hospital financial performance, limited ability to invest, and barriers to adoption of new technology. This cycle reinforces patient preferences for academic medical centers and teaching hospitals, even for routine hospital care.

For patients left behind in communities like Windham and New London, especially those (i) without transportation to the central hospital, (ii) good health insurance, or (iii) well-connected doctors, this practice results *in patient red-lining*, leaving the poor and aged to be served by inferior hospitals, made inferior as their patients are drawn out of local services, and into the central "name-brand" academic medical center.

The initial and understandable community "rapture" at being part of a larger, more exciting, more capable health system becomes, in short order, the recognition that the community hospital has been "left behind."

- e. The Applicants have offered no evidence that the acquisition of Lawrence + Memorial Physicians Association, L+M's 70-physician group medical practice, will create efficiencies with any meaningful return to patients and payers. Extensive bibliographic evidence of studies in academic, professional and public service literature, submitted as the **fifth attachment**, indicates that such efficiencies will not result.
- f. For example, Robinson<sup>6</sup> et al, found that physician practices in California that were owned by local community hospitals had costs 10% higher than physician-owned organizations. Practices owned by regional multi-hospital systems generated costs 20% higher than physician-owned practices.
- g. **Excessive bureaucracy** will increase expenses, including (a) more layers of management between the physician and the patient, (b) attempts to conform

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<sup>6</sup> Robinson, J. and K. Miller, "Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California," *JAMA*, October 22/29, 2014;312(16):1663-1669

physician behavior to purchasing, referral or other financial direction, (c) hospital-oriented -- that is, institutional and hospital revenue cycle-oriented -- information systems.

- h. OHCA should view with skepticism the idea that installation of the EPIC electronic medical record system will generate efficiency or improve quality. The Partners system in Massachusetts spent \$1.2 billion to go live in 2015, double the original budgeted \$600 million. Auditors for Southcoast Health hospitals in Massachusetts attribute a \$30 million 2014 operating loss and 105 layoffs in part to the cost of EPIC.<sup>7</sup> Southcoast (and other Massachusetts hospitals) are attempting to “keep up” with the highest priced system, Partners, as Partners attempts to meet its own budget requirements by electronic steering of patients from distant corners of that State.

Moreover, “efficiencies” or quality improvements resulting from the use of one or another brand of electronic health record systems are purely speculative. There is no generalizable data showing that EHRs are actually helping control health costs, and EPIC is an extraordinarily expensive product.

- (3) If acquired by Yale-New Haven Health Services Corporation, Lawrence + Memorial would achieve *higher quality* in care provided.
  - a. The recent comprehensive study of all hospitals in Massachusetts by the Health Policy Commission (HPC), cited above, reveals that spending at community hospitals is lower for low acuity inpatients and “is not associated with any difference in quality.”
  - b. In fact, the HPC study showed that “Most community hospitals provide care at a lower cost per discharge, without significant differences in quality,” nearly \$1,500 less per inpatient according to that study. This HPC study is **the sixth attachment** to this testimony.
  - c. The **fifth attachment** (as also noted above) is a list of peer-reviewed journal articles that report, among other findings, no evidence that consolidation of large and small hospital systems produces higher quality care. There is, to the contrary, some evidence that care improvements and patient safety both become victims of bureaucratic inertia and indifference.
  - d. Extensive bibliographic evidence of studies in academic, professional and public service literature indicates that the “quality” of physician services will not increase, and may, in fact, be compromised.

(4) That *access to primary and advanced specialty care will be greatly enhanced* for the citizens of the Lawrence and Memorial hospital service area through the acquisition. This argument is contradicted by:

- a. The example of Windham Hospital’s acquisition by Hartford HealthCare, to which testimony will be given by others.

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<sup>7</sup> Akanksha Jayanthi, “8 Epic EHR implementations with the biggest price tags in 2015,” *Becker’s Health IT and CIO Review*, 7/1/2015

- b. Compromise to physician resistance achieved through acquisition of medical practices. Doctors will ordinarily be fighting for their patients' rights, with insurance companies, vendors and even with hospitals. When the doctor is owned by the hospital, judgments may be altered concerning necessary services, referrals and costs. See the **fifth attachment** for journal studies in this area;
- c. Changing governance and control will render local officials and L+M itself incapable of protecting local services. The hearing notice makes clear that OHCA rejects the notion that this is not an acquisition. Upon consummation, the deal will leave all relevant decision-making authority in the hands of Yale-New Haven Health System.
- d. **Patient choice** will be severely compromised, if not eliminated. The Massachusetts Health Policy Commission study indicated that, as the result of consolidation in that state, "Patients often mentioned that they did not feel they had a choice of hospitals because their primary care provider or insurance plan determined where they could go for care."

In fact, insurance carriers are driven by the financial impact of monopolist pricing to develop narrow networks of providers. This results in limited or non-existent flexibility for the patient and the patient's treating physician. Insurers are compelled to this strategy as a means of attempting to secure discounted prices from price-gouging monopolist systems, in return for assurance of increased volume.

- e. **Physician integrity** may be compromised. Since patients rarely evaluate the quality of medical care, instead valuing the recommendations of physicians, those recommendations become very important.

Contracts involving "owned" physicians reveal requirements for which service to use, what imaging center, what laboratory, what pharmaceutical products have been included in the formulary of the monopolist system, all of these limitations on the ability of the practicing physician to put their patients' interest first.

Many physicians in independent practice face overwhelming bureaucracy and micro-regulation. These bureaucratic challenges are complicated by the extraordinary difficulty of actually being paid for work done. Many therefore have thrown in this particular "towel," resigned to doing the best they are able under the constraints of monopolist systems. By way of recompense, physicians who have ceded such freedoms now have salaries or practice income guarantees supported by double billing and price-gouging associated with large health systems.

- f. Applicants' submission of misleading data about the flow of patients to out-of-state providers, obscuring a potential reduction in the diversity of providers. The applicants break out discharges from New York and Massachusetts providers, but neglect discharges from Rhode Island Hospital. RIH, the affiliated hospital of Brown University Medical School, is the most obvious competitor for subspecialty care to Yale-New Haven Hospital – the two hospitals are exactly equidistant from New London.

OHCA must ask the Applicants what mechanism they will use to shift patient flows from "distant" competitors. Why should an acquisition change referral patterns? Without reviewing all provider employment, affiliation and practice management

agreements between YNHHS, NEMG and all employed physicians and/or affiliated group practices, OHCA cannot fairly evaluate the impact on access. If doctors are contractually bound to refer to YNHHS, patients – especially those in towns west of the Thames River – will lose choice and will incur higher costs due to monopoly pricing effects.

The cancellation of L+M’s affiliation with the Dana Farber Institute offers an ominous foreshadowing of this effect. There is no reason L+M can’t allow its doctors and their patients access to two brand-name cancer hospitals. Patients should have their choice of providers when their care requires subspecialty services only available outside New London.

- g. The terms of the supposed **\$300 million investment** in health in Southeastern Connecticut. The applicants refuse to offer specifics about how much they will really invest, what they will invest in, or where the money will come from.

All of the hypothetical \$300 million appears to be contingent on future programs being consistent with the YNHHS strategic plan, mutually agreed upon (between YNHHS and L+M), and *displaying a positive return on investment*. In other words, there would be no new investment in the Greater New London community’s health unless that investment earns Yale-New Haven Health System a profit.

The proposed expenditures for “physician and clinical recruitment” require scrutiny. The system spent \$54.5 million in cash to buy PriMed LLC in 2014. If by “recruitment,” Yale actually means “buying up the physician practices that L+M hasn’t already purchased,” patients will not benefit.

In fact some or all of the \$300 million is supposed to come from efficiencies that lead to lower expenses in L+M’s future operations, or perhaps from the other YNHHS hospitals. The application assumes that L+M will eliminate more than 200 jobs and more than \$130 million in wage and benefit expense *during the first three years*. (See **attachment seven**, excerpts from the application.) Over seven to ten years, L+M could generate its own \$300 million in funds to invest, and have control over how they would be invested. Of course, these may be needed jobs for the delivery of patient services.

- h. **Financial pressure on patients** will be increased, perhaps intolerably so, as evidenced by these examples:

There is a well-known history of abusive bill collection practices at Yale-New Haven. These abuses were investigated by the then-Attorney General;

Approximately 35% of the accounts receivable of the nation’s hospitals is now categorized as “patient responsibility.” Articles in the hospital field call the patient the “new payer.” Pressure on hospital revenue cycle performance will, of necessity, be addressed now more directly and forcefully to patients;

Also, narrow networks allow referral only to “approved” doctors, leading to “surprise” bills (for out-of-network services, specialties not covered, services in other parts of Connecticut, other states).

## Hospitals Owning Doctors

The shift of physician practices from 70% physician-owned in 2003 to less than 55% physician-owned by the end of 2010 (Mathews, A., “When the Doctor Has a Boss,” *The Wall Street Journal*, November 8, 2010) was accompanied by extraordinary increases in the cost of medical care, even by the standards of high prices and inflation in the health care field.

**Who benefits?** If these proposals before OHCA will not produce efficiency, improvement in quality or control of cost, but will, to the contrary, lead to bureaucratic inefficiency, decline in physician integrity and accountability, and increase in cost, why then do their sponsors put them forward?

## Hospitals and the Public Interest

Put simply, executives prosper. At Yale-New Haven, for example, **attachment eight** demonstrates that compensation of the top ten most highly compensated executives has increased by 100% in the time period (2006-2014) when smaller and independent hospitals have had increases of 20 – 25%.

Moreover, the doubling of administrative cost has an impact on the perception of those less handsomely compensated, such as practicing doctors. The surge of doctors seeking to become administrators has spawned extraordinary growth in schools of business, public health and hospital administration. Doctors see the lavish compensation of executives, the unhurried hours, and quickly deduce the market strategy (get bigger, earn more). Of course, all of this affects the patient.

A study published in *Health Affairs* and summarized by the Commonwealth Fund compared hospital administrative costs in eight countries and found that such costs accounted for 25% of hospital spending in the United States, twice the proportion seen in other advanced nations.

*The hospital administration share of gross domestic product for the entire country rose from .98% to 1.43% between 2000 and 2011. Moreover, “There was no apparent link between higher administrative costs and better-quality care.”*

This anomaly—societal concern and even outrage over health prices, yet skyrocketing compensation for hospital administrators—is made possible by the financial insulation enjoyed by members of those hospital boards.

In short, public agencies—not private boards or conflicted executives—will have to “stand in” for governance, if public interests are to be served.

## C. Summary

In summary, the applicants have failed to successfully address these issues identified by OHCA:

### (1) Public need:

- a. There is no “public need” demonstrated for this proposal;
- b. To the contrary, the public good (preservation of the lowest possible rates for health services and health insurance; the guarantee of local autonomy concerning decisions involving access to services; measures preserving the independence and integrity of physicians) argues against this proposal;

- (2) **Impact on residents**, including how access to services (including specialty care) will be maintained or improved:
- a. The applicants have failed to provide evidence that the access to specialty services will be improved. To the contrary, evidence has been presented that in other acquisitions by market-leading health systems in Connecticut (e.g., Hartford HealthCare acquisition of Windham Hospital), services have diminished. In that example, specialty and hospital care has been transferred incrementally to centrally-located specialists with Hartford.
  - b. Similar migration of specialty services has been demonstrated in a comprehensive study of community hospitals in Massachusetts by the Massachusetts Health Policy Commission.
- (3) **Benefits achieved** in the Bridgeport/Greenwich Hospitals service areas:
- a. There is no evidence that has been presented that either financial stability or enhanced programs or services have taken place in the Bridgeport and/or Greenwich Hospital services areas, beyond whatever trends and factors have applied to the hospital industry as a whole.
  - b. Neither OHCA nor the applicants have produced complete records of the “before” and “after” assessment of “financial stability or enhanced programs or services.” The submission of incremental and selected information by the applicants more than six months after the beginning of the CoN process indicates that demonstration of the benefits of previous hospital acquisitions has not been a priority.

These applications fail to meet the standards in PA 14-168 Section 7(a)(3), (4), (5), (11) and (12).

(3) Applicants have not demonstrated a clear public need.

(4) By refusing to provide price data, applicants have failed to adequately demonstrate how the proposal will impact the financial strength of the health care system, particularly if one views patients and payers as part of the system.

(5) Applicants have not satisfactorily demonstrated how the proposal will improve the quality, accessibility, and cost effectiveness of health care. Intervenors have presented a large volume of evidence to the contrary.

(11) Applicants have not satisfactorily demonstrated that the proposal will *not* negatively impact the diversity of health care providers and patient choice in the geographic region. This is a new and much higher burden of proof for both OHCA and the Applicants. Intervenors have raised a series of questions about the vague generalities in the application, without answers to which OHCA cannot plausibly certify having met this standard.

(12) Applicants have failed to provide any evidence that the consolidation from the proposal will *not* adversely affect health care costs or accessibility to care. Again, this is a new standard, enacted by the General Assembly specifically to address the circumstances currently under review. When OHCA pressed the applicants to say whether any of the supposed cost savings from the acquisition would be passed on to consumers, they simply refused.

These proposals should not be ruled on until January 15, 2017 or until the Governor's Task Force makes its recommendations. If forced to rule by the statutory calendar, OHCA must deny them. Regardless of Executive Order 51, the applications as written fail the relevant statutory tests and must be denied whenever they ripen for decision.

The only possible scenario under which a proposed takeover of L+M by YNHHS or any other major system could proceed is with permanent, concrete written guarantees on access, cost, quality and workplace standards, all negotiated directly with a representative cross-section of the community and with ongoing enforceable community oversight. We have attached our coalition's "Vision and Values Statement" which includes details of our vision for the future of the Southeastern Connecticut health care system.

Thank you for your attention.

# **EXHIBIT 1**

YNHHS and L+M, Holding Company Profit and Loss, Hospital Profit, Physician Subsidy

	2015	2014	2013	2012	2011
<b>Yale New Haven Health System</b>					
Holding Company Profit (Loss)	\$144,091,000	\$204,301,000	\$168,660,000	\$130,416,000	\$71,016,000
Hospital/Hosp + Sub Profit	\$105,816,000	\$160,785,000	\$178,722,000	\$130,609,000	\$67,162,000
Physician Subsidy	\$53,931,000	\$45,621,000			
<b>Lawrence + Memorial</b>					
Holding Company Profit (Loss)	\$1,536,369	(\$3,388,068)	\$2,253,354	\$7,721,331	\$15,902,773
Hospital Profit	\$14,522,752	\$5,979,688	\$10,767,187	\$17,549,573	\$16,766,396
Physician Subsidy	\$20,061,502	\$20,865,372	\$15,724,357	\$12,069,947	\$9,263,443

Source: audited financial statements

## **EXHIBIT 2**

## **Exhibit One**

### **Monopoly Prices in Health Care, The Result of Hospital Consolidation**

Abelson, R., "Health Care Companies in Merger Frenzy," *The New York Times*, October 29, 2015

Abelson, R., "Regulators Tamp Down on Mergers of Hospitals," *The New York Times*, December 18, 2015

Advocate Health Care Network, et al, Complaint, Docket No. 9369, Federal Trade Commission, December 17, 2015

Auer, D. and N. Petit, "Two-Sided Markets and the Challenge of Turning Economic Theory into Antitrust Policy," *The Antitrust Bulletin*, 2015, Vol. 60(4), 426-461

Bai, G. and G. Anderson, "A More Detailed Understanding Of Factors Associated With Hospital Profitability," *Health Affairs*, No. 5 (May 2016): 889-897

Brennan, J., "Sixth Circuit Reinstates Antitrust Challenge to Hospital Joint Operating Agreement," *AHLA Weekly*, April 8, 2016

Brill, J., "Competition in Health Care Markets," Transcript of Keynote Address by Julie Brill, Commissioner, Federal Trade Commission, 2014 Hal White Antitrust Conference, June 9, 2014, Washington, DC

Brown, M., "Mergers, network, and vertical integration: Managed care and investor-owned hospitals," *Health Care Management Review*, 1996, 21(1), 29-37

Cabell Huntington Hospital, Inc. et al, Complaint, Docket No. 9366, Federal Trade Commission, November 5, 2015

Canback, S., "Limits of Firm Size, An Inquiry into Diseconomies of Scale," Doctoral Thesis, Henley Management College, September 11, 2000

Capps, C., et al, "Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?," NBER, August 2010

Commins, J., "Another Study Links Hospital Mergers to Higher Prices," *HealthLeadersMedia*, March 28, 2016

Cooper, Z. et al, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," NBER Health Care Pricing Project, December 2015

Cutler, D. and F. Morton, "Hospitals, Market Share, and Consolidation," *JAMA*, Volume 310, Number 18, November 13, 2013

Dafny, L., et al, "The Price Effects of Cross-Market Hospital Mergers," NBER, March 18, 2016

Daly, R., "Insurer Role Underscored in FTC Hospital M&A Reviews." HFMA Healthcare Business News, December 15, 2015

Dranove, D. and A. Sfekas, "The Revolution in Health Care Antitrust: New Methods and Provocative Implications," *The Millbank Quarterly*, Vol. 87, No. 3, 2009, pp. 607-632

Ellison, A., "FTC moves to block Advocate, NorthShore merger," *Becker's Hospital Review*, December 18, 2015

Ellison, A., "NorthShore CEO: FTC gerrymandered hospital market to oppose merger," *Becker's Hospital Review*, January 6, 2016

Ellison, A., "Penn State Hershey, PinnacleHealth will fight FTC to merge," *Becker's Hospital Review*, December 17, 2015

Evans, M., "Hospital consolidation drives prices for privately insured, data suggest," *Modern Healthcare*, December 21/28, 2015

Federal Trade Commission, "FTC and Pennsylvania Office of Attorney General Challenge Penn State Hershey Medical Center's Proposed Merger with PinnacleHealth System," Press Release, December 8, 2015

Federal Trade Commission, "FTC Challenges Proposed Merger of Two Chicago-area Hospital Systems," Press Release, December 18, 2015

Fuse Brown, E.C. and J. King, "The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control," Georgia State University College of Law, Legal Studies Research Paper No. 2016, 1. 92 Ind. L.J. (forthcoming 2016-2017)

Federal Trade Commission, "FTC Staff: Proposed Health Care Legislation in West Virginia Would Likely Be Anticompetitive and Harm Consumers," Press Release, March 10, 2016

Federal Trade Commission and Department of Justice, "Improving Health Care: A Dose of Competition," July 2004

Federal Trade Commission and Department of Justice, Joint Statement on Certificate-of-Need Laws and South Carolina House Bill 3250, January 11, 2016

Feller, H., "A Primer on Antitrust Law Fundamentals," Association of Corporate Counsel National Capital Region Program Presentation, May 18, 2015

Fifer, J., "The consolidation conundrum: time to reframe," *Healthcare Financial Management*, January 2016

Gaynor, M., et al, "A Structural Approach to Market Definition With an Application to the Hospital Industry," NBER, March 14, 2012

Gaynor, M. and R. Town, "The impact of hospital consolidation – Update," Robert Wood Johnson Foundation, Synthesis Report, June 2012

Ginsburg, P., "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," Center for Studying Health System Change, No. 16, November 2010

Gold, Jenny, "Health Reform Roils Downton Abbey," *Kaiser Health News*, February 17, 2016

Gowrisankaran, G., et al, “Mergers When Prices Are Negotiated: Evidence from the Hospital Industry,” *The American Economic Review*, March 2013

Haas-Wilson, D. and C. Garmon, “Two Hospital Mergers on Chicago’s North Shore: A Retrospective Study,” Federal Trade Commission Bureau of Economics Working Paper No. 294, January 2009

Havighurst, C. and B. Richman, “The Provider Monopoly Problem in Health Care,” *Oregon Law Review*, Vol. 89, 847, March 31, 2011

Herzlinger, R., et al, “Market-Based Solutions to Antitrust Threats – The Rejection of the Partners Settlement,” *NEJM*, 372;14, April 2, 2015

Hiltzik, M., “Mergers in the healthcare sector: why you’ll pay more,” *Los Angeles Times*, May 27, 2016

Howard, P. and Y. Feyman, “Keeping Score: How New York Can Encourage Value-Based Health Care Competition,” Manhattan Institute Report 4, March 2016

Investing Answers, Herfindahl Index definition, [www.investinganswers.com](http://www.investinganswers.com), December 11, 2015

Krugman, P., “Robber Barron Recessions,” *The New York Times*, April 18, 2016

Lewis, J., “‘Oh help me, please doctor, I’m damaged’ – What does the Future Hold for Hospital-Physician Acquisitions?”, BakerHostetler, [www.antitrustadvocate.com](http://www.antitrustadvocate.com), February 12, 2015

Mathews, A., “When the Doctor Has a Boss,” *The Wall Street Journal*, November 8, 2010

Meier, M., et al, “Overview of FTC Actions in Health Care Services and Products,” Health Care Division, Bureau of Competition, Federal Trade Commission, Washington, DC, May 2016

Meier, M., et al, “Topic and Yearly Indices of Health Care Antitrust Advisory Opinions by Commission and by Staff,” Health Care Division, Bureau of Competition, Federal Trade Commission, Washington, DC, May 2016

Melnick, G. and K. Fonkych, “Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-hospital Systems,” *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, Volume 53: 1-7, 2016

Modern Healthcare, “FTC moves to block proposed Advocate-NorthShore merger,” *Modern Healthcare*, December 21/28, 2015

Pear, R., “F.T.C. Wary of Mergers, by Hospitals,” *The New York Times*, September 17, 2014

Penn State Hershey Medical Center and PinnacleHealth System, Complaint, Docket No. 9368, Federal Trade Commission, December 7, 2015

Pope, C., “How the Affordable Care Act Fuels Health Care Market Consolidation,” The Heritage Foundation Backgrounder, No. 2928, August 1, 2014

Ramirez, E., “Antitrust Enforcement in Health Care – Controlling Costs, Improving Quality,” *The New England Journal of Medicine*, 371;24, December 11, 2014

Rangers Renal Holding, et al, Complaint, Federal Trade Commission, December 30, 2016

Richman, B., "Antitrust and Nonprofit Hospital Mergers: A Return to Basics," *University of Pennsylvania Law Review*, Vol. 156, 2007

Scheffler, R., et al, "Differing Impacts Of Market Concentration On Affordable Care Act Marketplace Premiums," *Health Affairs*, 35, No. 5 (May 2016): 880-888

Singer, T. and N. Harris, "Federal Judge Denies Health First's Motion to Dismiss Suit by Physicians Alleging Unlawful Exclusion," AHLA Antitrust Practice Group News, February 2, 2015

Stuck, T., "Tomblin signs bill with antitrust exemption for hospital deal," *The Herald-Dispatch*, March 19, 2016

United States Government Accountability Office, "Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform," GAO-16-189, Report to Congressional Requesters, December 2015

Xu, T., et al, "The Potential Hazards of Hospital Consolidation; Implications for Quality, Access and Price," *JAMA*, Vol. 314, Number 13, October 6, 2015

## **EXHIBIT 3**

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Septicemia or Severe Sepsis W MV 96+ Hours

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	81	\$310,648	\$85,235	\$74,434	\$10,801
St. Francis Hospital & Medical Center	29	\$158,137	\$60,347	\$48,067	\$12,280
Bridgeport Hospital	15	\$158,715	\$57,016	\$53,003	\$4,013
Hospital of Central Connecticut	28	\$124,601	\$52,428	\$41,063	\$11,365
Hartford Hospital	33	\$139,676	\$52,283	\$46,420	\$5,863
Manchester Memorial Hospital	16	\$174,226	\$50,655	\$49,772	\$883
William W. Backus Hospital	11	\$91,957	\$48,128	\$38,732	\$9,396
Saint Mary's Hospital	19	\$72,890	\$45,681	\$42,864	\$2,817
Lawrence & Memorial Hospital	15	\$93,194	\$44,932	\$44,211	\$721
Waterbury Hospital	25	\$143,911	\$43,622	\$39,899	\$3,723
Middlesex Hospital	16	\$161,074	\$43,016	\$41,385	\$1,631
MidState Medical Center	12	\$71,954	\$38,774	\$38,038	\$736

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Infectious & Parasitic Diseases W O.R.  
Procedure W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	12	\$140,156	\$68,723	\$62,636	\$6,087
Yale-New Haven Hospital	120	\$202,690	<b>\$63,477</b>	\$56,019	<b>\$7,458</b>
Norwalk Hospital Association	15	\$214,160	\$62,501	\$56,386	\$6,115
Bridgeport Hospital	23	\$156,619	<b>\$54,100</b>	\$43,510	<b>\$10,590</b>
Stamford Hospital	34	\$178,845	\$51,370	\$49,450	\$1,920
St. Francis Hospital & Medical Center	34	\$128,416	\$51,080	\$44,622	\$6,458
Waterbury Hospital	25	\$200,489	\$50,593	\$46,907	\$3,686
Hartford Hospital	98	\$114,399	\$48,902	\$43,311	\$5,591
Saint Mary's Hospital	25	\$78,892	\$44,855	\$42,893	\$1,962
St. Vincent's Medical Center	22	\$108,916	\$43,810	\$36,102	\$7,708
Griffin Hospital	15	\$111,374	\$41,967	\$40,039	\$1,928
Lawrence & Memorial Hospital	37	\$86,724	<b>\$41,567</b>	\$39,538	<b>\$2,029</b>
William W. Backus Hospital	37	\$83,688	\$41,302	\$36,969	\$4,333
Danbury Hospital	16	\$86,609	\$40,480	\$38,556	\$1,924
Middlesex Hospital	27	\$152,242	\$39,522	\$37,910	\$1,612
Hospital of Central Connecticut	42	\$78,346	\$38,158	\$34,812	\$3,346
Greenwich Hospital Association	11	\$123,456	<b>\$38,080</b>	\$36,732	<b>\$1,348</b>
Manchester Memorial Hospital	30	\$112,079	\$37,533	\$36,745	\$788
MidState Medical Center	26	\$71,300	\$35,872	\$33,463	\$2,409
Charlotte Hungerford Hospital	17	\$53,134	\$31,503	\$30,075	\$1,428

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Major Small & Large Bowel Procedures W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	11	\$130,340	\$63,059	\$58,620	\$4,439
Yale-New Haven Hospital	90	\$174,277	<b>\$58,706</b>	\$52,041	<b>\$6,665</b>
Stamford Hospital	24	\$205,005	\$50,763	\$48,905	\$1,858
Norwalk Hospital Association	17	\$161,687	\$49,798	\$46,130	\$3,668
Bridgeport Hospital	14	\$183,169	<b>\$49,112</b>	\$45,626	<b>\$3,486</b>
St. Francis Hospital & Medical Center	34	\$138,873	\$48,929	\$45,632	\$3,297
Danbury Hospital	26	\$122,442	\$47,977	\$42,206	\$5,771
St. Vincent's Medical Center	22	\$168,701	\$46,987	\$43,328	\$3,659
Hartford Hospital	42	\$99,028	\$42,729	\$39,399	\$3,330
Middlesex Hospital	21	\$172,377	\$42,616	\$41,002	\$1,614
Lawrence & Memorial Hospital	12	\$96,118	<b>\$40,832</b>	\$35,154	<b>\$5,678</b>
Saint Mary's Hospital	11	\$96,824	<b>\$40,716</b>	\$38,949	\$1,767
Greenwich Hospital Association	12	\$125,846	\$38,204	\$36,592	\$1,612
Bristol Hospital	16	\$118,331	\$37,414	\$36,530	\$884
Waterbury Hospital	15	\$136,953	\$37,140	\$35,004	\$2,136
Hospital of Central Connecticut	27	\$88,070	\$36,713	\$35,055	\$1,658
MidState Medical Center	27	\$75,716	\$36,492	\$33,697	\$2,795
Manchester Memorial Hospital	13	\$89,343	\$34,247	\$29,579	\$4,668
William W. Backus Hospital	14	\$61,329	\$32,713	\$31,709	\$1,004
Charlotte Hungerford Hospital	14	\$57,485	\$31,433	\$30,673	\$760

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Respiratory System Dx W Ventilator Support  
96+ Hours

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	60	\$202,775	\$60,818	\$56,656	\$4,162
Bridgeport Hospital	13	\$176,297	\$56,366	\$52,897	\$3,469
Norwalk Hospital Association	26	\$185,081	\$54,524	\$52,202	\$2,322
Hartford Hospital	28	\$176,005	\$52,351	\$47,429	\$4,922
Manchester Memorial Hospital	14	\$145,965	\$52,058	\$40,189	\$11,869
Danbury Hospital	13	\$123,626	\$50,969	\$36,085	\$14,884
St. Francis Hospital & Medical Center	24	\$142,835	\$50,483	\$47,648	\$2,835
St. Vincent's Medical Center	12	\$169,032	\$47,863	\$39,396	\$8,467
Saint Mary's Hospital	14	\$72,570	\$42,707	\$33,796	\$8,911
Lawrence & Memorial Hospital	20	\$72,632	\$42,362	\$35,254	\$7,108
William W. Backus Hospital	14	\$94,899	\$42,219	\$35,684	\$6,535
Hospital of Central Connecticut	24	\$102,087	\$40,720	\$38,574	\$2,146
Waterbury Hospital	11	\$133,217	\$38,140	\$34,802	\$3,338
MidState Medical Center	13	\$84,483	\$37,188	\$36,733	\$455
Middlesex Hospital	21	\$127,717	\$35,824	\$34,429	\$1,395
Charlotte Hungerford Hospital	13	\$58,770	\$34,149	\$32,069	\$2,080

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Spinal Fusion Except Cervical W/O MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	107	\$88,003	\$41,497	\$35,917	\$5,580
John Dempsey Hospital	55	\$54,387	\$40,845	\$37,805	\$3,040
Bridgeport Hospital	23	\$100,121	\$37,203	\$31,497	\$5,706
Hartford Hospital	78	\$57,900	\$34,783	\$27,294	\$7,489
Norwalk Hospital Association	29	\$100,576	\$34,032	\$32,417	\$1,615
Danbury Hospital	54	\$72,815	\$33,594	\$27,322	\$6,272
Stamford Hospital	17	\$129,246	\$32,690	\$29,709	\$2,981
Saint Mary's Hospital	25	\$81,847	\$32,119	\$25,184	\$6,935
St. Vincent's Medical Center	21	\$70,481	\$32,054	\$30,560	\$1,494
Greenwich Hospital Association	28	\$158,360	\$31,394	\$27,047	\$4,347
St. Francis Hospital & Medical Center	70	\$42,545	\$31,302	\$27,700	\$3,602
Lawrence & Memorial Hospital	16	\$75,241	\$30,013	\$28,832	\$1,181
Waterbury Hospital	26	\$144,435	\$29,952	\$25,218	\$4,734
Hospital of Central Connecticut	29	\$79,744	\$29,488	\$28,308	\$1,180
New Milford Hospital	13	\$36,857	\$28,916	\$24,487	\$4,429
Middlesex Hospital	19	\$110,939	\$28,693	\$25,097	\$3,596
MidState Medical Center	12	\$72,749	\$27,806	\$26,627	\$1,179
William W. Backus Hospital	72	\$47,418	\$27,151	\$24,440	\$2,711
Rockville General Hospital	29	\$45,887	\$24,461	\$22,523	\$1,938
Charlotte Hungerford Hospital	33	\$21,714	\$23,945	\$21,278	\$2,667

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Other Vascular Procedures With MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Middlesex Hospital	12	\$174,250	\$38,456	\$36,551	\$1,905
Yale-New Haven Hospital	79	\$135,606	<b>\$38,296</b>	\$35,731	<b>\$2,565</b>
Stamford Hospital	12	\$159,728	\$34,254	\$32,540	\$1,714
Danbury Hospital	22	\$96,541	\$32,267	\$25,353	\$6,914
Hartford Hospital	73	\$83,857	\$29,041	\$26,612	\$2,429
St. Francis Hospital & Medical Center	30	\$83,915	\$26,624	\$25,165	\$1,459
St. Vincent's Medical Center	16	\$76,358	\$25,618	\$24,552	\$1,066
Saint Mary's Hospital	13	\$52,451	\$25,068	\$24,006	\$1,062

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Hip L& Femur Procedures Except Major Joint  
W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	41	\$138,463	\$38,348	\$33,057	\$5,291
Stamford Hospital	13	\$127,169	\$29,561	\$28,118	\$1,443
Bridgeport Hospital	14	\$81,959	\$28,016	\$25,755	\$2,261
Hartford Hospital	56	\$60,199	\$25,384	\$22,919	\$2,465
Norwalk Hospital Association	13	\$79,773	\$25,255	\$23,679	\$1,576
St. Vincent's Medical Center	15	\$86,790	\$25,218	\$23,223	\$1,995
Lawrence & Memorial Hospital	16	\$46,929	\$24,778	\$19,022	\$5,756
St. Francis Hospital & Medical Center	25	\$69,793	\$24,706	\$23,328	\$1,378
Danbury Hospital	25	\$57,373	\$24,119	\$22,871	\$1,248
Hospital of Central Connecticut	25	\$64,529	\$22,876	\$21,677	\$1,199
Waterbury Hospital	15	\$79,965	\$22,327	\$20,985	\$1,342
Greenwich Hospital	14	\$101,216	\$22,016	\$20,670	\$1,346
Middlesex Hospital	20	\$78,502	\$20,670	\$19,232	\$1,438
MidState Medical Center	15	\$55,966	\$20,173	\$19,315	\$858
Charlotte Hungerford Hospital	12	\$37,816	\$18,874	\$17,996	\$878

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Major Small & Large Bowel Procedures W CC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	14	\$47,604	\$27,884	\$25,212	\$2,672
Yale-New Haven Hospital	93	\$74,952	<b>\$26,205</b>	\$21,802	<b>\$4,403</b>
Stamford Hospital	24	\$124,873	\$25,037	\$23,465	\$1,572
Norwalk Hospital Association	23	\$86,327	\$24,176	\$21,118	\$3,058
Bridgeport Hospital	20	\$74,235	<b>\$23,887</b>	\$19,380	<b>\$4,507</b>
Greenwich Hospital Association	42	\$78,156	<b>\$23,388</b>	\$17,851	<b>\$5,537</b>
Waterbury Hospital	19	\$106,740	\$23,111	\$21,013	\$2,098
Hartford Hospital	68	\$51,502	\$22,477	\$18,355	\$4,122
MidState Medical Center	25	\$53,290	\$22,143	\$13,714	\$8,429
St. Francis Hospital & Medical Center	62	\$56,193	\$21,189	\$18,850	\$2,339
Danbury Hospital	33	\$67,201	\$20,728	\$18,782	\$1,946
St. Vincent's Medical Center	32	\$52,380	\$20,438	\$17,881	\$2,557
Hospital of Central Connecticut	33	\$43,989	\$19,505	\$17,296	\$2,209
Saint Mary's Hospital	25	\$54,208	\$19,306	\$17,936	\$1,370
Griffin Hospital	13	\$67,822	\$19,135	\$17,659	\$1,476
Middlesex Hospital	31	\$86,394	\$18,870	\$17,074	\$1,796
Lawrence & Memorial Hospital	17	\$48,783	<b>\$18,657</b>	\$17,678	<b>\$979</b>
William W. Backus Hospital	45	\$39,831	\$17,888	\$15,142	\$2,746
Manchester Memorial Hospital	21	\$50,777	\$17,071	\$14,998	\$2,073
Bristol Hospital	15	\$57,521	\$16,599	\$15,813	\$786
Charlotte Hungerford Hospital	21	\$31,548	\$15,957	\$14,889	\$1,068

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Circulatory Disorders Except AMI, W Card Cath  
W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	65	\$120,592	\$28,531	\$25,275	\$3,256
Hartford Hospital	64	\$71,032	\$21,132	\$16,888	\$4,244
St. Vincent's Medical Center	26	\$79,241	\$19,916	\$16,494	\$3,422
St. Francis Hospital & Medical Center	40	\$53,805	\$18,661	\$16,819	\$1,842
Danbury Hospital	12	\$48,886	\$18,543	\$13,047	\$5,496
Lawrence & Memorial Hospital	14	\$39,395	\$15,344	\$14,496	\$848
Hospital of Central Connecticut	11	\$36,002	\$14,949	\$13,855	\$1,094

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Intracranial Hemorrhage or Cerebral Infarction  
W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	138	\$94,839	\$24,649	\$21,717	\$2,932
John Dempsey Hospital	19	\$27,682	\$20,308	\$18,596	\$1,712
Bridgeport Hospital	29	\$49,352	\$19,343	\$15,691	\$3,652
Hartford Hospital	143	\$55,092	\$17,903	\$15,145	\$2,758
St. Francis Hospital & Medical Center	86	\$57,287	\$17,058	\$15,649	\$1,409
Windham Community Memorial Hospital	13	\$19,960	\$16,147	\$15,323	\$824
Danbury Hospital	50	\$37,247	\$15,970	\$14,198	\$1,772
Norwalk Hospital Association	39	\$48,086	\$15,837	\$13,720	\$2,117
St. Vincent's Medical Center	33	\$45,394	\$15,776	\$14,137	\$1,639
Stamford Hospital	39	\$62,925	\$15,021	\$13,826	\$1,195
Saint Mary's Hospital	29	\$25,038	\$14,670	\$13,448	\$1,222
Hospital of Central Connecticut	53	\$34,972	\$14,643	\$12,615	\$2,028
Waterbury Hospital	33	\$49,025	\$14,378	\$13,132	\$1,246
Griffin Hospital	15	\$42,608	\$13,961	\$12,562	\$1,399
Greenwich Hospital Association	37	\$47,276	\$13,639	\$12,463	\$1,176
Lawrence & Memorial Hospital	41	\$30,269	\$13,047	\$12,207	\$840
Middlesex Hospital	36	\$55,045	\$12,635	\$11,568	\$1,067
William W. Backus Hospital	19	\$26,775	\$12,458	\$11,657	\$801
MidState Medical Center	31	\$32,481	\$12,041	\$11,245	\$796
Charlotte Hungerford Hospital	15	\$14,539	\$11,321	\$10,460	\$861

## **EXHIBIT 4**

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HOSPITAL MARKET CONCENTRATION  
IN CONNECTICUT:

# The Impact of Yale-New Haven Health System's Expansion

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# EXECUTIVE SUMMARY

The last twenty years have transformed the Connecticut health care system. As recently as 1995, every hospital in the state was independent, but the era of the community hospital is over. If currently proposed mergers are completed, more than 80% of Connecticut's patients will receive care from hospitals owned by large, powerful multi-hospital systems. Driven in part by new "shared savings" reimbursement policies in the state Medicaid and federal Medicare programs, this trend is accelerating.

Connecticut now has five major acquisitions pending, including the expansion of the state's most powerful health care entity. The Yale-New Haven Health System has proposed to buy Lawrence and Memorial Health, which owns both Lawrence and Memorial Hospital in New London and Westerly Hospital in Rhode Island. At the same time, Milford Hospital was forced to shut down Labor and Delivery services when its leading Obstetrician/Gynecologists defected to Yale-New Haven Hospital. Financially distressed, Milford now leases space to Yale-New Haven Hospital for its regional inpatient rehabilitation services. A slow-motion takeover appears to be in process.

The most recent data available show that Connecticut has the 4<sup>th</sup> highest health care costs in the United States, but lags in most measures of quality. Numerous academic studies show that as providers take each other over and limit competition, prices go up without service improvement—and the more heavily concentrated the market is to begin with, the higher the price increases.

The co-authors of *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, have worked together on legislative solutions to the challenges of growing hospital monopoly for the past several years. In continuing that work, we have analyzed state inpatient hospital discharge data and mapped the potential changes to the state's health care markets if Yale-New Haven buys L+M and swallows up Milford Hospital. The report examines five geographic areas, from L+M's relatively small self-defined service area, to an area covering the southern half of the state.

The data yield three key metrics: the percentage market share held by Yale-New Haven Health, the score for each area on a standard government measure of market concentration called the Herfindahl-Hirschmann Index, or “HHI”, and the amount of change in the concentration of the hospital market in each area. The findings include:

- Though consumers already face a market with limited competitive pressure to protect them, the Milford and L+M takeovers will significantly increase the Yale-New Haven Health System’s market share in all five areas. In L+M’s primary service area, Yale-New Haven Health System will grow from 14% to 83% of inpatient discharges.
- All five geographic regions studied easily meet the federal government’s standard for a “highly concentrated” market even before the two takeovers. Highly concentrated markets lack competition and can lead to artificially excessive prices.
- In the market areas studied, the size of the increase in consolidation caused by YNHHS’s expansion would be significantly higher—by a factor ranging between 50% and 900%—than the level that requires regulators to presume that merging entities will “obtain market power,” which federal regulatory standards warn against.<sup>1</sup> Studies show that mergers in already highly consolidated markets can often lead to price increases of 20%.
- Although hospitals are consolidating across the state, the shoreline areas dominated by YNHHS are the most heavily concentrated regions in Connecticut, and thus most vulnerable to price increases. The three-hospital Yale-New Haven system claims a “local service area” comprising nearly half the state’s population. Upon full absorption of Milford and L+M, the Yale-New Haven system will account for 59% of discharges in this area.

The report’s co-authors urge public officials to take three steps before any decisions are made on whether or not, and under what conditions, the merger should proceed.

- In 2015, Connecticut passed a sweeping health care consumer protection law, SB 811. The law requires a cost and market analysis prior to regulatory action on hospital mergers. Although Yale-New Haven and L+M applied for approval before the new law took effect, state officials should conduct the cost and market analysis prior to any action on the proposed merger.
- In particular, state officials should examine the pricing impact in Greater New Haven of Yale-New Haven Hospital’s 2012 takeover of the Hospital of St. Raphael. No data will better illuminate the potential impact of Yale-New Haven’s expansion than what happened to prices after this deal, which created the 6<sup>th</sup> largest hospital in the United States.
- The L+M transaction should not be viewed in isolation. Yale-New Haven’s market power on the shoreline is expanding by leasing a wing of Milford Hospital. This adds a small but significant further increase in the extent of Yale-New Haven’s market control. State officials should include the potential absorption of Milford in their analyses.

# 1. GROWING CONCENTRATION IN THE HEALTH CARE MARKETPLACE

The last twenty years have transformed the Connecticut health care system. As recently as 1995, every hospital in the state was independent, but the era of the community hospital is over. If current proposed mergers are completed, more than 80% of Connecticut's inpatients will pass through hospitals owned by large, powerful multi-hospital systems, with few legal checks on price increases to protect them.

The Affordable Care Act has delivered health insurance to millions of people, a significant policy victory. At the same time, however, changes in reimbursement policies, mandates for technology improvements, and new regulations have tilted the market even further in favor of large, wealthy hospital systems. In Connecticut, the State Innovation Model (SIM) and "shared savings" policies for Medicare and Medicaid are creating incentives for large combinations of hospitals and doctors that can accept risk for broad patient populations. These systems are taking advantage of the new conditions to overrun their smaller competitors and build market power.

Unfortunately, the ACA contains few proven cost control measures. Congress largely left it up to states, employers, payers, municipalities, and individual patients to rein in costs as health care

systems undergo rapid consolidation. Academic studies consistently show that the main impact of hospital consolidation is increased prices without improvement in quality.<sup>2</sup> Nationally, ballooning prices threaten newly expanded access. Although increasing numbers of Americans have health insurance, out of pocket costs are rising at 3-4 times the rate of wages.<sup>3</sup> More Americans than ever report delaying needed medical care for cost reasons.<sup>4</sup> Without cost control, the long-overdue expansion of health insurance coverage will not be sustainable.

These challenges have become clear in Connecticut in recent years. Despite a dramatic growth in their market power – which will continue if the combined \$91 billion Anthem-Cigna and Aetna-Humana deals are completed – health insurers have done little to restrain costs.<sup>5</sup> Meanwhile, the rise of multi-hospital systems has created concentrated markets in the state, and the Yale-New Haven and Hartford HealthCare systems have developed a dominant grip on health care statewide. The two major health systems account for nearly half the inpatient discharges in the state, and each has even tighter regional control in its respective market. Hospital consolidation and price inflation will continue unless checked at the state level.

## Acquisition and Absorption: Yale-New Haven Expands

Yale-New Haven Hospital (YNHH) began the process of industry consolidation in Connecticut in 1995, when YNHH added Bridgeport Hospital to its network. Greenwich Hospital joined the growing system in 1998. In 2010, the health system added Northeast Medical Group, a start-up physician multispecialty group that now employs over 550 doctors and is wholly owned by the Yale-New Haven Health Services Corporation, the parent corporation of the Yale-New Haven Health System (YNHHS).

In 2012, Yale-New Haven Hospital's takeover of the Hospital of St. Raphael created the 6<sup>th</sup> largest hospital in the country.<sup>6</sup> After the merger, the Yale-New Haven Health System (YNHHS) market share rose to 98% of inpatient discharges among New Haven residents and 76% in Greater New Haven, up from 68% and 48% respectively.<sup>7</sup>

In 2014, Texas-based for-profit hospital operator Tenet Healthcare proposed purchasing five Connecticut hospitals in an equity partnership with YNHHS, with Tenet owning 80% and Yale-New Haven 20%. Adding five of its competitors to Yale-New Haven's existing market share would have meant that 37.5% of all discharges in the state were from the newly merging system, a major expansion of the Yale network. The deal fell through after the Office of Health Care Access imposed unusually strong requirements on the terms of the deal, in the face of concerns about the impact of the transaction on cost, access, services, financial burden on the uninsured, and accountability of the hospitals to local communities.

Now, YNHHS has two impending hospital takeovers that will expand its control over the health care market along Connecticut's coastline.

One is widely known. The Yale-New Haven Health System has announced a deal to purchase Lawrence + Memorial Health, a smaller system that controls: Lawrence + Memorial Hospital in New London; Westerly Hospital in Westerly, Rhode Island; L+M Physicians Association, a 72-member

multispecialty physician practice; and several other outpatient facilities.<sup>9</sup>

In a series of less publicized moves, YNHHS seems to be quietly acquiring pieces of financially struggling Milford Hospital.

Milford has reported negative operating margins in each of the last seven years. The hospital's license allows it to operate 118 beds, but due to declining patient volume, only 43 are currently staffed. Documents filed with the state Office of Health Care Access reveal that physician defections to Yale-New Haven Hospital contributed to those losses and inflicted severe competitive damage on Milford's labor and delivery service. According to these documents, in 2012, six OB/GYN doctors who accounted for a majority of Milford Hospital's deliveries told management that they would no longer deliver babies there. One had decided to stop delivering babies altogether, but the other five told Milford management that they were making Yale-New Haven Hospital their "exclusive hospital provider."<sup>10</sup>

Milford subsequently attempted to hire additional obstetricians, but could not keep them. In February of 2015, Milford applied for state approval to terminate its Labor and Delivery service. Milford's family birthing center, which occupies a large portion of the hospital's third floor, will no longer accept patients.<sup>11</sup>

Having expanded its OB/GYN network due to Milford's financial distress, Yale-New Haven Hospital announced last fall that it would open a 24-bed inpatient rehabilitation clinic on one of the three floors of Milford Hospital. The clinic would serve patients suffering from certain neurological, orthopedic, musculoskeletal, and other conditions. These patients typically have received inpatient treatment such as surgery for their conditions, and require extensive nursing care and supervision while undergoing treatments such as physical or occupational therapy.

YNHH's proposal would shift all patients who would have been treated in the current rehab unit at the St. Raphael's campus to Milford. Shortly after, YNHHS-owned Bridgeport Hospital submitted its

own paperwork to terminate its inpatient rehabilitation services as well.<sup>12</sup> In essence, YNHHS is regionalizing its inpatient rehabilitation services at its leased space at Milford Hospital, even as Milford's traditional hospital services decline and close. Taken together, these events suggest that Yale-New Haven Health System's absorption of Milford Hospital is in process. Yet state regulators have treated each submission—Milford's closure of its Labor and Delivery service, the opening of Yale-New Haven's inpatient rehabilitation unit, and the two separate YNHHS inpatient rehabilitation unit closures—as distinct, unrelated events.

In contrast to Milford Hospital, Lawrence + Memorial Hospital is a financially successful 256-bed hospital in New London that recently acquired Westerly Hospital in Rhode Island, pledging to invest \$36.5 million over five years in the new acquisition. In September, the parent company of the two hospitals and Yale New Haven Health System filed a Certificate of Need application for YNHHS to take over the L+M system. In the application, YNHHS promises to make a \$300 million capital investment in the region.<sup>13</sup> This deal is now in front of state regulators seeking approval.

## Connecticut's Growing Monopolies

Hospital consolidation is a recent and rapid phenomenon in Connecticut: twenty years ago, every hospital in the state was independent.

The trend has accelerated recently. A tally of transactions by the Universal Health Care Foundation in December 2014 reported that "between 2009 and 2013 there were thirteen attempted and seven successful hospital consolidations and/or partnerships [in Connecticut], a substantial increase from the four that occurred in the previous decade."<sup>14</sup>

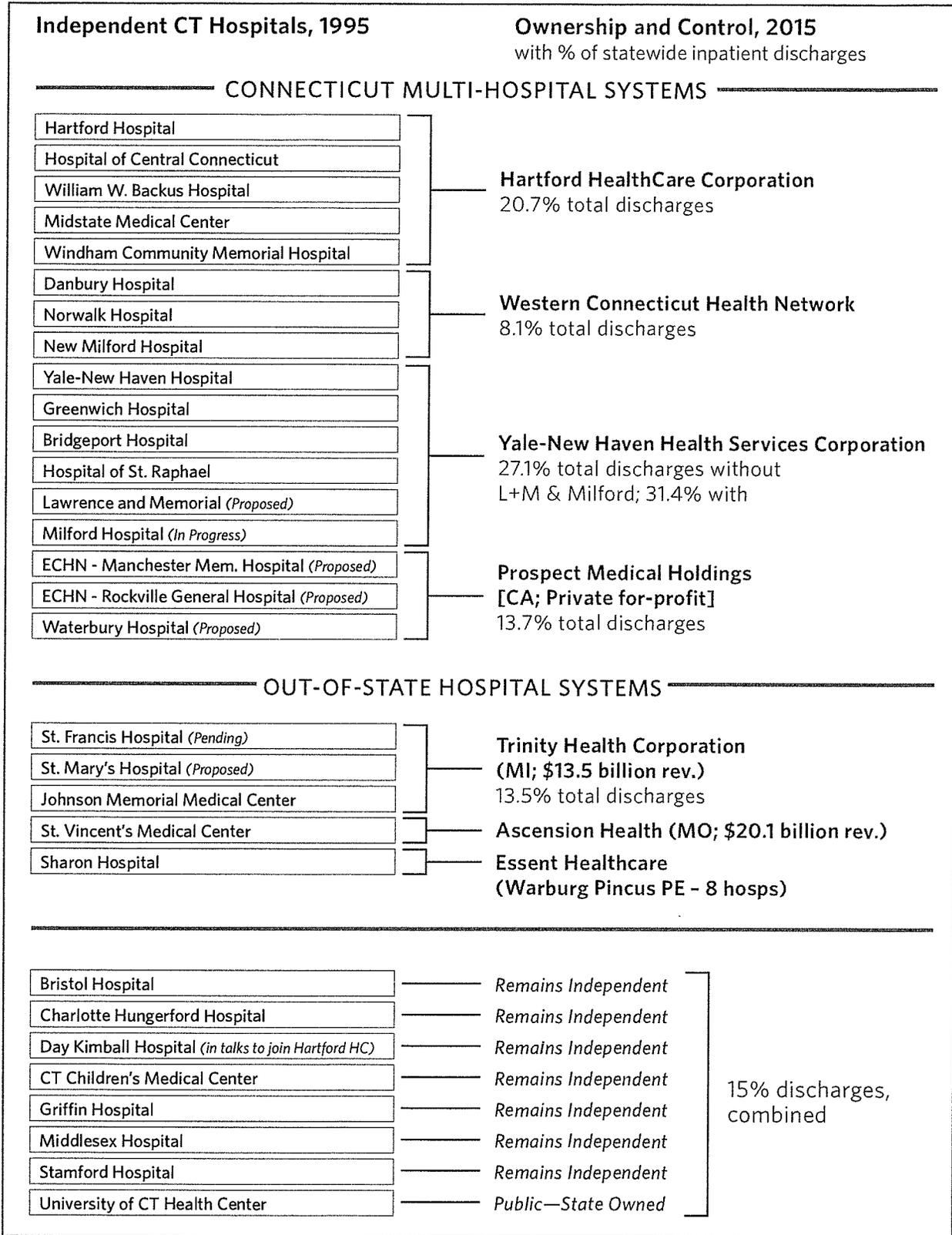
As a result of these consolidations, Hartford HealthCare accounted for 20.7% of inpatient discharges in the state in FY 2013, while Yale-New Haven Health System saw another 27.1%. The two health systems combine for nearly half of the

state's discharges, a lopsided market for Connecticut consumers.

In the year since the UHCF report, at least five major hospital affiliations or purchases have been announced or proposed: private for-profit Prospect Medical Holdings has moved to purchase the Eastern Connecticut Health Network and Waterbury Hospital; St. Francis Hospital affiliated with Trinity Health Corporation, a \$16 billion national company based in Michigan, has acquired Johnson Memorial Hospital, and has moved to acquire St. Mary's Hospital; and Ascension Health has purchased St. Vincent's Medical Center—all in addition to Yale's proposed acquisition of L+M and progressive annexation of Milford. Today, the eight hospitals that will remain independent if all pending transactions are approved provide only 15% of inpatient discharges in the state.

Unless radical change to reimbursement and support for financially distressed hospitals is on the horizon, some consolidation is inevitable. Unlike many of the other recent and proposed hospital acquisitions, however, the Lawrence + Memorial deal is not spurred by a community hospital's financial crisis. The conditions of this proposal create an opportunity for regulators to take a closer look at the growing monopolies in the state.

Figure 1: Hospital Ownership Changes, 1995-2015



## 2. THE DATA: YALE-NEW HAVEN'S LATEST MOVES INCREASE CONSOLIDATION

New data make it possible to chart the development of Connecticut's hospital systems, including the expansion of Yale's regional control in the last several years, and to anticipate how such control will grow as hospital networks expand. The authors obtained general acute inpatient care discharge data from the Office of Health Care Access, showing the number of discharges from each hospital by patients' town of residence during fiscal year 2013.

The question of how to define health care markets is highly contested and technically complex. For a detailed discussion, see Appendix A. Courts, hospitals, and regulators have disputed market boundaries for a quarter of a century while hospital systems completed 1,881 mergers.<sup>15</sup>

Recently, economists have developed improved tools to measure market boundaries, but courts are still catching up. Despite an academic consensus that hospital markets are much smaller and therefore more concentrated than courts were willing to accept a decade ago, only a handful of cases have actually seen anti-trust remedies applied to mergers.<sup>16</sup> Meanwhile, mergers are proceeding at a rate of more than 90 per year.<sup>17</sup>

For our initial analysis, we focus on market areas defined by the health systems and hospitals themselves, including concentric areas surrounding different hospitals that define smaller and larger

markets. This approach gives a thorough preliminary analysis of market concentration at varying scales. The analysis examines five areas:

- **Yale-New Haven Health System's local service area:** In the Official Statement accompanying its most recent bond offering, YNHHS defined the "local service area" for its full system as a 55-town region encompassing roughly the southern half of the state. The area includes 1.6 million people, 46% of the state's population.<sup>18</sup>
- **Yale-New Haven Hospital local service area:** A 34-town region also defined in YNHHS bond statements.<sup>19</sup>
- **Greater New Haven Area/Southern Connecticut Region Council of Governments (SCRCOG):** We use the area defined by membership in the Southern Connecticut Regional Council of Governments (SCRCOG) as a definition of Greater New Haven. SCRCOG contains fifteen towns with 16% of the state's population.
- **Lawrence + Memorial Hospital Primary Service Area:** L+M Hospital defines its primary service area as a ten-town region surrounding New London, both in the Official

Statement for its most recent bond issue and in its Certificate of Need application.

- **Lawrence and Memorial Hospital Secondary Service Area:** In the same sources, L+M also identifies as its secondary service area a twenty-town area surrounding New London.<sup>20</sup>

Within these five areas, our analysis focuses on three key metrics:

- The percentage market share for the Yale-New Haven Health System in each area prior to and after the absorption of Milford and the purchase of L+M Health.
- The Herfindahl-Hirschman Index, or “HHI,” score for each area pre- and post-acquisitions. HHI measures the degree to which a market is concentrated, and thus how likely consumers are to face anticompetitive practices. It is a standard FTC and DOJ metric, also used by the American Medical Association, Congressional Budget Office, Kaiser Family Foundation, insurance industry, and other economists and regulators for analyses.
- The change in HHI for each area before and after a transaction, a prediction of merging hospitals’ gain in market power.

In examining these metrics, we found that:

- Though consumers already face a market with limited competitive pressure to protect them, the ongoing absorption of Milford and the proposed purchase of L+M will significantly increase the Yale-New Haven Health System’s market share in all five areas we examined – by a factor of 5 or 6 in the markets surrounding New London – at the further expense of competition.
- All five geographic regions studied easily meet the federal government’s standard for a “highly concentrated” market even before the two takeovers. Highly concentrated markets can lead to artificially excessive prices.

- In the market areas studied, the size of the increase in consolidation caused by YNHHS’s expansion would be significantly higher—by a factor ranging between 50% and 900%—than the level that requires regulators to presume that merging entities will “obtain market power,” which federal regulatory standards warn against.<sup>21</sup>
- Although there is rapid consolidation across the state, the coastline areas dominated by YNHHS are the most heavily concentrated regions of the state and therefore are most vulnerable to price increases.

In each of these areas, the expansion is significant. The ultimate absorption of Milford Hospital and the L+M deal as proposed will leave YNHHS with nearly 60% of inpatient discharges in the Yale-New Haven Health System’s local service area, which covers roughly the southern half of the state, including 46% of its population. It will also add the L+M service area to the swath of coastal areas in which YNHHS dominates the market. [See Figures 3 and 4.] Yale-New Haven Hospital already treats the second highest volume of patients in L+M’s primary service area and third highest in its larger secondary service area. Combining the two hospital networks will leave YNHHS with monopoly pricing power.

When federal and state anti-trust regulators measure the degree to which a market is concentrated, they use a tool called the Herfindahl-Hirschman Index (HHI), which measures market concentration by aggregating measures of firms’ market shares.

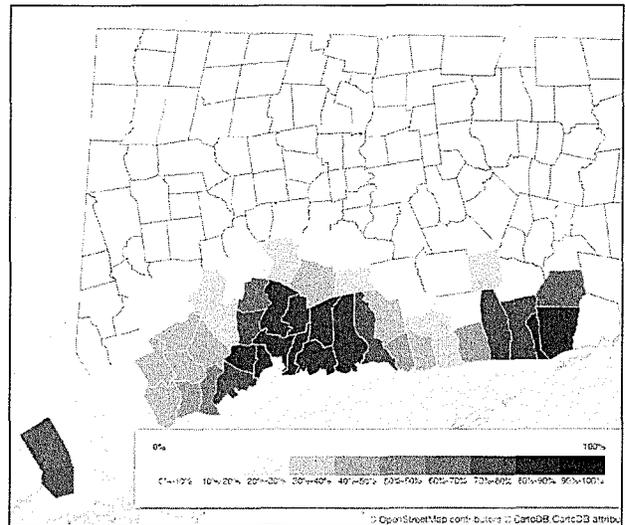
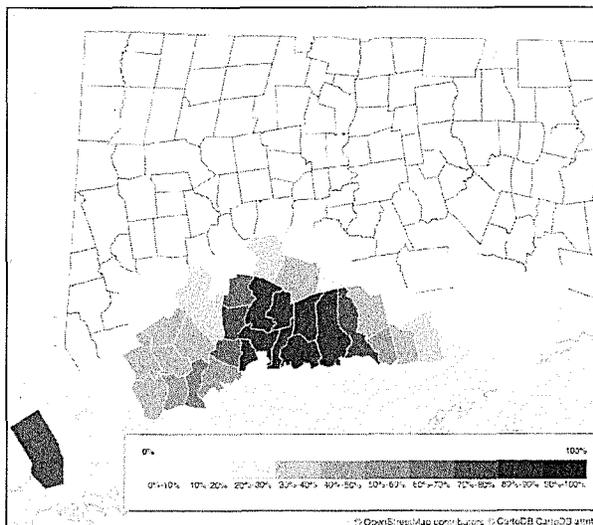
The DOJ and FTC assert that “mergers should not be permitted to create, enhance, or entrench market power or to facilitate its exercise” because of the threat to competition. When a merger increases the HHI in a highly concentrated market by 100 points, regulators expect that merger to “potentially” raise significant concerns because of an increase in market power. When it increases by 200 points or more, they “presume” that an impermissible market power increase is likely. This presumption can be rebutted only by “persuasive evidence showing that the merger is unlikely to enhance market power.”<sup>22</sup> We applied HHI to the discharge data from towns and multi-town areas to determine the health of the state’s markets.

Figure 2: YNHHS inpatient discharge share by region, before and after addition of L+M and Milford

	Population	YNHHS discharge share now	YNHHS discharge share with deals
Statewide	3,570,000	27%	31%
YNHHS local service area	1,650,000	51%	59%
YNHH local service area	1,096,135	60%	65%
GNH/SCRCOG	570,000	74%	83%
L+M primary service area	175,000	14%	83%
L+M secondary service area	362,000	12%	59%

Figures 3 and 4: YNHHS local service area market share, before and after

These maps illustrate the percentage of inpatients from each town within the Yale-New Haven Health System's local service area who were discharged from a hospital in the YNHHS, before and after the addition of L+M and Milford.



### Measuring Market Power

To calculate HHI, one adds the squares of the market shares together to get a number on a scale of 100–10,000:

- A region with a pure monopoly on a good or service would score an HHI of 10,000:  $(100\%)^2 = 10,000$ .
- A region with 10 competitors, each with equal market shares of 10% would score 1,000:  $(10\%)^2 = 100$  for each competitor.  $100 \times 10$  competitors = 1,000.
- A region with five competitors, one with 50% market share, one with 20% market share, and three with 10% market share would score 3,200 on HHI.  $(50\%)^2 = 2,500$ ;  $(20\%)^2 = 400$ ;  $(10\%)^2 = 100 \times 3$  competitors = 300.

The federal government divides markets into three categories based on HHI scores to assess the risk of monopoly:

- Less than 1,500—unconcentrated market with adequate competition
- Between 1,500 and 2,500—“moderately concentrated” market
- Above 2,500—“highly concentrated” market with an elevated risk of inefficiency and collusion to fix prices.

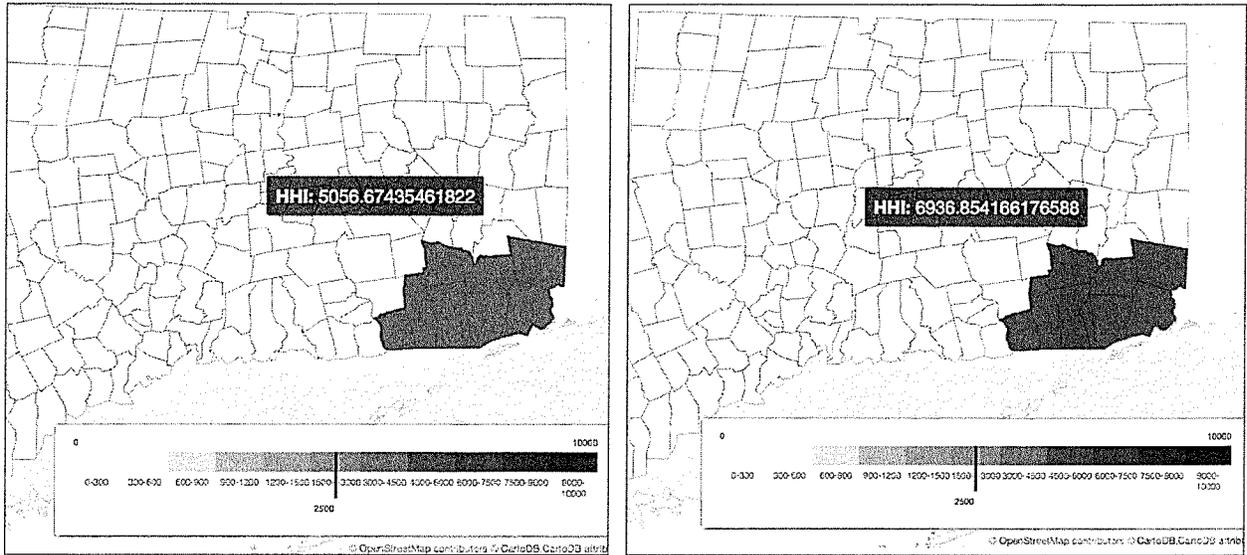
Regulators apply the strictest scrutiny to “highly concentrated” markets with scores of 2,500 or above.<sup>18</sup>

We found that every one of the five regions is already a highly concentrated hospital market to begin with. In every region, the increase in HHI was dramatic. The maps on the opposite page illustrate the HHI increase in the L+M service area. For the full table showing HHI and change in HHI for each geographic area, see Appendix B.

In every relevant local or regional area we examined, the HHI indicates that the market is already highly concentrated. When concentration is already high, increases to HHI are more concerning: federal standards indicate that the strictest scrutiny should be applied to markets like these because of the risk to competition. In every one of these markets, the magnitude of the HHI increase is far higher than the 200-point threshold at which federal regulations presume an impermissible increase to market power. In the L+M primary service area, the increase is over nine times the 200-point standard. In the YNHHS local service area—which encompasses 46% of the state’s population—the increase is more than quadruple the standard.

The state of Connecticut is far too large to consider a “market.” Even if we did consider Connecticut as a “market” of its own, however, it would already have an HHI of 1412. After these transactions, it would have an HHI of 1716—an increase of 304 points that would move it from the “unconcentrated” category to the “moderately concentrated” category. These two acquisitions constitute a substantial increase to overall market concentration in the state because they bolster the market power of its largest health system.

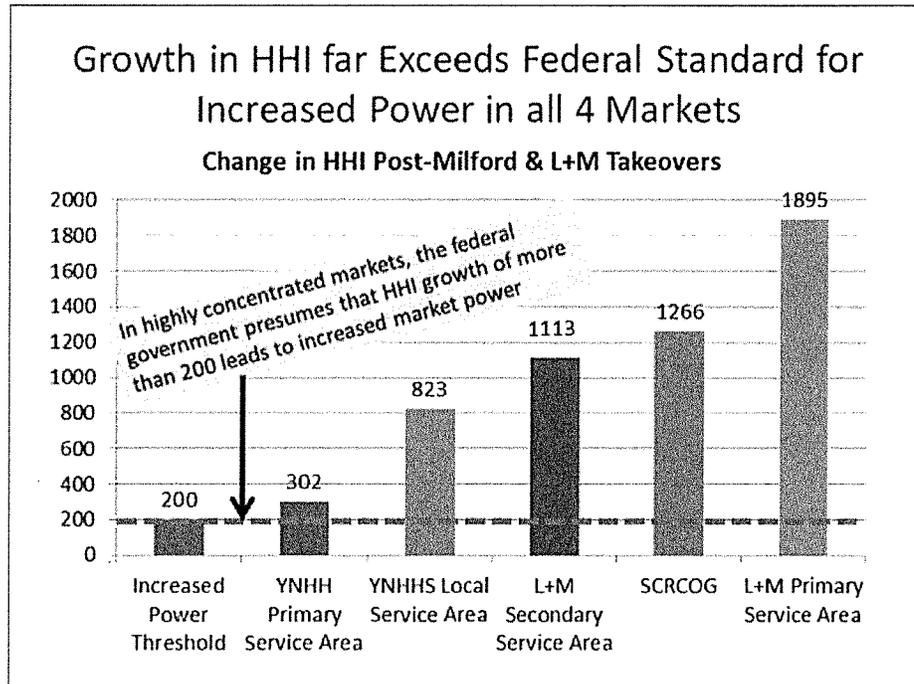
Consolidation is not equally threatening everywhere, however. We also calculated market concentration on a town-by-town basis for the entire state to demonstrate the distribution and comparative level of concentration across regions. Hartford’s expansion in northern Connecticut has been more diffuse than Yale-New Haven’s southern growth to date. In Hartford, for example, Hartford Hospital continues to face direct competition from St. Francis, which is now aligned with a multi-billion dollar national non-profit chain and is itself seeking to buy two hospitals. In the southern half of the state, highly concentrated multi-town regions clearly show the dominance of the Yale-New Haven Health System.



Figures 5 and 6: L+M Service Area HHI, before and after YNHHS takeover

This map demonstrates the dramatic increase in market concentration for the L+M Primary Service Area that will result from the potential takeovers. Because the market is already highly concentrated before the acquisition, combining YNHHS and L+MH will cause a large spike in market concentration, leaving few alternatives to the newly dominant Yale-New Haven system.

Figure 7



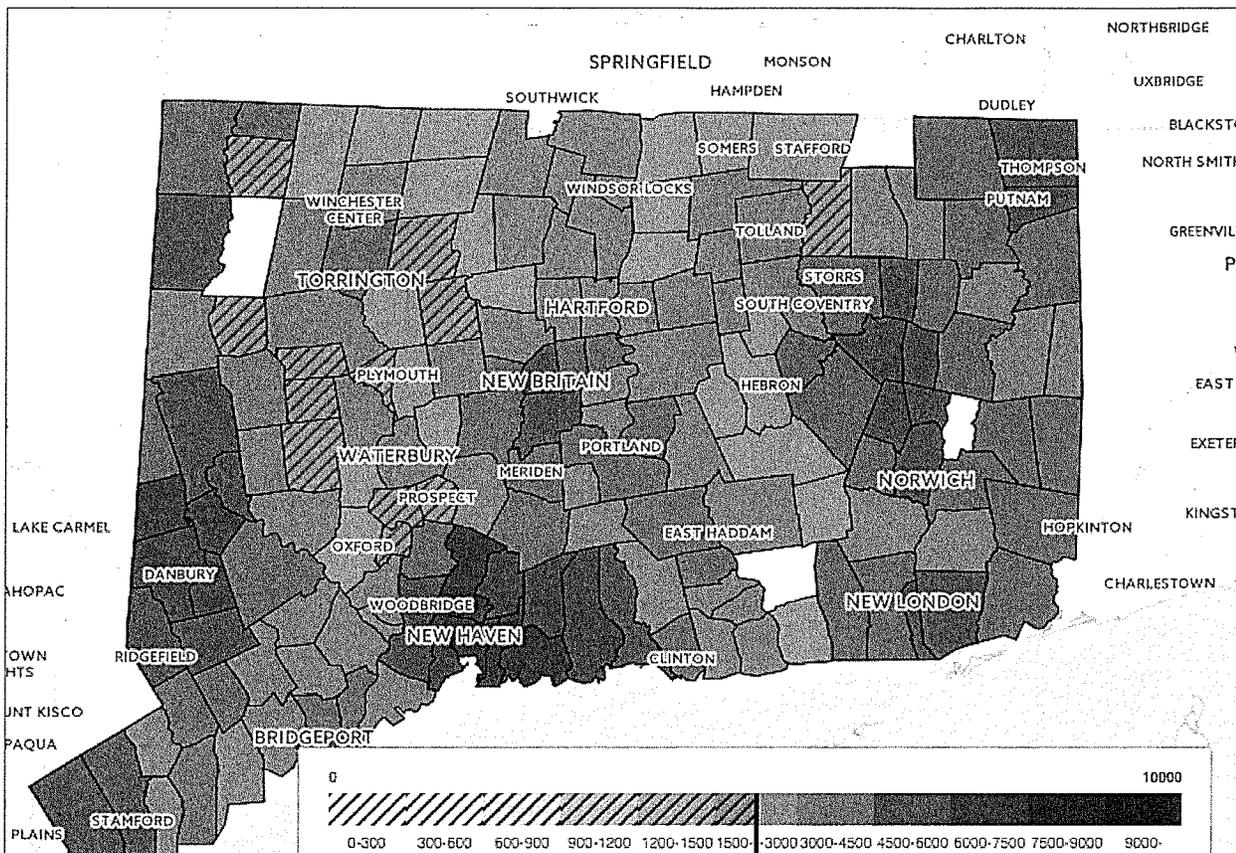


Figure 8: Town-by-town market concentration, Connecticut

This map shows the existing HHI scores for each town in Connecticut. Though discrete towns are not complete health care markets in themselves, the map shows roughly the distribution of highly and extremely concentrated markets throughout the state. Though Hartford HealthCare controls a large number of hospitals statewide, its hospitals are distributed in such a way that most towns in the north of the state exhibit comparatively lower market concentration, although most would still be defined as "highly concentrated" under federal standards. In the Yale-New Haven-controlled southern half, however, we see the highest density of towns with extremely high market concentration—above 6,000, indicating that Yale-New Haven's control of the market is geographically consolidated. Note that the region around New London is already heavily concentrated, and will become even more so if Yale-New Haven takes over L+M.

# 3. THE UNAFFORDABLE CONSEQUENCES OF MARKET CONCENTRATION

## Prices Go Up as Hospitals Gain Market Power

Hospitals often claim that consolidation increases efficiency. There is little evidence to support this claim.

Independent comprehensive reviews of the academic literature have rejected this interpretation. Nationally, the Robert Wood Johnson Foundation reports, based on a review of five independent studies, that when hospitals “merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent.”<sup>23</sup> Locally, the Universal Health Care Foundation of Connecticut concluded in its December 2014 review that “almost all retrospective studies suggest that hospital consolidation results in concentration of market power and a rise in the price of care.”<sup>24</sup>

In Massachusetts, the Attorney General has documented that monopoly pricing, especially by the non-profit Harvard-affiliated Partners system, is the state’s most significant cost driver.<sup>25</sup> In a court ruling this year against a hospital merger involving Partners, the Massachusetts judge found that the system was able to “exercise ‘near monopoly power’ that allows it to charge prices far in excess of its competitors for the same services.”<sup>26</sup>

The fact that the dominant systems in Connecticut are nominally not-for-profit corporations does not protect Connecticut patients. A majority of U.S. acute care hospitals are structured as private, non-profit enterprises. That fact has not prevented a massive wave of mergers and skyrocketing prices.

For years, judges permitted mergers of non-profit hospitals on the theory that they would behave

charitably with greater market power. In 2007, the Federal Trade Commission studied the pricing impacts of a non-profit merger in Illinois. It found that, according to the hospitals’ own economist, managed care prices increased by 42% over four years, 12% above the market as a whole.<sup>27</sup>

With rising health care costs one of the largest drivers of perennial state budget crises, state officials are increasingly concerned about the long-term cost of consolidation to taxpayers. Comptroller Kevin Lembo, who administers the state employee health plan covering 210,000 people at a cost of \$1.4 billion annually, recently testified stating, “We’re going to be negotiating potentially with 2 or 3 large systems and that’s basically it, if things keep going the way they are going. I don’t think you need to be an actuary to know that that’s going to be a tough spot for us.”<sup>28</sup>

Non-profit hospitals claim they need surplus revenue to serve low income people. But Duke University Professor Clark Havighorst points out that the IRS allows non-profit hospitals “to spend their untaxed surpluses on anything that arguably ‘promotes health.’ Much of what hospitals count as charitable behavior or community benefit is not spent on lower income people.”<sup>29</sup> University of Illinois tax law professor John Colombo adds:

*“The standard non-profit hospital doesn’t act like a charity any more than Microsoft does—they also give some stuff away for free. Hospitals’ primary purpose is to deliver high quality health care for a fee, and they’re good at that. But don’t try to tell me that’s charity. They price like a business. They make acquisitions like a business. They are businesses.”<sup>30</sup>*

## **We're Not Getting the Quality Care We're Paying For**

Already, Connecticut has the 4<sup>th</sup> highest per capita health care costs in the nation: we paid 27% more per person than the national average for health care in 2009, the most recent year for which data are available,<sup>31</sup> and what we spend at the hospital annually nearly tripled from 1991 to 2009, from \$3.9 billion to \$9.3 billion.<sup>32</sup>

The science of measuring hospital quality is still in its infancy. No single set of metrics is backed by a wide consensus. However, we examined several federal and independent evaluations. The available data provide no evidence that Connecticut's high health care costs are correlated to high quality. On several currently available metrics, Connecticut ranks among the states with the lowest scores.

For example, Medicare penalizes hospitals if patients are frequently readmitted within a month of their discharge. Based on these readmission standards, 90% of Connecticut hospitals received penalties for the 2015-2016 fiscal year, the second highest penalty rate for any state.<sup>33</sup> These 28 penalized hospitals included all three in the Yale-New Haven Health System, and Yale-New Haven Hospital itself received the seventh most severe penalty in the state.<sup>34</sup>

Medicare also assesses hospitals based on patient satisfaction across a number of areas like communication, cleanliness, and pain management. In the most recent scores compiled from quarterly Hospital Consumer Assessment of Healthcare Providers and Systems surveys, no Connecticut hospital received the top rating of five stars. Eighteen out of twenty-five hospitals received a three star rating, including YNHHS's Bridgeport and Yale-New Haven hospitals.<sup>35</sup>

The independent Leapfrog Group assesses hospital quality nationally and grades hospitals "A" to "F" based on factors such as safe surgery practices, infection rates, and use of correct staffing and procedures to minimize mistakes.<sup>36</sup> Connecticut ranked 36<sup>th</sup> in the percentage of hospitals scoring "A" in Fall

2015.<sup>37</sup> Maine and Massachusetts were 1<sup>st</sup> and 2<sup>nd</sup> nationally. Yale-New Haven and Greenwich Hospitals received "C" grades, Bridgeport a "D". Three of Hartford HealthCare's five hospitals received "C" grades, one a "B" and one a "D".<sup>38</sup>

As the science of quality measurement improves, and analysts are better able to account for factors such as the severity of patients' conditions across populations, these scorecards may yield different results. However, the Robert Wood Johnson Foundation examined the literature on hospital consolidation in relation to currently available quality indicators, and found that "a slim majority of studies find that, at least for some procedures, increases in hospital concentration reduce quality. The strongest studies confirm this result."<sup>39</sup>

# 4. CONFRONTING CONNECTICUT'S HOSPITAL MONOPOLIES

The Affordable Care Act and new Connecticut reimbursement policy are accelerating changes in how care is delivered and measured, and how the business of health care is structured. Before our very eyes, Connecticut is being carved up by a few hospital systems. The leader is clearly Yale-New Haven, with a level of control in many areas that easily meets any definition of market power. Meanwhile, our patients and payers are carrying a heavier and heavier financial burden as their health care costs rise.

Fortunately, Connecticut's legislative leaders have acted to curb the threat of consolidation by giving more tools to public consumers and to regulators. Two hospital regulatory bills in the last two years leave Connecticut better prepared to protect its consumers from the ill effects of monopoly. These reforms have put us in the forefront of states asserting the public interest in creating a fair health marketplace that benefits all. State regulators and advocates should use those tools now.

The acquisition of Lawrence + Memorial Health by the Yale-New Haven Health Services Corporation is a pivotal opportunity for stemming the growth

of monopoly in Connecticut's health care market and limiting the ill effects of consolidation. The proposal will be reviewed under Public Act 14-168, which passed in 2014. Portions of Public Act 14-168 were quickly superseded by SB 811, which passed in 2015. However, the L+M acquisition application was submitted before the newer law took effect. Nevertheless, PA 14-168 added new standards for the Certificate of Need. In any decision to grant or refuse a CoN, the law requires the Office of Health Care Access to take into account whether the applicants have

*"satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region; and [w]hether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care."<sup>40</sup>*

The sale as proposed unquestionably poses a threat to both provider diversity and health care costs along the shoreline.

In light of this threat, state officials should

rigorously examine the likely consequences of the transaction in order to decide whether to allow it to proceed. In particular, we recommend that prior to any approval or rejection, and prior to developing any proposed conditions, regulators take the following steps:

- SB 811 requires the state to undertake a “cost and market analysis” for such mergers. Although SB 811 does not formally apply, the Attorney General retains responsibility to enforce the Connecticut Anti-trust Act, and the Office of Health Care Access now must specifically examine the impact of merger-related consolidation on cost and access. Having public market analysis was critical to the process of public comment to the judge in the case of proposed mergers by Partners Health System in Massachusetts. Accordingly, we urge regulators to conduct the cost and market analysis that our state legislators have deemed appropriate for sales like this one.
- In order to understand the likely results of these acquisitions, we also believe that a thorough analysis of potential consolidation-related cost and access impacts calls for a retrospective look at any price changes following YNHH’s acquisition of the Hospital of St. Raphael three years ago. This is a clear test of whether or not YNHHS exercises market power to artificially inflate prices: if St. Raphael’s or Yale-New Haven’s overall prices increased significantly post-merger, there is no question that the system is flexing monopoly muscle within the SCRCOG region. Understanding any changes in the two hospitals’ prices may portend similar behavior in eastern Connecticut.
- We urge OHCA and the Attorney General to view the L+M acquisition in tandem with the unannounced takeover of Milford Hospital. To date, the relationship between YNHHS and

Milford Hospital has been viewed as a series of individual transactions.

The changes to the market statewide pose high potential risks to patients. In the interest of quality and affordability in our health care marketplace, regulators must use these tools and more before they decide whether this transaction should proceed.

## APPENDIX A: DEFINING AND MEASURING HOSPITAL MARKETS

The authors have chosen to apply HHI to the five geographic areas identified in the report as an initial illustration of the challenges posed by YNHHS's slow-motion consumption of Milford Hospital and proposed acquisition of L+M Health. We are awaiting further data to allow more thorough analysis, and also expect that regulators will apply a more rigorous methodology as full information on the transaction becomes available.

The definition and measurement of hospital markets is a hotly contested legal subject. As noted in the body of the report, for many years courts tended to assume that it was appropriate to entrust not-for-profit entities with market power because of their "charitable" nature. As courts began to take the threat to competition from consolidating non-profit hospitals seriously, the prosecution of anti-trust cases foundered on the use of analytic tools that fail adequately to account for the inelasticity of hospital demand.

In 1982, the FTC and Department of Justice Guidelines adopted a test that sets the boundaries of a monopoly market at the furthest limits at which a potential cartel or monopolist can impose a small but significant non-transitory increase in price ("SSNIP"). A SSNIP is generally assumed to be a 5% increase for a year without losing market share.

To define the SSNIP boundary, economists used two tests. For hospitals, the Elzinga-Hogarty test uses "patient flow" data to determine consumers' ability to enter and exit the market boundaries. Any boundary in which 10% or more patients leave to get care elsewhere is assumed to have enough competition to preclude anti-competitive behavior. "Critical Loss Analysis" examines the ability of firms to withstand profitably the loss of customers expected under a given market definition following a price increase. Once the market was defined,

analysts would then apply a measure of market concentration such as the Herfindahl-Hirschman Index (HHI) to determine the anti-trust risk.

E-H and CLA both proved inadequate for hospital mergers. Neither accounts for factors that influence patient choice other than price (3rd party payment, role of the physician, proximity, availability of subspecialty services, etc.). Standard CLA analysis often results in "inconsistent logic and erroneous conclusions." Use of these tools allowed hospital defendants to win a series of cases between 1997 and 2004 in part by successfully defining markets as large geographic areas within which any single combination of hospitals posed a minimal threat to competition.

Gaynor, Kleiner, and Vogt estimate that these older methods overstated the elasticity of hospital demand "by a factor of 2.4 to 3.4 and were likely a contributing factor to the permissive legal environment for hospital mergers." That permissive environment allowed 1,425 mergers and acquisitions to be consummated between 1994 and 2009. Dr. Elzinga himself questioned the value of his own test on hospital markets in 2011.

In the early 2000s, economists developed the "option demand" analysis (Town and Vistnes, 2001; Capps, Dranove, and Satterthwaite, 2003) and the Differentiated Bertrand Oligopoly Model (DB). These models attacked the issue of third party reimbursement by envisioning a hypothetical health plan attempting to construct a provider network in the region of the merging competitors. "This is a reasonable characterization of managed care markets," write Gaynor, et al., of the option demand model.

The new methods yield markets far smaller and closer to economic reality than the older tests, and

lead to clearer pictures of market concentration. According to Gaynor et al, they allow analysts “to assess merger effects without a market definition.”

However, they are not yet universally accepted in court, and even though the new methods are capable of assessing merger effects without a market definition, courts expect definitions and FTC guidelines for state Attorneys General insist on them as well. The new tools are powerful, and once we obtain data sufficient to apply them we will attempt to do so.

For our initial analysis, we have chosen to examine markets defined by the hospitals in their public descriptions of themselves. These analyses serve as an adequate preliminary basis for gauging the degree of concentration, and we examine several concentric markets that present analyses at varying scales of market definitions.

However, we recognize that in the policy process, any attempt at market definition will be contentious. Therefore, we urge regulators to heed the words of Kenneth Elzinga closely. In evaluating the usefulness of his original model in the context of

hospital mergers, Dr. Elzinga notes “where direct evidence of anticompetitive effects attributable to a merger is available, its use may diminish the need to rely on geographic market definition tools such as the E-H test,” writes Dr. Elzinga. “Such direct evidence is most readily available in post-closing merger challenges such as the FTC’s Evanston case.”

Connecticut patients cannot wait until Milford and L+M are fully in the Yale-New Haven orbit to understand the potential price impact of the deals. Although there is no direct evidence, there is a useful precedent. Yale-New Haven’s purchase of the Hospital of St. Raphael resulted in intense market concentration in the Greater New Haven area.

The Certificate of Need filed for that transaction in 2012 states that “YNHH has no plans to raise charges as a result of the HSR acquisition,” language similar to that in the Certificate of Need for L+M. If an analysis of the market before and after that merger reveals significant price increases, there will be little question that YNHHS exerts monopoly pricing power.

**APPENDIX B:  
HHI TABLE, BEFORE AND AFTER BOTH HOSPITAL ACQUISITIONS, BY AREA**

<b>Market name</b>	<b>HHI before</b>	<b>HHI after</b>	<b>Change</b>
Lawrence + Memorial Primary Service Area	5087	6982	+1895
Lawrence + Memorial Secondary Service Area	3485	4598	+1113
YNHHS Local Service Area	2911	3735	+823
Greater New Haven (SCRCOG)	5665	6931	+1266
YNHH Primary Service Area	3920	4222	+302

**APPENDIX C:  
MARKET SHARE AND HHI CALCULATIONS FOR L+M ACQUISITION ONLY,  
WITHOUT MILFORD HOSPITAL ACQUISITION, BY AREA**

*Data in this table include YNHHS's proposed acquisition of L+M, but not the addition of Milford Hospital. HHI increase is compared to HHI with the Yale-New Haven system as is.*

<b>Market name</b>	<b>YNHHS Discharges</b>	<b>HHI</b>	<b>HHI Increase</b>
State	31%	1667	+254
Lawrence + Memorial Primary Service Area	83%	6972	+1884
Lawrence + Memorial Secondary Service Area	59%	4592	+1107
YNHHS Local Service Area	57%	3539	+628
Greater New Haven (SCRCOG)	79%	6309	+643
YNHH Primary Service Area	61%	3933	+14

# NOTES

- 1 US Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, August 19, 2010. <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.
- 2 The Synthesis Project, Update: New Insights from Research Results, the Robert Wood Johnson Foundation, <http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html>
- 3 Kaiser Family Foundation "Out of Pocket Pain: Cumulative Growth in Worker Health Expenses vs. Earnings," April 8, 2015. <http://kff.org/health-costs/slide/out-of-pocket-pain-cumulative-growth-in-worker-health-expenses-vs-earnings/>
- 4 Rebecca Riffkin, "Cost Still a Barrier Between Americans and Medical Care," The Gallup Organization, November 28, 2014. <http://www.gallup.com/poll/179774/cost-barrier-americans-medical-care.aspx>
- 5 Ana Radelat, "Congress scrutinizes Aetna-Humana and Anthem-Cigna deals, Connecticut Mirror, September 10, 2015. <http://ctmirror.org/2015/09/10/congress-scrutinizes-aetna-humana-and-anthem-cigna-deals/>
- 6 Dani Gordon, "100 Largest Hospitals in America, Becker's Hospital Review August 7, 2014. <http://www.beckershospitalreview.com/lists/8-7-14-100-largest-hospitals-in-america.html>
- 7 Greater New Haven defined as the fifteen towns represented in the Southern Connecticut Regional Council of Governments. <http://www.scrkog.org/municipalities.html>
- 8 See Connecticut Office of Health Care Access Certificate of Need Docket #s 13-31838-CON (Waterbury), 14-31926-486 (ECHN), 14-31928-486 (Bristol), and 14-31927-486 (St. Mary's). Note that Tenet and Yale-New Haven would split St Mary's equity 64%/16%, with a community foundation controlling 20%, see p. 52.
- 9 Connecticut Office of Health Care Access Certificate of Need, "Affiliation of Lawrence + Memorial Corporation with Yale-New Haven Health Services Corporation," Docket #15-32033, October 7, 2015.,Page 23. [http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15\\_32033\\_con.pdf](http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15_32033_con.pdf)
- 10 Connecticut Office of Health Care Access Certificate of Need "Application to Terminate Inpatient Obstetrical Labor and Delivery Services at Milford Hospital, Docket #15-31998, page 9. [http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15\\_31998\\_con.pdf](http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15_31998_con.pdf).
- 11 OHCA Docket #15-31988, [http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15\\_31998\\_con.pdf](http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15_31998_con.pdf)
- 12 State of Connecticut, Department of Public Health, Office of Health Care Access, Annual Report on the Financial Status of Connecticut's Acute Care Hospitals for Fiscal Year 2014. [http://www.ct.gov/dph/lib/dph/ohca/hospitalfillings/2014/fsreport\\_2014.pdf](http://www.ct.gov/dph/lib/dph/ohca/hospitalfillings/2014/fsreport_2014.pdf)
- 13 OHCA Docket #15-32033, [http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15\\_32033\\_con.pdf](http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15_32033_con.pdf)
- 14 Universal Health Care Foundation of Connecticut, Hospital Consolidations and Conversions: A Review of the Literature, December, 2014 [http://universalhealthct.org/images/publications/Hospital\\_Consolidations\\_and\\_Conversions.pdf](http://universalhealthct.org/images/publications/Hospital_Consolidations_and_Conversions.pdf) citing <http://c-hit.org/2014/03/23/hospital-mergers-raise-concerns-over-patient-costs>
- 15 For 1994-2009, Martin Gaynor, Samuel A. Kleiner, and William B. Vogt, "A Structural Approach to Market Definition with an Application to the Hospital Industry" The Journal of Industrial Economics, June 2013, 61(2); 243-289; for 2010-2013, Seth Freedman, Effects of Provider Consolidation in Healthcare: The Latest Research, November 21, 2014; for 2014, Lisa Phillips, 2015 Health Care Services Acquisition Report, Irving Levin Associates, March 31, 2015. <http://www.businesswire.com/news/home/20150331006369/en/Newly-Published-Report-2014-Health-Care-Services>
- 16 Cf Martin Gaynor, Samuel A. Kleiner, William B. Vogt, "A Structural Approach to Market Definition with an Application to the Hospital Industry" Carnegie Mellon University, March 4, 2012.; Dranove and Sefkas, "The Revolution in Health Care Antitrust: New Methods and Provocative Implications," The Milbank Quarterly, 2009 Sep; 87(3); 607-632.; Kenneth Elzinga, Anthony Swisher, "Limits of the Elzinga-Hogarty Test in Hospital Mergers: The Evanston Case," International Journal of the Economics of Business, (18)2011; 1133-146.
- 17 Seth Freedman, Effects of Provider Consolidation in Healthcare: The Latest Research, November 21, 2014; for 2014, Lisa Phillips, 2015 Health Care Services Acquisition Report, Irving Levin Associates, March 31, 2015. <http://www.businesswire.com/news/home/20150331006369/en/Newly-Published-Report-2014-Health-Care-Services>
- 18 <http://emma.msrb.org/EA608904-EA476406-EA872921.pdf>
- 19 <http://emma.msrb.org/EA507875-EA395651-EA792545.pdf>
- 20 <http://emma.msrb.org/EA570061-ER555314-ER956343.pdf>
- 21 US Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, August 19, 2010. <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.
- 22 Horizontal Merger Guidelines

- 23 The Synthesis Project, Update: New Insights from Research Results, the Robert Wood Johnson Foundation, [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf73261](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261) accessed 5/18/2015
- 24 Universal Health Care Foundation of Connecticut, Hospital Consolidations and Conversions: A Review of the Literature, December, 2014. [http://universalhealthct.org/images/publications/Hospital\\_Consolidations\\_and\\_Conversions.pdf](http://universalhealthct.org/images/publications/Hospital_Consolidations_and_Conversions.pdf) p. 8
- 25 Examination of Health Care Cost Trends and Cost Drivers, Office of the Attorney General, June 22, 2001. <http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf>
- 26 Commonwealth v. Partners Healthcare System, Inc., & Others, Memorandum of Decision and Order on Motion for Joint Entry of Amended Final Judgement by Consent, SUCV2014-02033-BLS2, <http://www.mass.gov/ago/docs/press/2015/partners-memo-of-decision-and-order.pdf>
- 27 In the Matter of Evanston Northwestern Healthcare Corporation, Opinion of the Commission. Federal Trade Commission Docket No. 9315, August 6, 2007. <https://www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf> p.38.
- 28 Authors' transcription of Comptroller Lembo's oral remarks to the Bipartisan Roundtable on Hospitals and Healthcare, 12/18/2014
- 29 Clark Havighorst and Barak Richman, "The Provider Monopoly Problem in Health Care," Oregon Law Review 89:858, 3/31/2011. [http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2905&context=faculty\\_scholarship](http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2905&context=faculty_scholarship)
- 30 <http://www.nytimes.com/2013/12/17/us/benefits-questioned-in-tax-breaks-for-nonprofit-hospitals.html>
- 31 ", Kaiser Family Foundation, "Health Care Expenditures Per Capita by State of Residence". <http://kff.org/other/state-indicator/health-spending-per-capita/>
- 32 Centers for Medicare and Medicaid Services, "Total All-Payer State Estimates by State of Residence - Personal Health Care" <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/res-tables.pdf>
- 33 Medicare Readmission Penalties by Hospital, Year 4, Kaiser Health News, August 3, 2015. <http://khn.org/news/half-of-nations-hospitals-fail-again-to-escape-medicares-readmission-penalties/#state>
- 34 Medicare Readmission Penalties by Hospital, Year 4, Kaiser Health News, August 3, 2015. <http://cdn.kaiser-healthnews.org/attachments/MedicareReadmissionPenaltiesByHospital,Year4.pdf>
- 35 <https://data.medicare.gov/data/hospital-compare>
- 36 Matthew J. Austin, et al, "Safety in Numbers: The Development of the Leapfrog's Composite Patient Safety Score for U.S. Hospitals," Journal of Patient Safety, 2013; 9 (1-9). [http://www.hospitalsafetyscore.org/media/file/JournalofPatientSafety\\_HospitalSafetyScore.pdf](http://www.hospitalsafetyscore.org/media/file/JournalofPatientSafety_HospitalSafetyScore.pdf)
- 37 The Leapfrog Group "How Safe is Your Hospital?," state rankings, Fall 2015. <http://www.hospitalsafetyscore.org/your-hospitals-safety-score/state-rankings>, December 3, 2015
- 38 The Leapfrog Group "How Safe is Your Hospital?," rankings for Connecticut, <http://www.hospitalsafetyscore.org/> December 3, 2015
- 39 Martin Gaynor and Robert Town, "The Impact of Hospital Consolidation - Update," Robert Wood Johnson Foundation, The Synthesis Project, June 2012, [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf73261](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261)
- 40 CGA 19a-639; Public Act 16-148 section 28(a)(11) and 28(a)(12).
- 41 US Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, August 19, 2010. <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>
- 42 Cf O'Brien and Wicklegren, "A Critical Analysis of Critical Loss," FTC, May 23, 2003; Frech, Langenfeld and McCluer, "Elzinga-Hogarty Tests and Alternative Approaches for Market Share Calculations in Hospital Markets," Antitrust Law Journal 2004; 3
- 43 See especially David Dranove and Andrew Sefkas, "The Revolution in Health Care Antitrust: New Methods and Provocative Implications," The Milbank Quarterly, 2009 Sep; 87(3); 607-632. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881459/#fn10>
- 44 Martin Gaynor, Samuel A. Kleiner, and William B. Vogt, "A Structural Approach to Market Definition with an Application to the Hospital Industry" The Journal of Industrial Economics, June 2013, 61(2); 243-289
- 45 Kenneth Elzinga, Anthony Swisher, "Limits of the Elzinga-Hogarty Test in Hospital Mergers: The Evanston Case," International Journal of the Economics of Business, (18)2011; 1133-146. <https://ideas.repec.org/a/taf/ijecbs/v18y2011i1p133-146.html>
- 46 Dranove and Sefkas, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881459/#fn10>
- 47 Gaynor, et al.
- 48 Kenneth Elzinga, Anthony Swisher, "Limits of the Elzinga-Hogarty Test in Hospital Mergers: The Evanston Case," International Journal of the Economics of Business, (18)2011; 1133-146. <https://ideas.repec.org/a/taf/ijecbs/v18y2011i1p133-146.html>



## **EXHIBIT 5**

## **Exhibit Two**

### **Higher Cost but No Higher Quality: Hospital-Owned Physician Groups, Academic Medical Centers**

Baker, L., et al, "Physician Practice Competition and Prices Paid by Private Insurers for Office Visits," *JAMA*, October 22/29, 2014, 312(16):1653-1662

Berenson, R., et al, "Unchecked Provider Clout in California Foreshadows Challenges To Health Reform," *Health Affairs*, 29, No. 4 (2010): 699-705

Burns, L., et al, Horizontal and Vertical Integration of Physicians: A Tale of Two Tails, Annual Review of Health Care Management: Revisiting the Evolution of Health Systems Organization, *Advances in Health Care Management*, Volume 15, 39-117, 2013

Carlin, C., et al, "Changes in Quality of Health Care Delivery after Vertical Integration," *Health Services Research*, 50:4, August 2015

Casalino, L., "The Federal Trade Commission, Clinical Integration, and the Organization of Physician Practice," *Journal of Health Politics, Policy and Law*, Vol. 31, No. 3, June 2006

Casalino, L., et al, "Small Primary Care Physician Practices Have Low Rates of Preventable Hospital Admissions," *Health Affairs*, 33, No. 9 (2014)

Frakt, A., "The Downside of Merging Doctors and Hospitals," *The New York Times*, June 13, 2016

Girod, C., et al, "2016 Milliman Medical Index: Healthcare costs for the typical American family will exceed \$25,000 in 2016. Who cooked up this expensive recipe?" Milliman, May 24, 2016

Goldsmith, J., et al, "Integrated Delivery Networks: In Search of Benefits and Market Effects," National Academy of Social Insurance, February 2015

Harris, G., "More Doctors Giving Up Private Practices," *The New York Times*, March 25, 2010

HIS Talk, "Epic: The Cold Hard Facts," Healthcare IT News & Opinion, February 29, 2016

Kirchhoff, S., "Physician Practices: Background, Organization, and Market Consolidation," Congressional Research Service, R42880, January 2, 2013

Kocher, R. and N. Sahni, "Hospitals' Race to Employ Physicians – The Logic behind a Money-Losing Proposition," *The New England Journal of Medicine*, 364:19, May 12, 2011

Laugesen, M., and S. Glied, "Higher Fees Paid to US Physicians Drive Higher Spending For Physician Services Compared To Other Countries," *Health Affairs*, 30, No. 9 (2011); 1647-1656

Massachusetts Health Policy Commission, Community Hospitals at a Crossroads, February 24, 2016

McWilliams, J., et al, "Early Performance of Accountable Care Organizations in Medicare," *The New England Journal of Medicine*, April 13, 2016

Neprash, H., et al, "Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices," *JAMA Internal Medicine*, 2015:175(12):1932-1939

Pineault, R., et al, "Why Is Bigger Not Always Better in Primary Health Care Practices? The Role of Mediating Organizational Factors," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 2016, 1-9

Robinson, J. and K. Miller, "Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California," *JAMA*, October 22/29, 2014;312(16):1663-1669

Rosin, T., "Moody's: High rate of physician employment linked to lower profitability," *Becker's Hospital Review*, December 9, 2015

Sun, E. and L. Baker, "Concentration In Orthopedic Markets Was Associated With A 7 Percent Increase In Physician Fees For Total Knee Replacements," *Health Affairs*, 34, No. 6 (2015): 916-921

Watson, S., et al, "Owned vertical integration and health care: Promise and performance," *Health Care Management Review*, 1996, 21(1), 83-92

## **EXHIBIT 6**

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# Community Hospitals at a Crossroads

Findings from an Examination of  
the Massachusetts Health Care  
System

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**MASSACHUSETTS**  
HEALTH POLICY COMMISSION

## Background of the report: building a path to a thriving, community-based health care system

### The need for the report

- Hospitals and health systems across the country are facing **unprecedented impetus to adapt** to new care delivery approaches and value-based payments
- Community hospitals are under particular pressure to change and are uniquely challenged by **current market and utilization trends**, as evidenced by a number of recent consolidations, closures, and conversions in Massachusetts
- The state is pursuing sweeping delivery system transformation to achieve shared cost containment goals, and effective, **action-oriented planning is necessary**

### Objectives of the report

- To understand and describe the **current state of and challenges facing community hospitals**
- To examine the implications of **market dynamics** that can lead to elimination or reduction of community hospital services
- To **identify challenges to and opportunities for transformation** in community hospitals
- To **encourage proactive planning** to ensure sustainable access to high-quality and efficient care and catalyze a **multi-stakeholder dialogue** about the future of community health systems

“ I don’t see any future for community hospitals...I think there’s a **fantastic future for community health systems**. If small stand-alone hospitals are only doing what hospitals have done historically, I don’t see much of a future for that. But I see a **phenomenal future** for health systems with a strong community hospital that breaks the mold [of patient care].”

COMMUNITY HOSPITAL CEO

## Key themes of the report

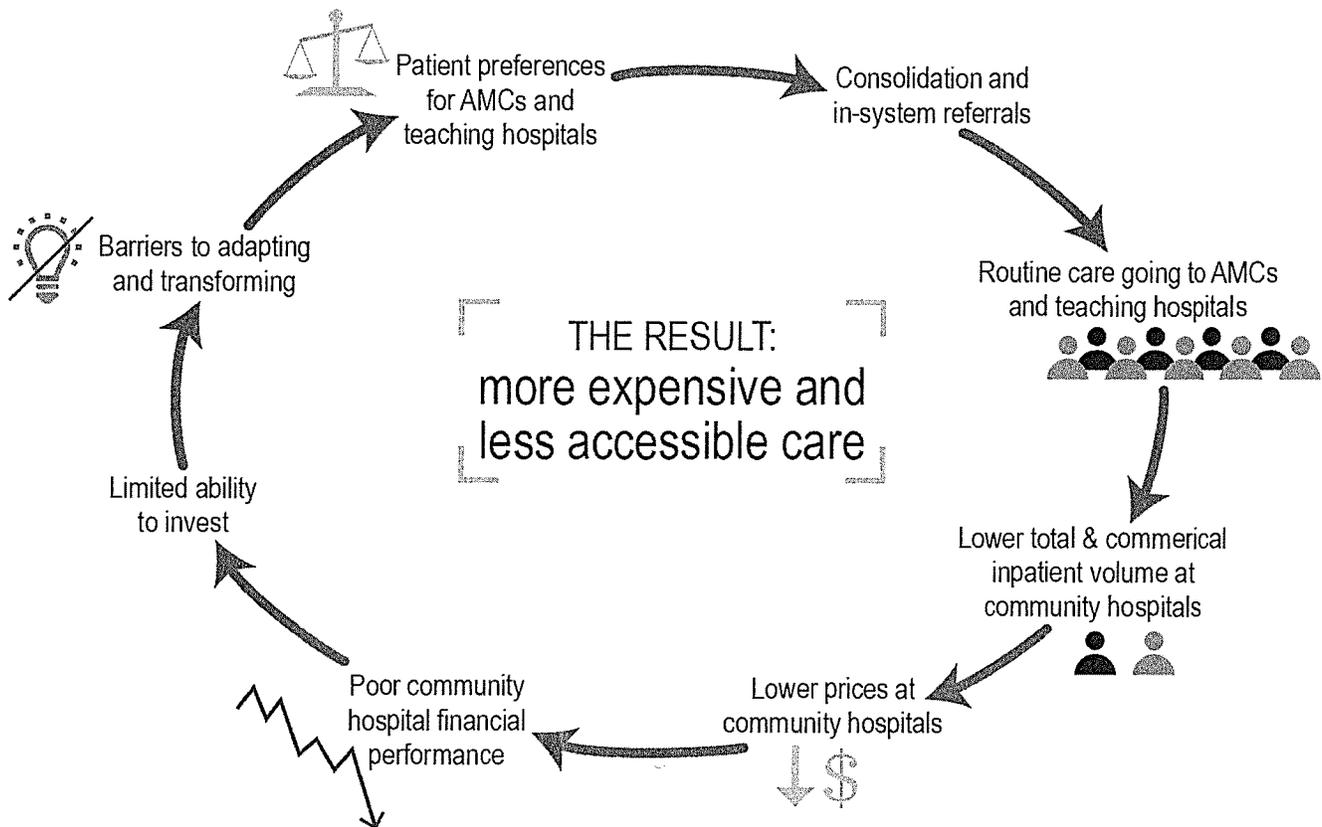
Community hospitals provide a unique value to the Massachusetts health care system

- While individual characteristics vary, as a cohort community hospitals play a critical role in care for publicly insured patients; providing local, community-based access; and, in particular, meeting behavioral health needs
- Community hospitals provide more than half of all inpatient discharges and more than 2/3 of all ED visits statewide
- Community hospitals generally provide high-quality health care at a low-cost, providing a direct benefit to the consumers and employers who ultimately bear the costs of the health care system

The traditional role and operational model for many community hospitals faces tremendous challenges

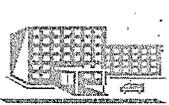
- Community hospitals generally have worse financial status, older facilities, and lower average occupancy rates than AMCs and teaching hospitals
- Many hospitals face barriers to transformation:
  - Consolidation of acute and physicians services into major health systems
  - Routine care going to AMCs and teaching hospitals
  - Lower commercial volume and prices leading to lack of resources for reinvestment
  - Difficulty participating in current alternative payment models

## Community hospitals face self-reinforcing challenges that lead to more expensive and less accessible care



## Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System

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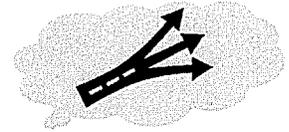
Overview



Value



Challenges

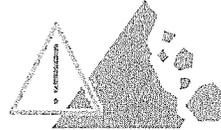
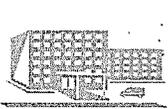


Path Forward

- An **overview** of community hospitals in Massachusetts
- The **value** of community hospitals to the health care system
- **Challenges** facing community hospitals
- The **path** to a thriving community-based health care system

## An overview of community hospitals in Massachusetts

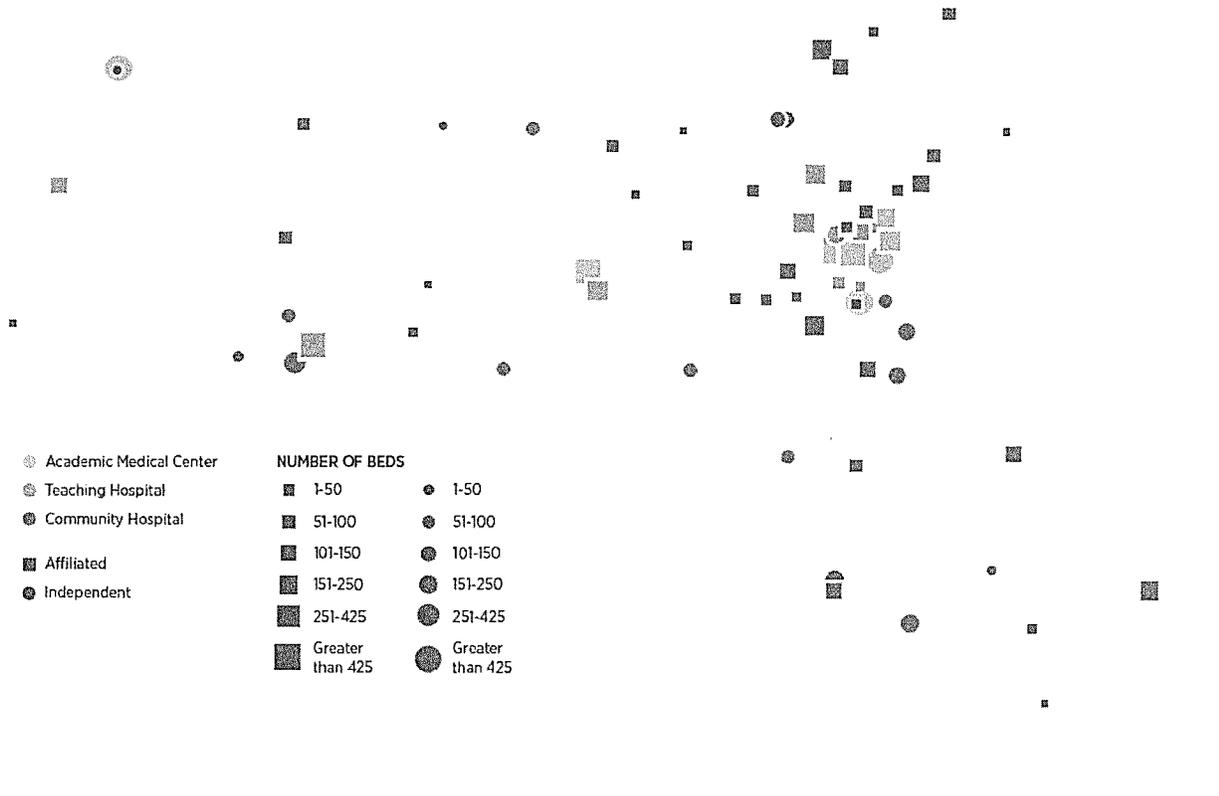
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### Overview

- Key distinguishing features of community hospitals (geographic distribution, patient populations, services, financial condition)
- Key community hospital trends (transitions, consolidation and closure)

# Community hospitals serve all parts of the Commonwealth



Source: HPC analysis of CHIA Hosp. Profiles, 2013

## Community hospitals at a glance

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**43**

Community  
Hospitals

**27 | 18**

DSH | non-DSH

**7,518 | 52%**

more than half of beds statewide  
(19 – 556)

**417,275 | 51.3%**

more than half of discharges statewide  
(556 – 40,303)

**5.8 | 42**

million | %  
outpatient visits

**1.9 | 65**

million | %  
2/3 of ED visits  
(10,329 – 155,236)

**64% | 84%**

community hospitals | AMCs

low occupancy rate  
(29% – 74%)

**0.8 | 1.33**

community hospitals | AMCs

low case mix index  
(0.60 – 0.93)

**9.3 | +11**

minutes | minutes

local patients drive 9.3  
minutes on average to  
community hospitals;  
they would drive 11  
minutes more on  
average to get to the  
next closest hospital

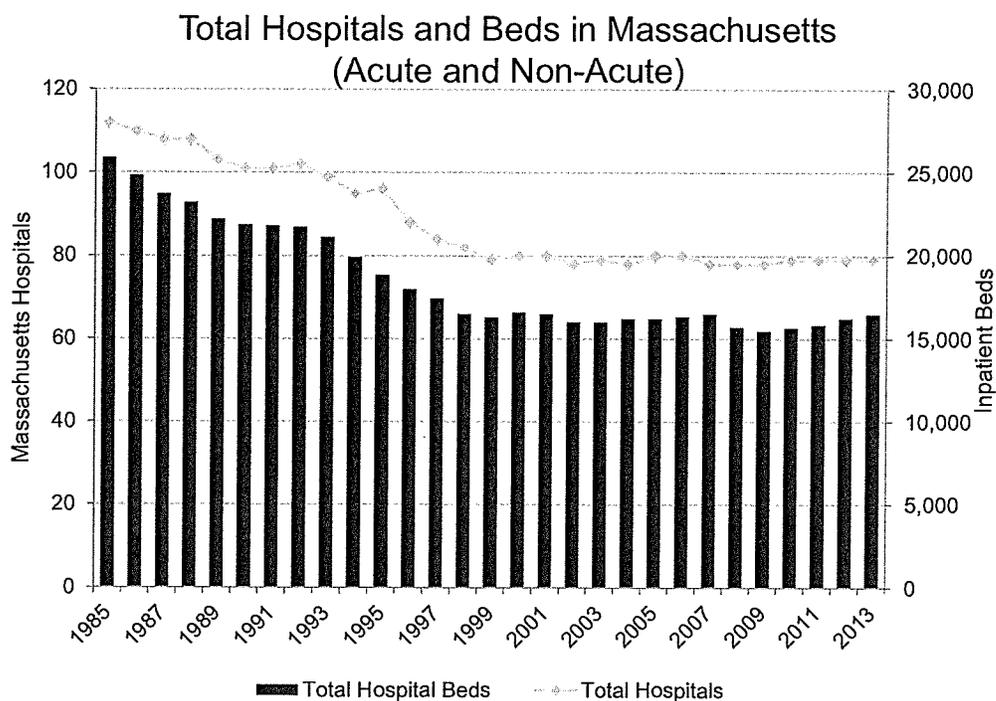
### Older age of plant

Community hospitals generally  
have older physical plants than  
AMCs or teaching hospitals

### Higher public payer mix

Community hospitals generally  
have disproportionately high  
shares of Medicaid and Medicare  
patients

## Consolidations and closures over the last 30 years have contributed to a dynamic hospital market in Massachusetts



Source: American Hospital Association

**Recent Conversions in Massachusetts Have Had Varied Impact**

*North Adams Regional Hospital*

*Steward Quincy Medical Center*

**Two Conversions Are Being Currently Contemplated**

*Baystate Mary Lane Hospital*

*Partners North Shore Medical Center – Union Hospital*

Hospital-related Material Change Notices Since 2013

**11**

mergers or acquisitions of one hospital by another

**16**

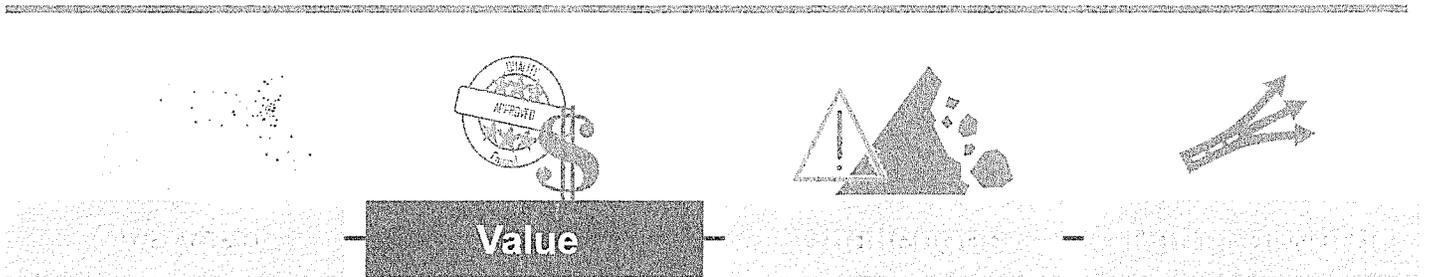
new contracting or clinical relationships between hospitals

**5**

hospitals acquiring physician groups

## The value of community hospitals to the health care system

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### *Community-based care and access*

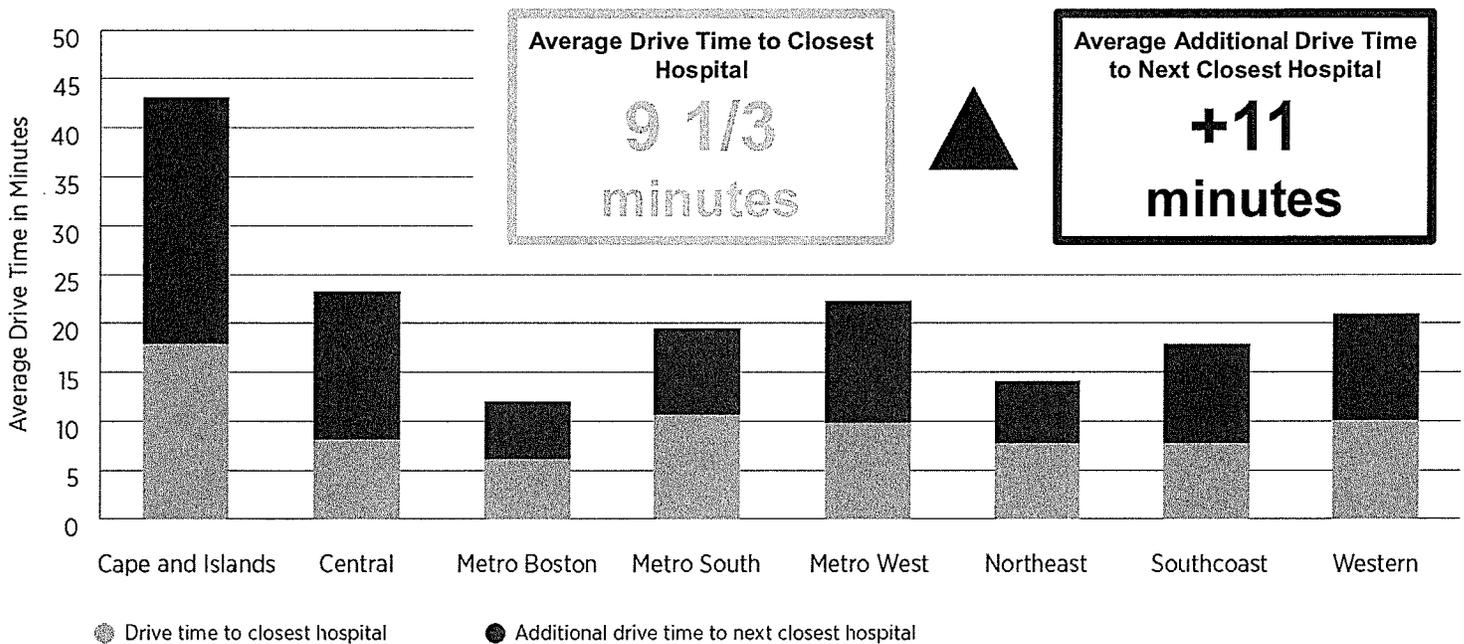
- Care close to home / drive time analyses
- Patient populations / payer mix

### *Quality and Efficiency*

- Examination of quality performance by community hospitals and patient perception of quality and value
- Variation in spending and costs for community-appropriate care at community vs other hospitals

## Community hospitals provide local access for local patients

Average Drive Times for Patients Using Their Local Community Hospital  
*Analysis of patients who use their closest community hospital as a usual site of care*

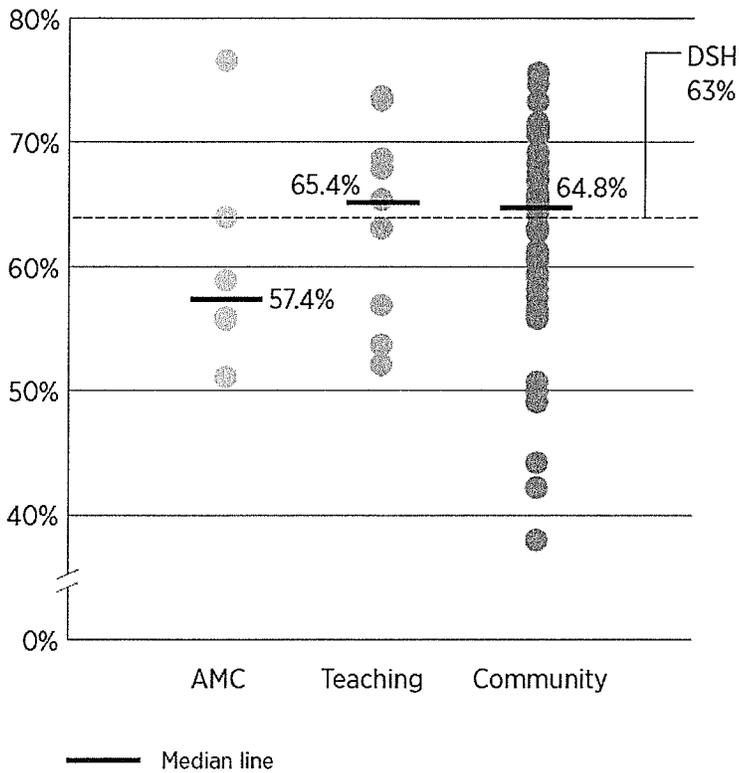


Source: HPC analysis of MHDC 2013 discharge data.

Notes: Drive times may underrepresent travel time and travel time differentials for populations relying on public modes of transportation. The Cape and Islands region includes only Falmouth and Cape Cod Hospital for the purposes of this analysis, since measuring drive times for Hospitals on Nantucket and Martha's Vineyard islands would not be meaningful.

**Community hospitals serve a high proportion of vulnerable populations for whom access to care is often difficult, such as elders, individuals with disabilities, and individuals with low incomes**

Percent of Hospital Gross Patient Revenue from Public Payers by Hospital Cohort, FY13



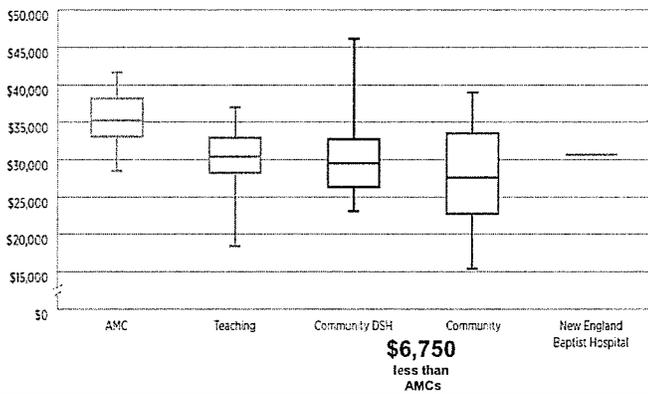
“  
*The community hospital plays a role as a cultural and social staple for the community that it serves. It’s the place you’re born at, that you grow up with, and get most of your basic care at...The state should ensure access to community-based, cost-effective care*  
 ”  
 MASSACHUSETTS STATE LEGISLATOR

Source: HPC analysis of CHIA Acute Hosp. Databook, supra footnote 11, at Appendix D.  
 Note: Public payers include Medicare and Medicaid/MassHealth fee for service and managed care plans, Health Safety Net payments, and charges designated by hospitals as “other government.”

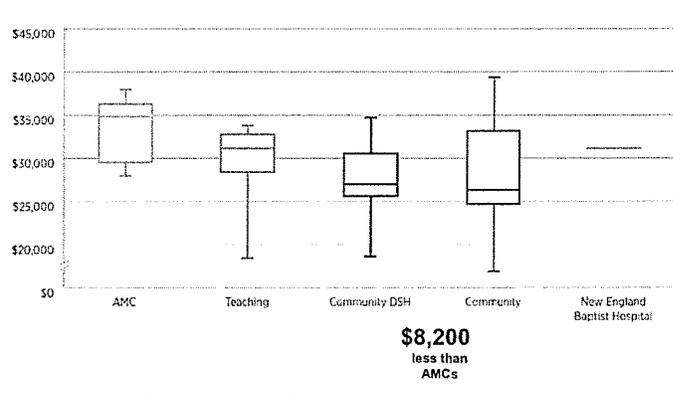
# Spending at community hospitals is generally lower for low-acuity orthopedic and maternity care and is not associated with any difference in quality

Orthopedics

Hip Replacement

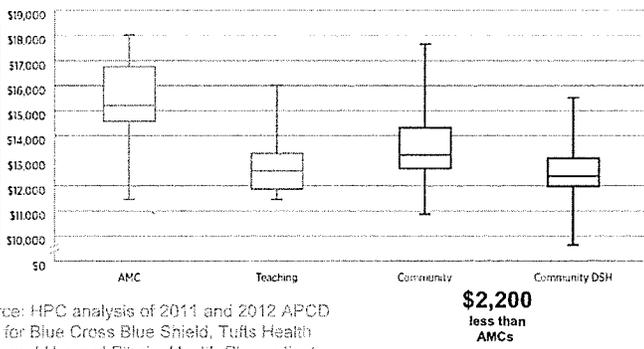


Knee Replacement

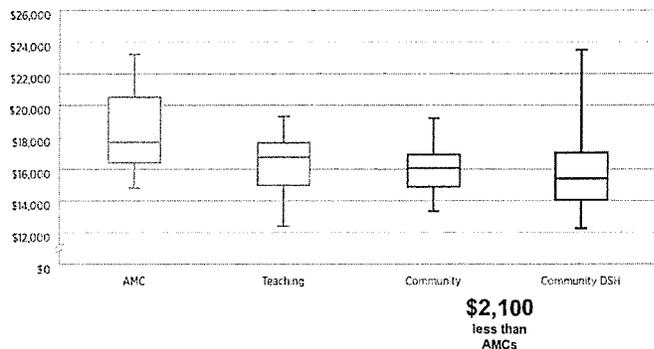


Deliveries

Pregnancy - Vaginal Delivery



Pregnancy - Caesarian Delivery

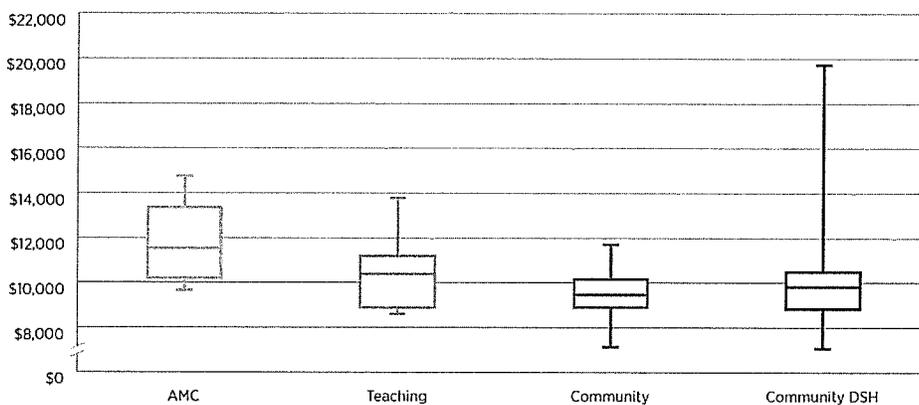


Source: HPC analysis of 2011 and 2012 APCD data for Blue Cross Blue Shield, Tufts Health Plan, and Harvard Pilgrim Health Plan patients

We found no correlation between hospital cost and quality. Each group of hospitals has higher and lower quality performers but no cohort outperforms any other overall.

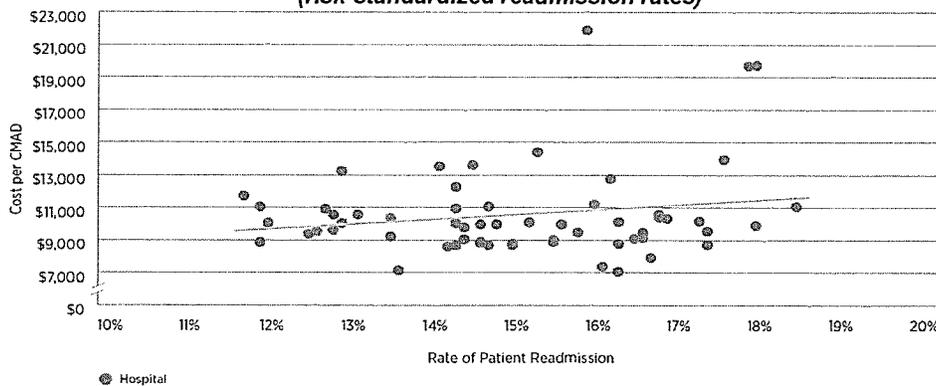
## Most community hospitals provide care at a lower cost per discharge, without significant differences in quality

Hospital costs per case mix adjusted discharge, by cohort



Source: HPC analysis of CHIA Hosp. Profiles, 2013

Costs per CMAD are not correlated with lower quality (risk-standardized readmission rates)



● Hospital

Source: HPC analysis of CHIA Hosp. Profiles, 2013; CHIA Focus on Provider Quality Databook, Jan 2015

On average, **community hospital costs are nearly \$1,500 less per inpatient stay** as compared to AMCs, although there is some variation among the hospitals in each group

Although costs per discharge for community hospitals have grown at a slightly higher rate than those for AMCs, the gap between AMC and community hospital costs has not substantially changed

Reasons for differences in efficiency likely vary, and may include service offerings, support for teaching programs, and, particularly for community hospitals, the pressure of tight operating margins

## **Increases in health care spending on inpatient care would result from the closure of most community hospitals, due to commercial price variation**

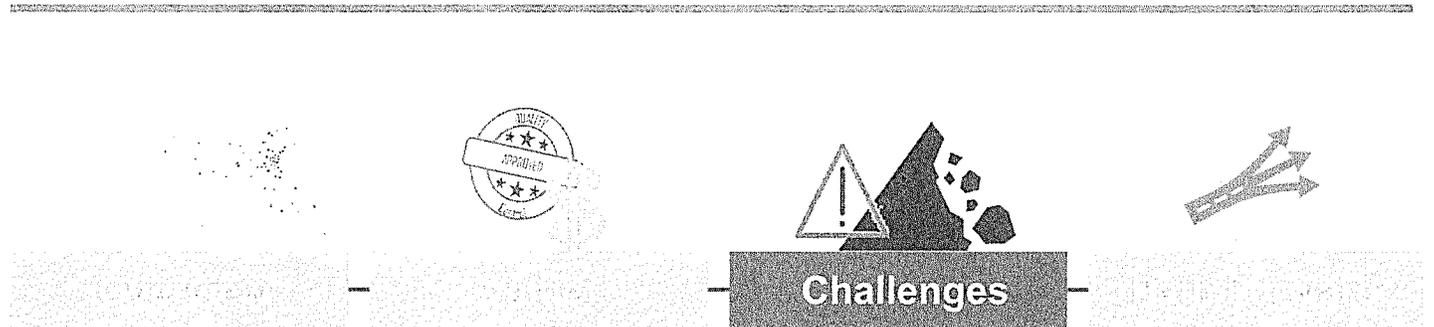
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The HPC modeled where patients would likely seek care if community hospitals were to close and to estimate commercial spending impact.

- In most cases, a community hospital closure would **increase annual spending on inpatient care**
- **The majority of these increases would be less than \$4 million**, due to the disproportionately low volume of commercially insured patients at many community hospitals
- Spending would increase by **more than \$5 million for seven community hospitals**
  - The closure of **Lowell General Hospital** would cause the greatest increase: **over \$16 million**
- Spending would actually **decrease** in the event of the closure of any of eight community hospitals, primarily those with higher relative prices
  - The greatest decreases in spending would result from **South Shore Hospital (\$4.2 million annually)** or **Cooley-Dickinson Hospital (\$2.8 million annually)** becoming unavailable

## Challenges facing community hospitals

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- Referral patterns and consumer perceptions
- Consolidation of hospitals and primary care providers with large systems
- Decreasing inpatient volume and misalignment of supply and demand for hospital services (current and future)
- Payer mix, service mix, and variation in prices
- Competition from non-traditional market entrants
- Implications if current trends continue

## Driven by referrals and perceived quality, many patients are choosing AMCs and teaching hospitals over community hospitals for routine care

HPC commissioned qualitative analyses (8 focus groups in four regions of the state) by Tufts University to better understand what drives consumer choices of hospitals

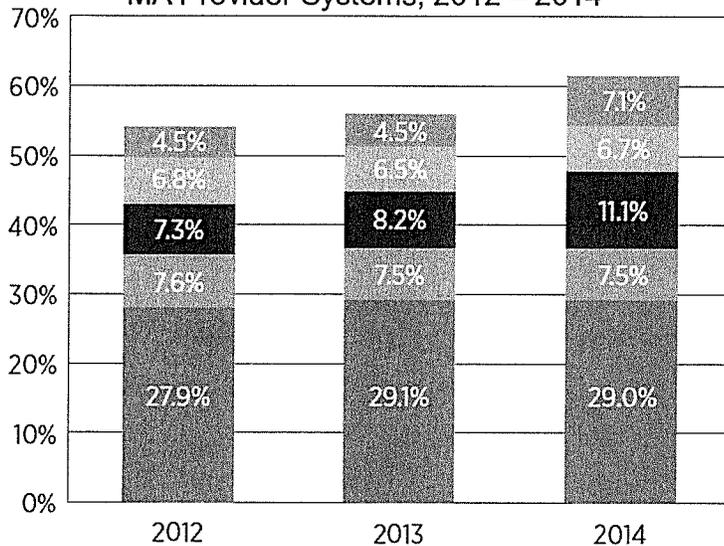
*“ I guess it might be something in your psyche because I like brand-name products. So maybe that’s what drives me to Boston. ”*

FOCUS GROUP PARTICIPANT

- Patients often mentioned that **they did not feel that they had a choice** of hospitals because their primary care provider or insurance plan determined where they could go for care
- **Two in three Massachusetts adults** have **never sought information** about the safety or quality of medical care, instead valuing the experiences of peers and recommendations of their primary care physicians.
- Many patients stated that they felt that **AMCs and teaching hospitals were better** because they had the best physicians, including doctors who had graduated from medical schools they considered prestigious. Many patients indicated that they **believed AMCs and teaching hospitals had developed reputable brands**
- Some patients stated that the **higher costs of AMCs and teaching hospitals must mean that they provided better quality**, regardless of what quality data showed. Many also said they wanted to “get their money’s worth” from the health care system after investing heavily in health insurance coverage. Others reported that **cost is not a factor when it comes to health**

## Increased consolidation of providers has driven referrals to large provider systems, including their anchor AMCs and teaching hospitals

Percent of Statewide Inpatient Discharges at the Five Largest MA Provider Systems, 2012 – 2014



- Lahey Health System
- UMass Memorial Health Care
- Beth Israel Deaconess Care Organization
- Steward Health Care System
- Partners Healthcare System

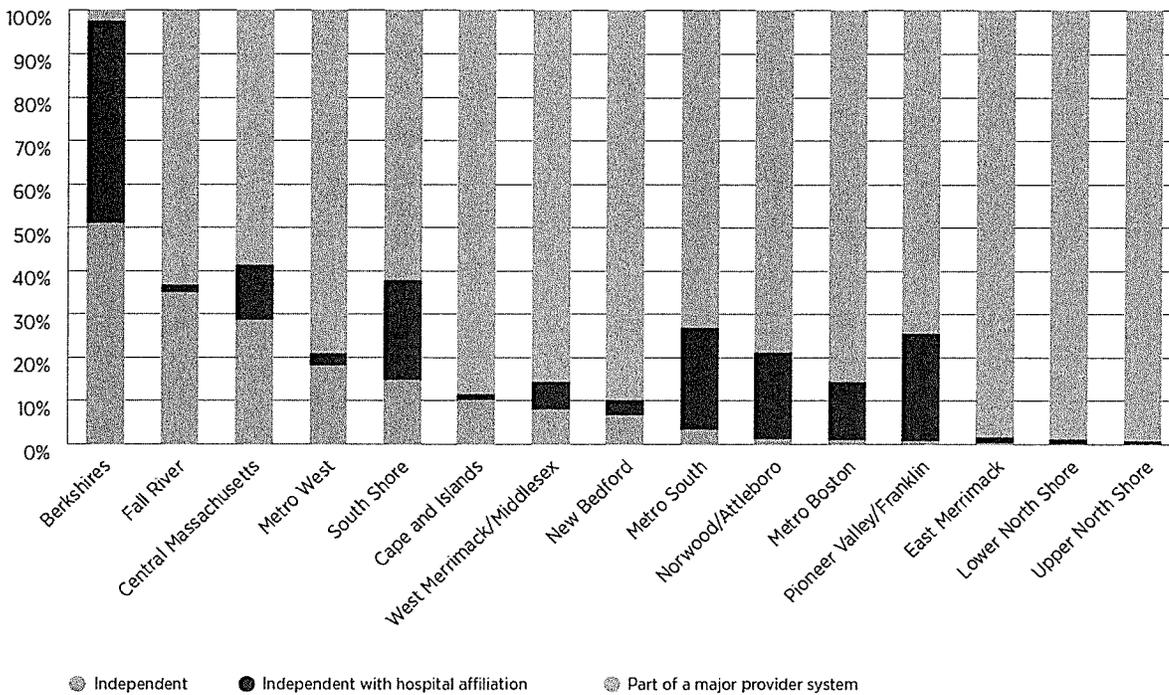
“Retaining primary care staff and specialists, ‘the gatekeepers to volume’ is challenging. Providers continue to leave for big-name systems and AMCs – and patients follow”

Synthesis of  
MASSACHUSETTS PROVIDER INTERVIEWS

Source: HPC analysis of MHDIC discharge data.  
Note: Systems shown have the highest total net patient service revenue among providers in the Commonwealth.

## Most primary care services are now delivered by physicians affiliated with major provider systems

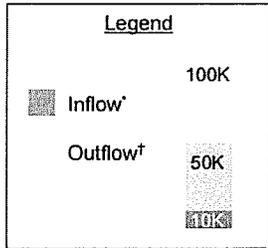
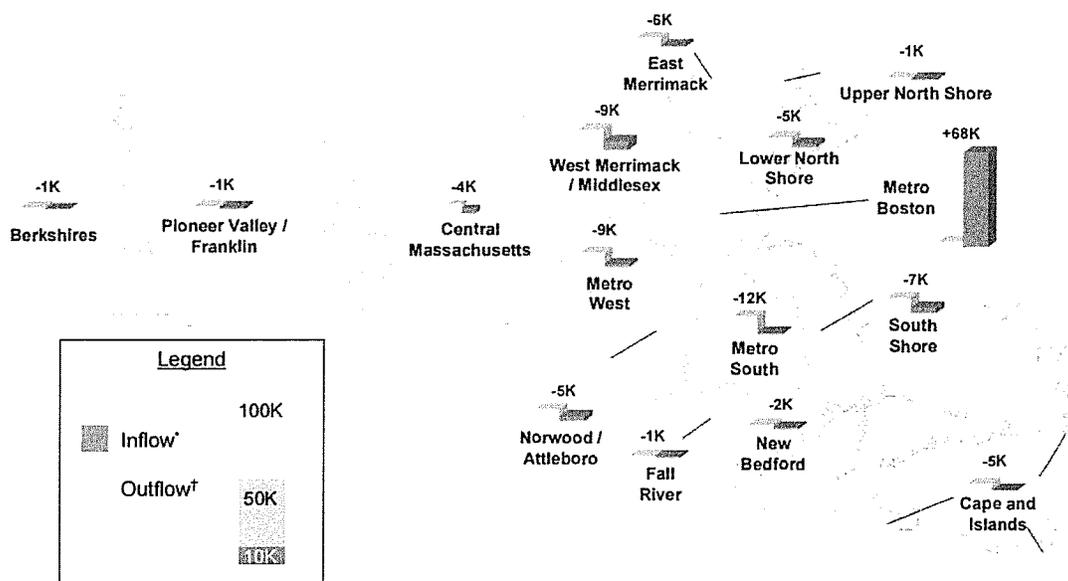
Percentage of Primary Care Services Delivered by Independent versus Affiliated Physicians by Region, 2012



Percentage of PCPs Affiliated with Eight Largest Systems Grew from **62%** in 2008 to **76%** in 2014

Source: HPC analysis of 2012 APCD claims for BCBS and HPHC; 2012 MHQP Master Provider Database.  
 Note: For the purposes of this analysis, major provider systems include Aetna Health, Baycare Health Partners, Beth Israel Deaconess Care Organization, Lahey Health System, New England Quality Alliance, Partners Community Health Care, Steward Health Care Network, and UMass Memorial Health Care. PCPs affiliated with multiple systems are counted as being part of a major provider system.

## Most Massachusetts residents who leave their home region for inpatient care seek care in Metro Boston at higher-priced hospitals



Commercially insured patients are most likely to outmigrate to Boston

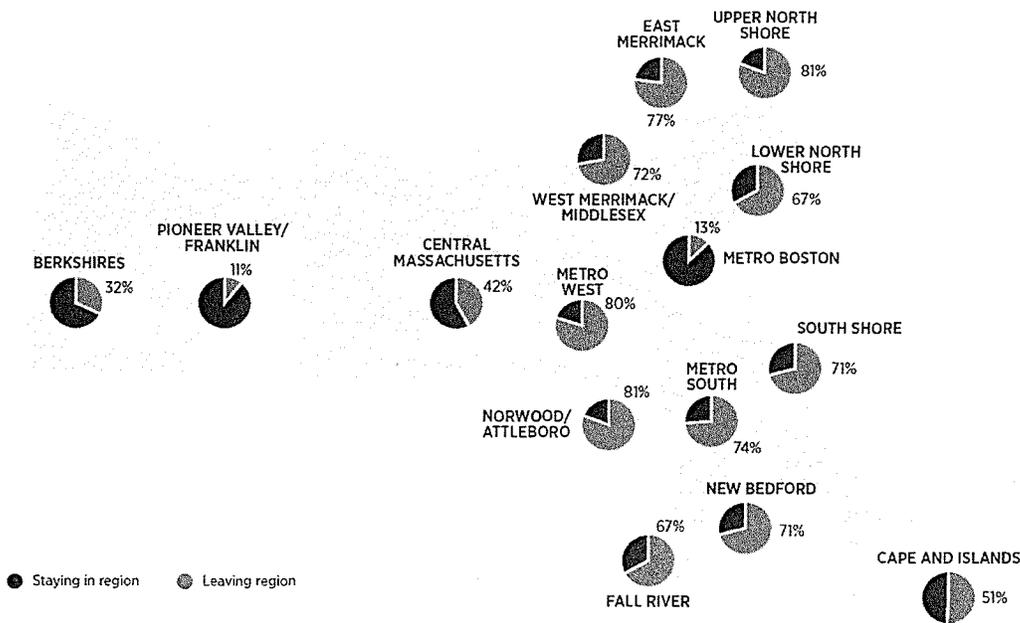
Patients from higher income regions are more likely to outmigrate to Boston

Trends hold across a variety of service lines, including deliveries

\* Discharges at hospitals in region for patients who reside outside of region  
 † Discharges at hospitals outside of region for patients who reside in region  
 Source: HPC Cost Trends Report, July 2014 Supplement

## Large proportions of patients leave their home regions for deliveries

Percentage of Patients Leaving their Home Regions for Community-Appropriate Deliveries, 2013



**74% → 50%**

change in proportion of all births in community hospitals from 1992 – 2012<sup>1</sup>

<sup>1</sup>Healthcare Equality and Affordability League. *Restoring Insurance in Massachusetts: Breaking the Vicious Cycle*

**6** hospitals saw **53%**

of low risk births in 2011-2012. 5 of these hospitals had above average delivery costs.

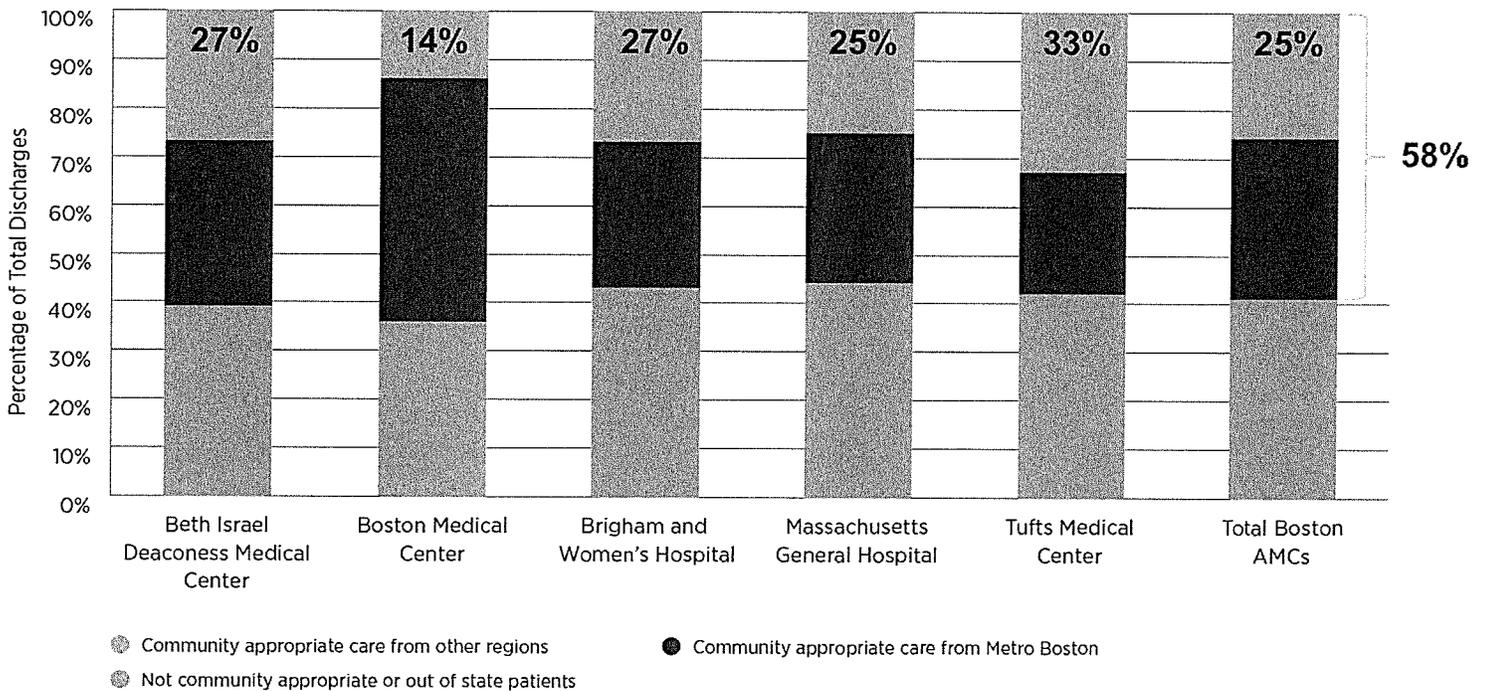
Massachusetts General Hospital and Brigham and Women's Hospital have highest costs statewide for maternity care and saw

**20%**

of all low-risk births in the state

## A significant portion of the care provided at Boston AMCs could be appropriately provided in a community hospital setting

Inpatient Discharges at Boston AMCs, 2013  
Community-Appropriate Volume as a Proportion of Total Volume

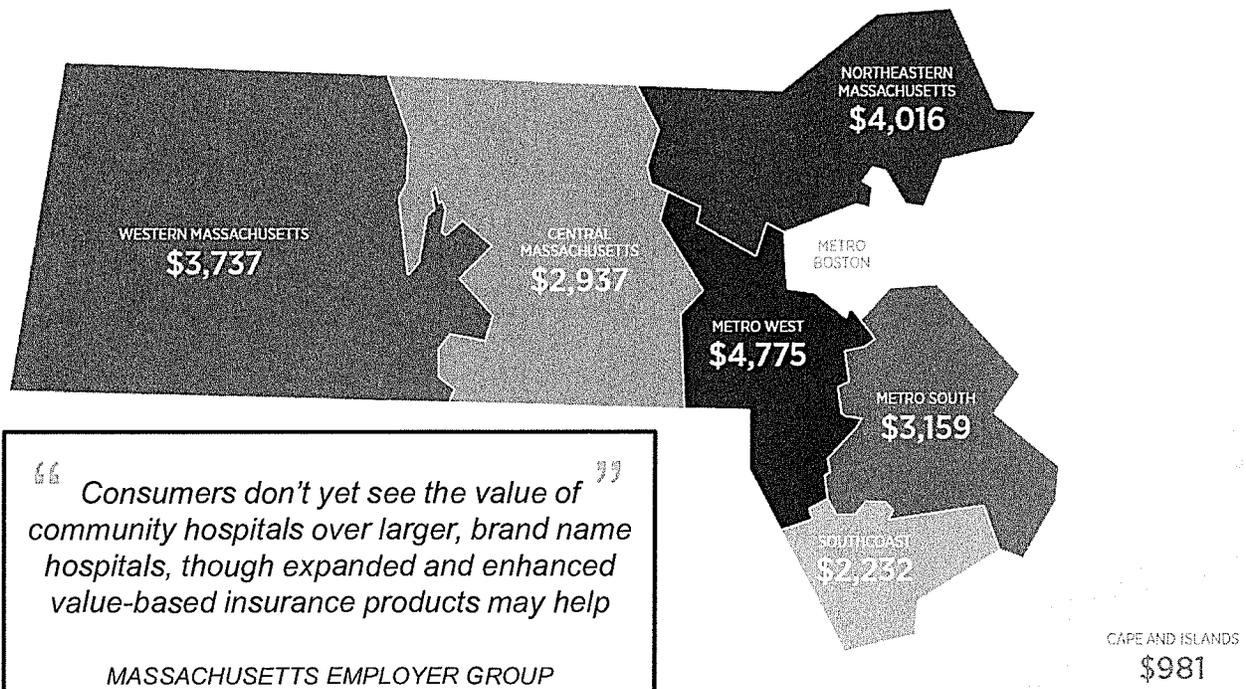


Source: HPC analysis of MHDC 2013 discharge data.

Note: Figure shows proportion of volume at each hospital, and does not reflect differences in total volume amongst the hospitals shown. Estimates of the volume of community appropriate care provide at AMCs are conservative as community appropriate care is defined to exclude cases which some community hospitals could effectively handle but that many community hospitals could not.

## Patient migration to Boston increases health care spending

Average Additional Case-Mix Adjusted Cost for Each Commercial Discharge at a Boston Hospital Rather Than a Local Hospital, by Region of Patient Origin

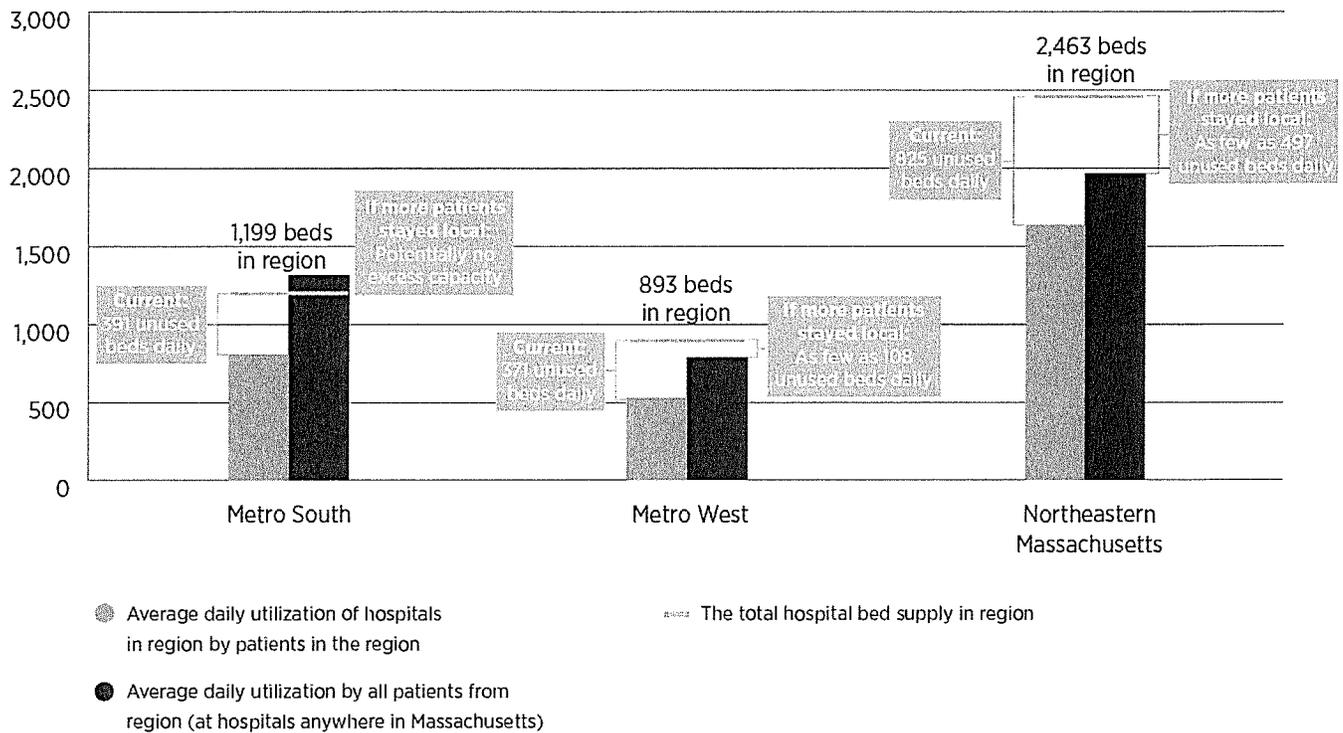


Source: HPC analysis of MHDC 2013 discharge data and raw CHIA relative price data.

Note: Figures shown are differences in average commercial revenue per CMAD for hospitals in each region compared to those in Metro Boston, adjusted for payer mix.

## In most regions, hospitals have the capacity to treat more patients locally

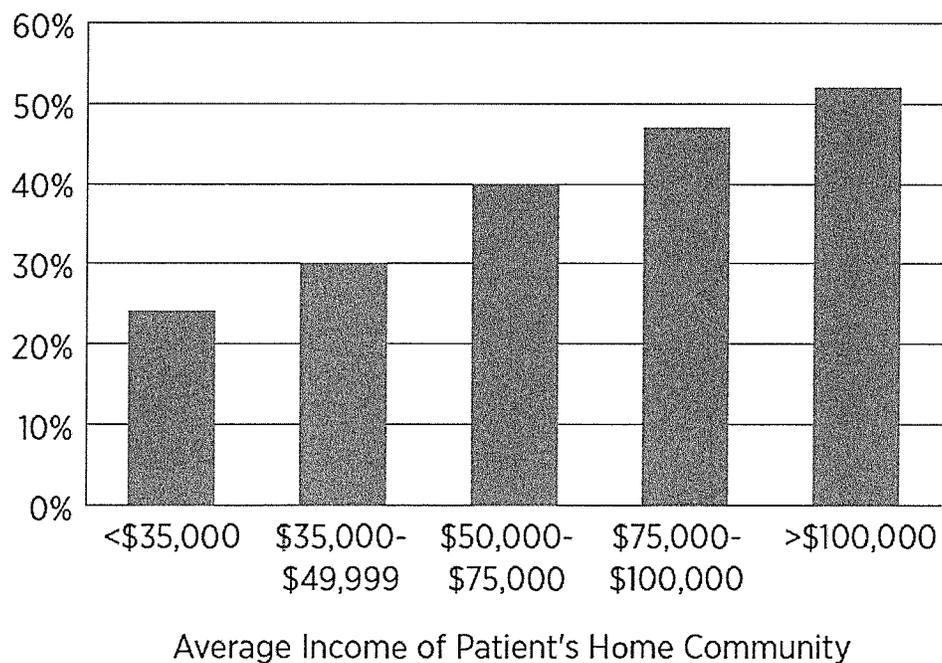
Average Use of Hospitals in Regions Neighboring Metro Boston versus Average Use of All Hospitals by Region Residents, 2013



Source: HPC analysis of MHDC 2013 discharge data and CHIA hospital 405 reports.

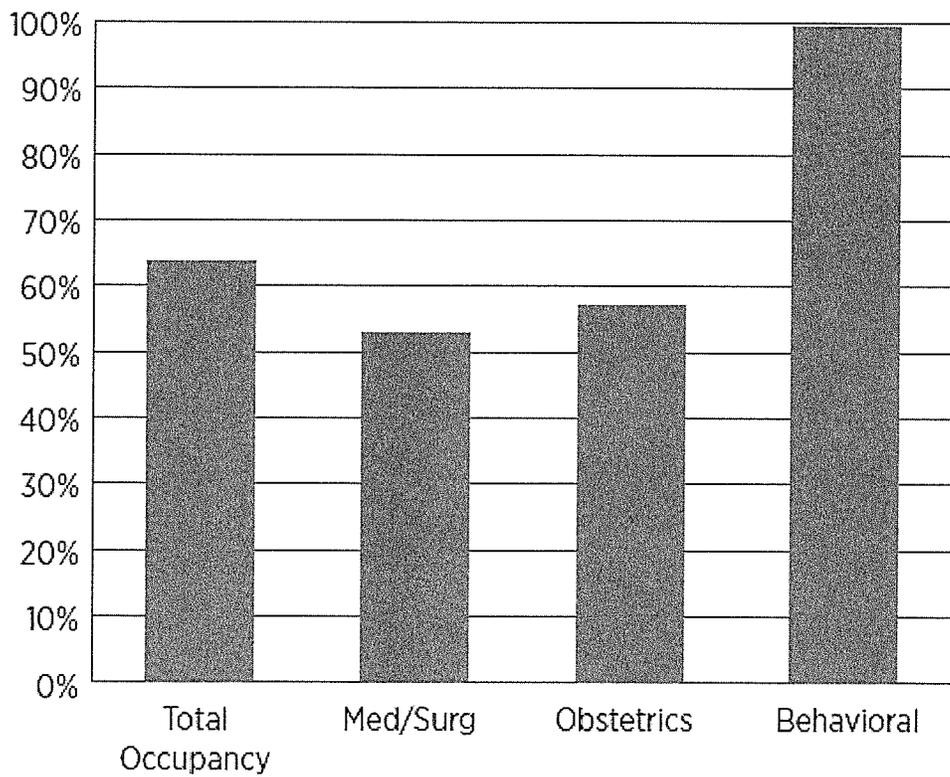
## Commercially insured patients and patients from wealthier communities are more likely to migrate to Boston for care

Probability that Patient will Travel Outside of His/Her Home Region for Inpatient Care, Based on Home Community Income



**In addition to lowering volume, migration results in community hospitals seeing larger proportions of government payer patients and those seeking low-margin services**

Community Hospital Staffed Bed Occupancy Rate by Admission Type



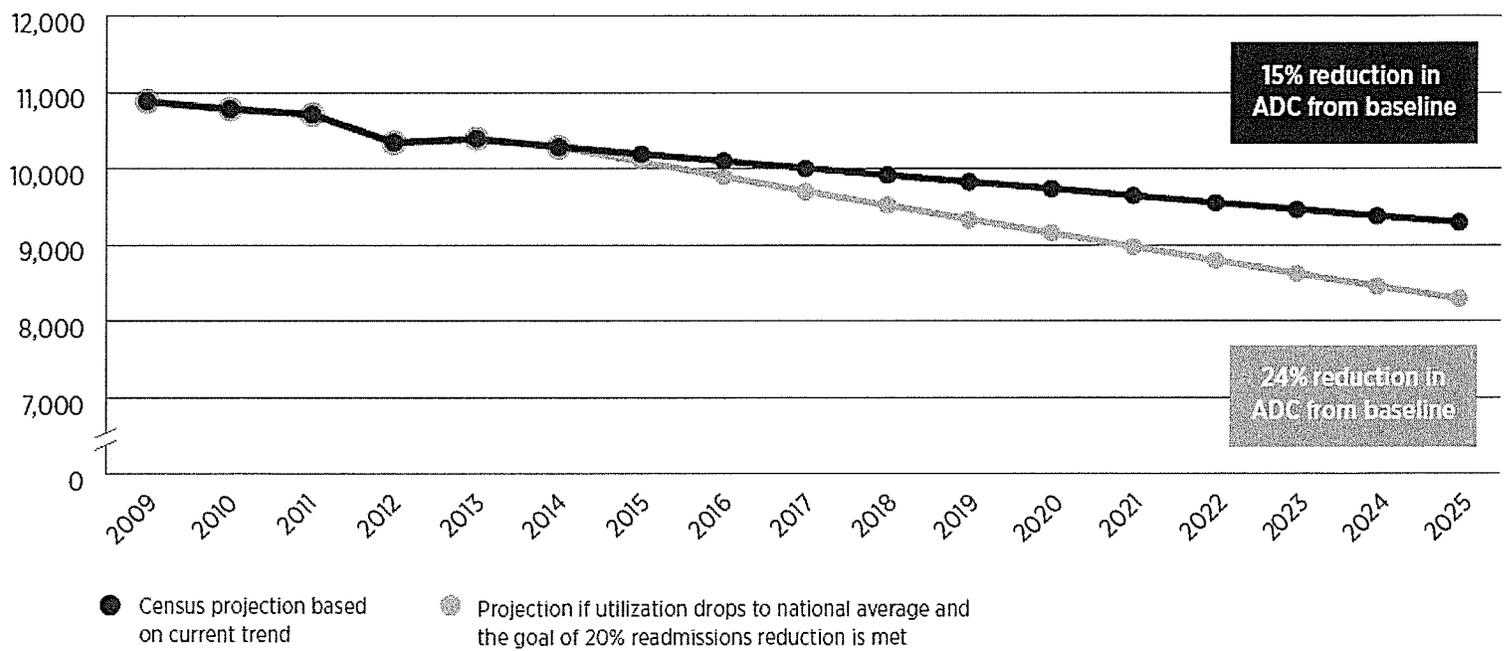
**Boarding of behavioral health patients in emergency departments increased by 40% from 2012 - 2014**

Source: HPC analysis of Department of Public Health data

Source: HPC analysis of NCHD 2013 discharge data and CHA hospital -09 rooms.

## Declining inpatient utilization poses a structural challenge to the traditional community hospital model

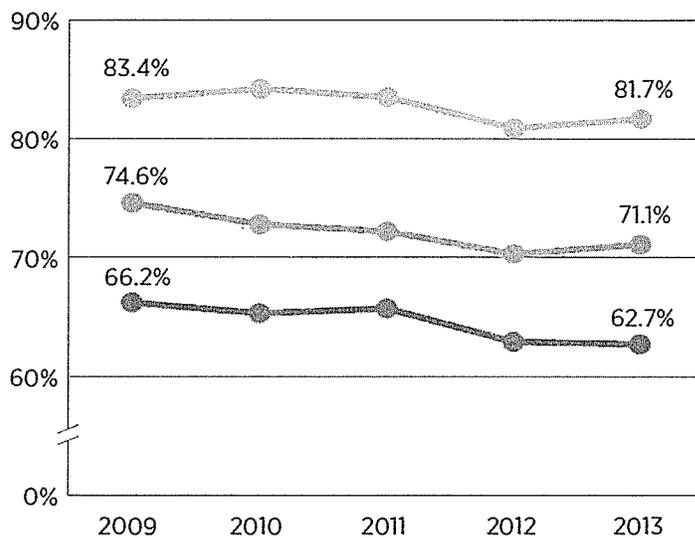
Total Average Daily Census Projections for all Massachusetts Hospitals, 2009 - 2025



Sources: HPC analysis of HPC database data, DHF hospital ADR records, HPI financial statements, and population data from the Executive Office of Massachusetts Department of State. Notes: Projection based on current trend assumes a continuation of recent utilization trends. Inpatient services coverage is not adjusted for net population growth. A factor is included in the model, for example, the replacement of more beds or care from inpatient to outpatient settings. The alternate projection assumes a 100% reduction that would bring Massachusetts in line with national hospital inpatient bed a DRG with national standards and to the goal of reducing inpatient readmissions.

## Community hospitals have lower average occupancy, and declining hospital utilization has further impacted occupancy rates

Total Inpatient Occupancy by Hospital Cohort,  
2009 – 2013



If current trend continues,  
community hospitals could  
face average occupancy rates  
of less than

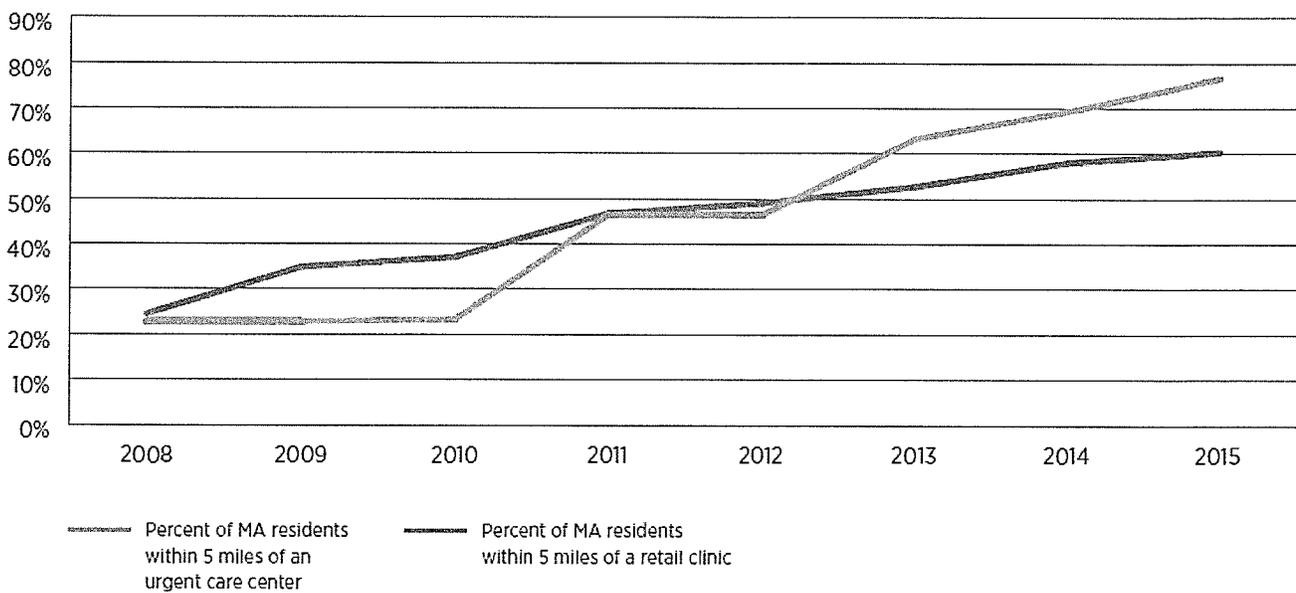
**50%** within  
**10 years**

- AMCs
- Teaching Hospitals
- Community Hospitals

Sources: HPI analysis of ICD-9 discharge data and CHA hospital AOS reports.  
Notes: Paired on assessment or discharges; did average patient length of stay compared to bed counts. Bed counts as of 2013. Bed types include the medical/surgical division (ICU), obstetric, behavioral, and neonatal (normal newborn bassinets are excluded).

## Declining inpatient utilization is driven in part by growing accessibility of non-hospital health care providers

Percent of MA Residents Living Within 5 Miles of Retail Clinics and Urgent Care Centers

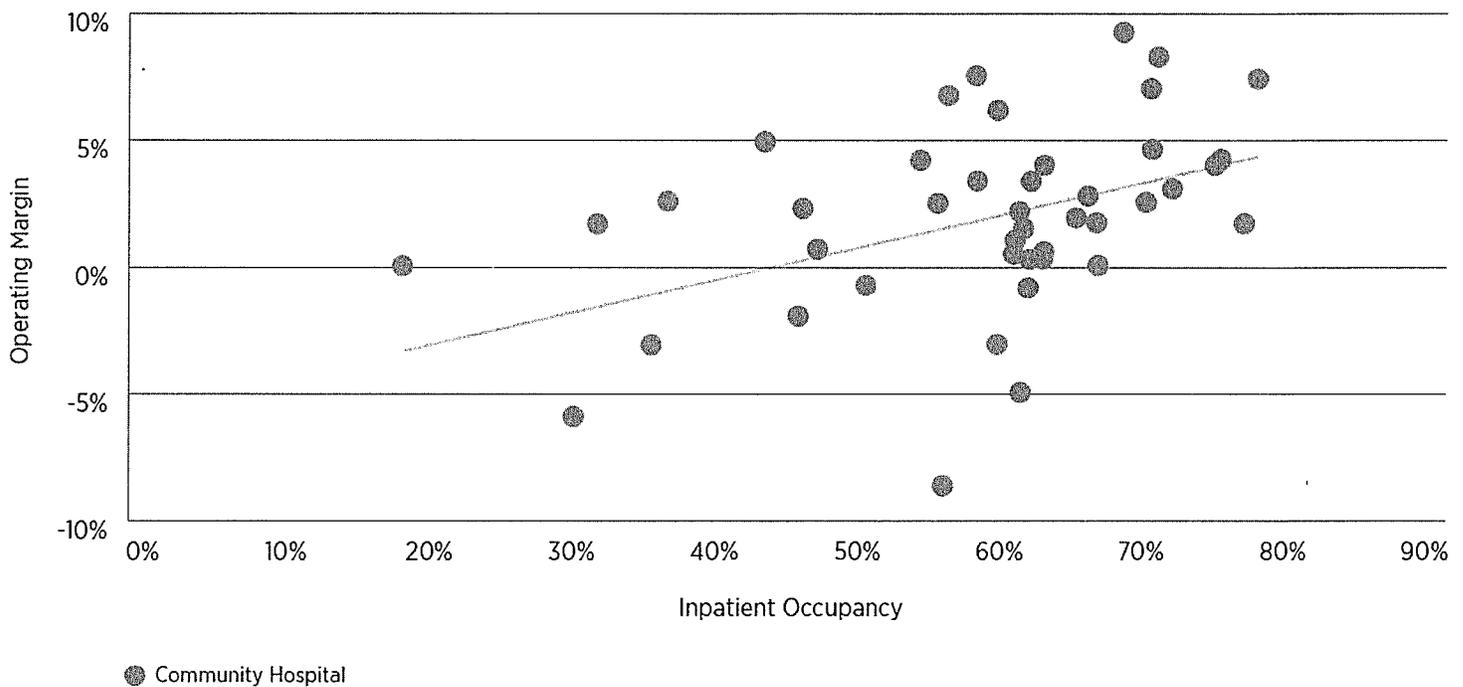


Source: HHS, Urban and Rural Health Institute, 2015. Data for 2008-2010 from the 2009 Survey of Health Care Resources in the United States. Data for 2011-2015 from the 2014 Survey of Health Care Resources in the United States.

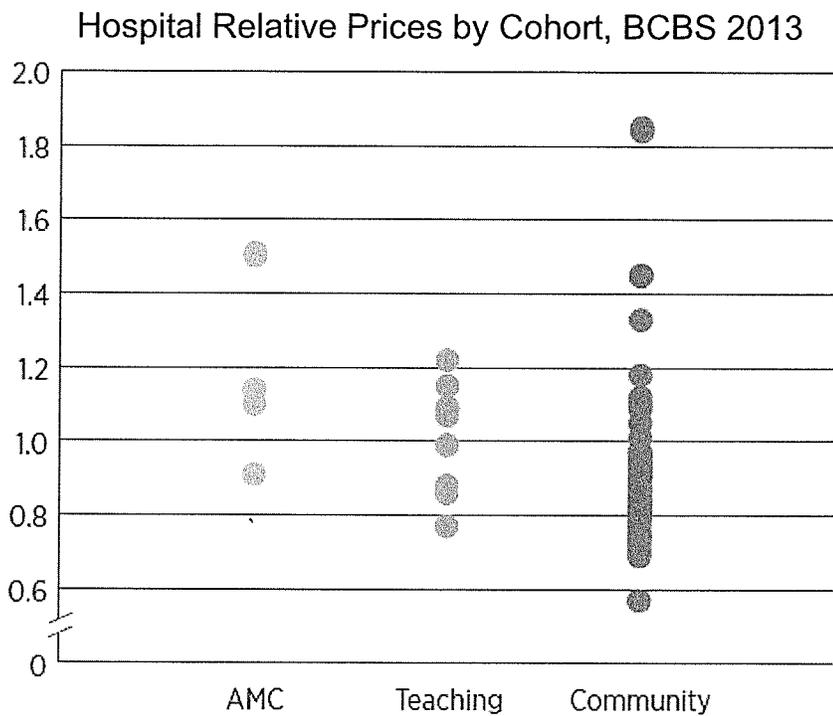
“ When [they] opened an urgent care center down the block we saw an immediate and precipitous decline in ED volume, especially the commercially insured, non-acute patients. It might be good for costs in the short term, but if we cannot keep our ED open, then what’s next?  
 COMMUNITY HOSPITAL CHIEF STRATEGY OFFICER

## Lower occupancy is associated with lower operating margins for community hospitals, and may threaten their financial stability

Massachusetts Community Hospitals  
Inpatient Occupancy vs. Operating Margin, FY13



## Community hospitals tend to receive lower commercial relative prices than AMCs or teaching hospitals



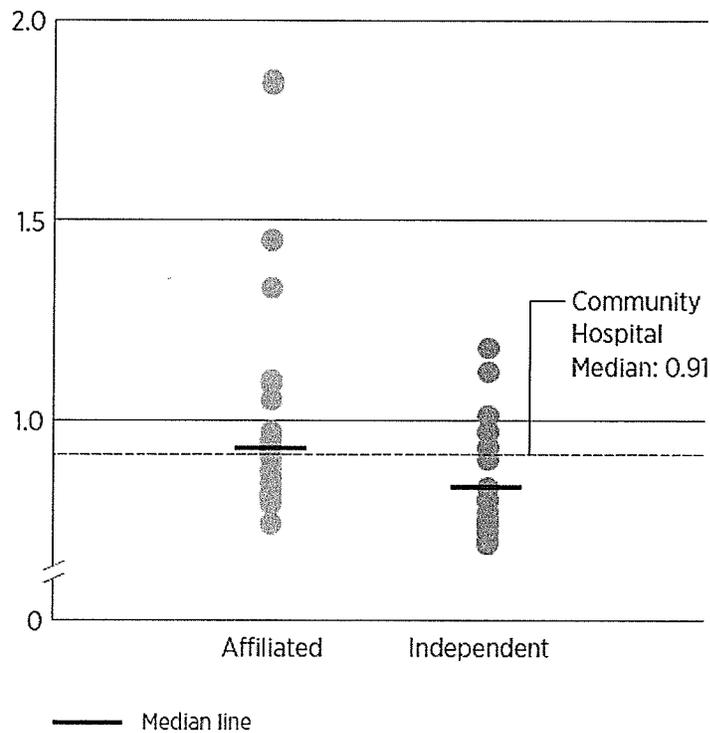
*“The gap in prices, [which is] a reflection of the market power dynamics in the state, is probably the biggest threat to a lot of the community hospitals”*

MASSACHUSETTS HEALTH INSURANCE LEADER

Sources: HPC analysis of Ctr. For Health Info & Analysis, Provider Price Variation in the Massachusetts Health Care Market (calendar year 2013 data), Databook (Feb. 2015), [hereinafter CHIA 2013 RP Databook] available at <http://chiamass.gov/assets/Uploads/relative-price-databook-2013.xlsx>

## Community hospitals affiliated with systems tend to have higher relative prices

Community Hospital Relative Prices and Affiliation Status, BCBS FY13

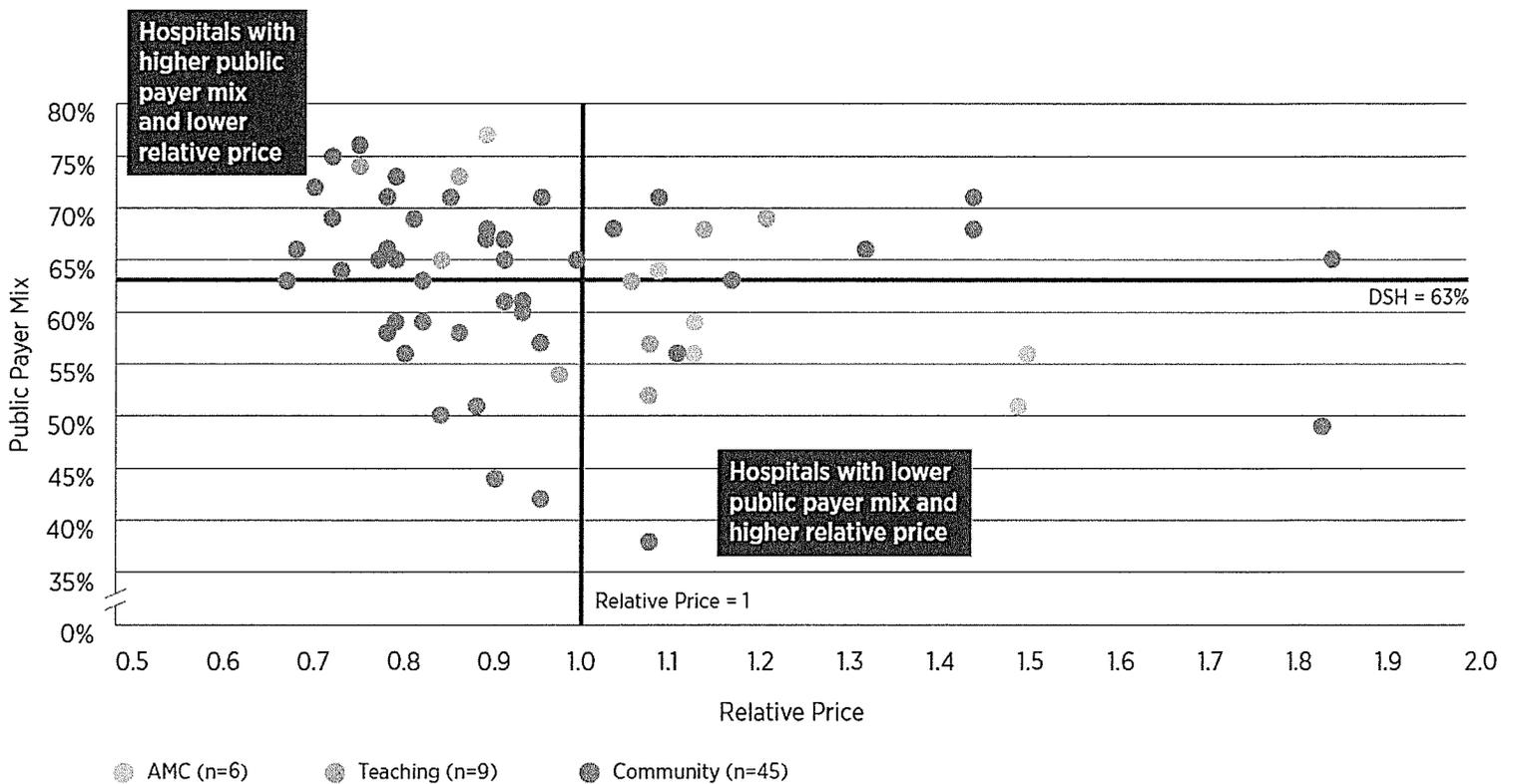


Source: HPC analysis of CHIA 2013 RP Databook

Note: While this graph shows relative prices for only one major commercial payer, price and affiliation status are similarly correlated for the other two major commercial payers.

**Hospitals with higher public payer mix tend to have lower relative prices, compounding financial stresses; cross-subsidization of higher public payer mix with higher commercial prices is not observed**

Hospital Commercial RP and Percent of Revenue from Public Payers by Cohort, BCBS FY13



## Market participants report facing additional barriers to transformation

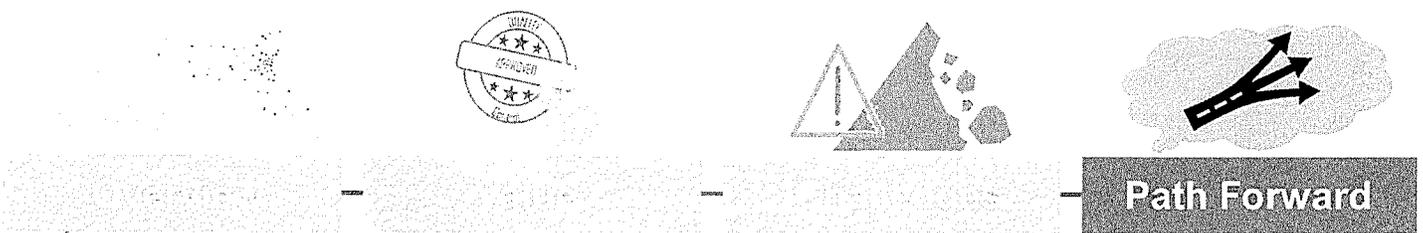
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To successfully meet challenges and adapt to a changing delivery and payment system, community hospitals must overcome barriers and utilize resources and capabilities that may not be readily available. Barriers reported to the HPC during stakeholder interviews include:

- Lack of **resources**, including financial resources and the ability to attract and retain new staff.
- Lack of needed **data and analytic support** to enable transformation efforts, including a lack of information about health needs and coordinated health planning.
- **Concern about change** by hospital governing bodies and community representatives.
- Challenges **aligning the interests of hospital labor and management** to more effectively pursue transformation efforts.
- Difficulty participating in **alternative payment models**, including challenges under current risk adjustment methodologies for hospitals serving patient populations with socioeconomic disadvantages.
- **Insufficient alignment** among programs designed to fund or assist transformation efforts.
- **Policy or regulatory frameworks** that limit deployment of new structures of care.

## The path to a thriving community-based health care system

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- Most patients should get most care in an efficient and high-quality setting close to home
- Providers must adapt to make this possible, and incentives and policies should align to support them
- Call to develop an Action Plan in concert with market participants

## Building a path to a thriving community-based health care system

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### Vision of Community-based Health

A health care system in which patients in Massachusetts are able to get most of their health care in a local, convenient, cost-effective, high-quality setting.

- **The traditional role and operational model for many community hospitals faces tremendous challenges:**
  - evolution in the health care delivery and payment system
  - persistent market dysfunction → resource inequities and overreliance on higher cost care settings
  
- **A re-envisioning of the role of community hospitals will require:**
  - development of a roadmap for care delivery transformation focused around the community
  - planning and investment for better alignment of providers with community needs
  
- **Multi-sector dialogue** is necessary to build consensus and identify a series of targeted actions to be taken by providers, payers, consumers, and government

## Fostering dialogue and developing an Action Plan

# Community Hospitals at a Crossroads: A Conversation to Foster a Sustainable Community Health System

Developing a successful path to a thriving community-based health care system requires multi-stakeholder engagement and incorporation of many diverse viewpoints.

The report findings are designed to spur market-wide dialogue and support identification of priority actions to be taken by providers, payers, purchasers and government.

### **March 29, 2016 at 9:00AM at Suffolk University School of Law**

The HPC Commissioners and staff will convene industry leaders and stakeholders to discuss findings from the report and its implications for transformation of the Commonwealth's community hospitals. Interested members of the public are invited to attend: register online at [www.mass.gov/hpc](http://www.mass.gov/hpc)

In collaboration with stakeholders, HPC will develop an Action Plan to address findings of the report. Action Plan recommendations will be oriented towards providers, payers, purchasers and policymakers

Key themes for further discussion, consensus-building, and action planning

## **Community Hospitals at a Crossroads: A Conversation to Foster a Sustainable Community Health System**

*Planning and support for community  
hospital transformation*

*Encouraging consumers to use high-value  
providers for their care*

*Creating a sustainable, accessible, and  
value-based payment system*

“ We need to **stop playing defense and start playing offense**. This [challenge of supporting community hospitals] is one of the most complex health policy issues we have, but we cannot keep just relying on short term fixes. These hospitals are the backbones of our communities — we owe it to our communities to come together to develop a plan for their future

MASSACHUSETTS STATE LEGISLATOR

## **EXHIBIT 7**

**NON-PROFIT**  
 Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the GON proposal in the following reporting format:

LINE	Total Entity Description	FY 2014			FY 2015			FY 2016			FY 2017			FY 2018			FY 2019			FY 2020		
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	
		FY 2014 Actual Results	FY 2015 Projected W/OUT GON	FY 2015 Projected Incremental	FY 2016 Projected W/OUT GON	FY 2016 Projected Incremental	FY 2017 Projected W/OUT GON	FY 2017 Projected Incremental	FY 2017 Projected With GON	FY 2018 Projected W/OUT GON	FY 2018 Projected Incremental	FY 2018 Projected With GON	FY 2019 Projected W/OUT GON	FY 2019 Projected Incremental	FY 2019 Projected With GON	FY 2020 Projected W/OUT GON	FY 2020 Projected Incremental	FY 2020 Projected With GON	FY 2021 Projected W/OUT GON	FY 2021 Projected Incremental	FY 2021 Projected With GON	
<b>A. OPERATING REVENUE</b>																						
1	Total Gross Patient Revenue	\$1,070,027,000	\$1,169,843,000	(\$15,527,000)	\$1,151,118,000	\$1,213,309,000	(\$24,104,000)	\$1,189,145,000	\$1,251,841,000	(\$9,784,000)	\$1,252,057,000	\$1,312,315,000	\$3,739,000	\$1,316,054,000								
2	Less: Allowances	\$916,867,000	\$873,832,000	(\$6,496,000)	\$867,349,000	\$717,136,000	(\$8,205,000)	\$709,831,000	\$762,089,000	\$105,000	\$762,194,000	\$811,675,000	\$8,494,000	\$820,169,000								
3	Less: Charity Care	\$5,783,000	\$7,336,000	\$36,000	\$7,374,000	\$7,430,000	\$130,000	\$7,780,000	\$7,835,000	\$232,000	\$8,167,000	\$8,262,000	\$328,000	\$8,590,000								
4	Less: Other Deductions	\$2,459,000	\$19,202,000	\$0	\$19,202,000	\$19,202,000	\$0	\$19,202,000	\$18,202,000	\$0	\$18,202,000	\$18,202,000	\$0	\$18,202,000								
5	Net Patient Service Revenue	\$455,518,000	\$447,273,000	(\$8,073,000)	\$455,194,000	\$470,241,000	(\$16,899,000)	\$454,352,000	\$473,616,000	(\$16,121,000)	\$457,495,000	\$473,689,000	(\$5,063,000)	\$468,626,000								
6	Medicare	\$181,244,000	\$189,588,000	(\$8,344,000)	\$189,705,000	\$170,103,000	(\$4,994,000)	\$165,109,000	\$173,220,000	(\$2,949,000)	\$170,271,000	\$171,418,000	(\$1,004,000)	\$170,414,000								
7	Medicaid	\$48,110,000	\$50,591,000	(\$2,481,000)	\$49,238,000	\$50,771,000	(\$2,490,000)	\$48,276,000	\$51,118,000	(\$1,889,000)	\$49,229,000	\$51,144,000	(\$1,983,000)	\$49,161,000								
8	CHAMPUS & Tricare	\$12,447,000	\$13,089,000	(\$642,000)	\$12,813,000	\$13,130,000	(\$493,000)	\$12,643,000	\$13,225,000	(\$338,000)	\$12,987,000	\$13,232,000	(\$200,000)	\$13,032,000								
9	Other	(\$2,459,000)	(\$18,202,000)	\$0	(\$18,202,000)	(\$19,202,000)	\$0	(\$18,202,000)	(\$18,202,000)	\$0	(\$18,202,000)	(\$18,202,000)	\$0	(\$18,202,000)								
10	Total Government	\$219,347,000	\$219,417,000	(\$4,485,000)	\$219,532,000	\$216,867,000	(\$7,483,000)	\$207,484,000	\$217,439,000	(\$5,070,000)	\$212,369,000	\$217,689,000	(\$1,497,000)	\$216,192,000								
11	Commercial Insurers	\$216,638,000	\$226,760,000	(\$4,072,000)	\$222,688,000	\$227,587,000	(\$7,250,000)	\$220,317,000	\$229,115,000	(\$4,517,000)	\$224,798,000	\$229,242,000	(\$2,170,000)	\$227,072,000								
12	Uninsured	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0								
13	Self Pay	\$9,055,000	\$10,490,000	\$24,000	\$10,403,000	\$10,606,000	\$100,000	\$10,615,000	\$10,577,000	(\$238,000)	\$10,339,000	\$10,583,000	\$344,000	\$10,927,000								
14	Workers Compensation	\$9,692,000	\$9,036,000	(\$124,000)	\$8,911,000	\$9,067,000	(\$293,000)	\$8,854,000	\$9,128,000	(\$194,000)	\$8,934,000	\$9,133,000	(\$1,000)	\$9,133,000								
15	Other	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0								
16	Total Non-Government	\$234,188,000	\$226,236,000	(\$8,694,000)	\$247,642,000	\$248,474,000	(\$8,105,000)	\$240,369,000	\$266,166,000	(\$5,010,000)	\$261,108,000	\$268,293,000	(\$598,000)	\$262,695,000								
17	Net Patient Service Revenue* (Government/Non-Government)	\$451,528,000	\$447,273,000	(\$8,073,000)	\$455,194,000	\$470,241,000	(\$16,899,000)	\$454,352,000	\$473,616,000	(\$16,120,000)	\$457,495,000	\$473,689,000	(\$5,262,000)	\$468,626,000								
18	Less: Provision for Bad Debts	\$20,238,000	\$17,177,000	(\$3,061,000)	\$17,123,000	\$17,240,000	(\$789,000)	\$16,451,000	\$17,339,000	(\$297,000)	\$17,068,000	\$17,369,000	(\$291,000)	\$17,070,000								
19	Net Patient Service Revenue less provision for bad debts	\$431,290,000	\$430,096,000	(\$1,194,000)	\$444,071,000	\$453,001,000	(\$15,708,000)	\$437,901,000	\$456,277,000	(\$15,830,000)	\$440,427,000	\$456,320,000	(\$14,792,000)	\$451,556,000								
20	Other Operating Revenue	\$20,795,000	\$18,925,000	(\$4,822,000)	\$14,093,000	\$18,626,000	(\$8,243,000)	\$9,383,000	\$18,625,000	(\$9,243,000)	\$9,382,000	\$18,626,000	(\$9,243,000)	\$9,383,000								
21	Net Assets Released from Restrictions	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0								
22	<b>TOTAL OPERATING REVENUE</b>	<b>\$454,992,000</b>	<b>\$469,721,000</b>	<b>(\$13,647,000)</b>	<b>\$465,074,000</b>	<b>\$471,725,000</b>	<b>(\$24,343,000)</b>	<b>\$446,783,000</b>	<b>\$474,861,000</b>	<b>(\$19,073,000)</b>	<b>\$455,808,000</b>	<b>\$475,138,000</b>	<b>(\$14,035,000)</b>	<b>\$461,103,000</b>								
<b>B. OPERATING EXPENSES</b>																						
1	Salaries and Wages	\$219,489,000	\$221,743,000	(\$18,904,000)	\$208,239,000	\$218,792,000	(\$32,826,000)	\$186,106,000	\$220,784,000	(\$33,138,000)	\$187,626,000	\$223,224,000	(\$37,879,000)	\$180,345,000								
2	Fringe Benefits	\$59,189,000	\$61,335,000	(\$2,483,000)	\$58,850,000	\$59,302,000	(\$4,859,000)	\$54,443,000	\$59,611,000	(\$4,869,000)	\$54,745,000	\$59,880,000	(\$4,877,000)	\$55,000,000								
3	Physicians Fees	\$64,479,000	\$69,253,000	(\$1,183,000)	\$67,468,000	\$68,592,000	(\$18,393,000)	\$49,815,000	\$69,231,000	\$17,197,000	\$49,426,000	\$69,015,000	\$18,070,000	\$49,685,000								
4	Supplies and Drugs	\$71,959,000	\$77,726,000	(\$1,408,000)	\$76,320,000	\$78,133,000	(\$2,333,000)	\$75,800,000	\$79,258,000	(\$1,760,000)	\$77,498,000	\$80,383,000	(\$1,273,000)	\$79,110,000								
5	Depreciation and Amortization	\$27,479,000	\$28,416,000	\$41,000	\$28,456,000	\$30,071,000	\$97,000	\$30,138,000	\$30,348,000	\$65,000	\$30,413,000	\$31,453,000	\$35,000	\$31,508,000								
6	Provision for Bad Debts-Other*	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0								
7	Interest Expense	\$3,598,000	\$3,598,000	\$0	\$3,368,000	\$3,169,000	\$0	\$3,188,000	\$3,674,000	\$0	\$3,674,000	\$3,749,000	\$0	\$3,749,000								
8	Medicare Insurance Cost	\$14,513,000	\$19,833,000	(\$1,288,000)	\$18,645,000	\$19,833,000	(\$2,671,000)	\$16,262,000	\$19,833,000	(\$2,671,000)	\$17,162,000	\$19,833,000	(\$2,671,000)	\$17,292,000								
9	Lease Expense	\$6,070,000	\$7,964,000	(\$1,068,000)	\$6,896,000	\$7,964,000	(\$2,136,000)	\$5,828,000	\$7,964,000	(\$2,136,000)	\$5,828,000	\$7,964,000	(\$2,136,000)	\$5,828,000								
10	Other Operating Expenses	\$21,044,000	\$23,787,000	(\$2,087,000)	\$21,710,000	\$20,819,000	(\$4,115,000)	\$19,605,000	\$21,103,000	(\$4,120,000)	\$19,375,000	\$21,578,000	(\$4,187,000)	\$17,439,000								
11	<b>TOTAL OPERATING EXPENSES</b>	<b>\$473,589,000</b>	<b>\$477,417,000</b>	<b>(\$13,875,000)</b>	<b>\$463,842,000</b>	<b>\$464,433,000</b>	<b>(\$32,219,000)</b>	<b>\$432,214,000</b>	<b>\$468,086,000</b>	<b>(\$31,338,000)</b>	<b>\$436,748,000</b>	<b>\$471,777,000</b>	<b>(\$35,849,000)</b>	<b>\$434,928,000</b>								
12	<b>INCOME/(LOSS) FROM OPERATIONS</b>	<b>(\$18,686,000)</b>	<b>(\$8,696,000)</b>	<b>(\$72,000)</b>	<b>(\$10,768,000)</b>	<b>\$7,233,000</b>	<b>\$7,276,000</b>	<b>\$14,569,000</b>	<b>\$6,795,000</b>	<b>(\$12,266,000)</b>	<b>\$18,060,000</b>	<b>\$1,262,000</b>	<b>\$16,513,000</b>	<b>\$18,875,000</b>								
<b>NON-OPERATING REVENUE</b>																						
13		\$15,297,000	\$8,659,000	\$0	\$9,869,000	\$8,869,000	\$0	\$8,959,000	\$8,859,000	\$0	\$8,858,000	\$8,859,000	\$0	\$8,869,000								
14	<b>EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES</b>	<b>(\$3,389,000)</b>	<b>\$163,000</b>	<b>(\$72,000)</b>	<b>\$9,101,000</b>	<b>\$16,162,000</b>	<b>\$7,276,000</b>	<b>\$23,428,000</b>	<b>\$16,654,000</b>	<b>(\$12,265,000)</b>	<b>\$27,819,000</b>	<b>\$16,221,000</b>	<b>\$15,513,000</b>	<b>\$25,734,000</b>								
15	Principal Payments	\$5,153,000	\$5,511,000	\$0	\$5,511,000	\$5,728,000	\$0	\$5,728,000	\$5,911,000	\$0	\$5,911,000	\$6,137,000	\$0	\$6,137,000								
<b>C. PROFITABILITY SUMMARY</b>																						
1	Hospital Operating Margin	-4.1%	-1.3%	0.6%	-1.9%	1.5%	-29.2%	3.3%	1.4%	-64.3%	-4.2%	0.3%	-110.5%	3.7%								
2	Hospital Non Operating Margin	3.4%	1.9%	0.0%	1.0%	1.9%	0.0%	2.0%	1.8%	-0.9%	1.9%	1.9%	0.0%	1.9%								
3	Hospital Total Margin	-0.7%	0.0%	0.6%	-0.9%	3.4%	-29.2%	5.3%	3.3%	-64.3%	-2.3%	2.2%	-110.5%	5.6%								
4	<b>FTEs</b>	<b>2,848</b>	<b>2,821</b>	<b>(191)</b>	<b>2,841</b>	<b>2,711</b>	<b>(326)</b>	<b>2,386</b>	<b>2,701</b>	<b>(323)</b>	<b>2,378</b>	<b>2,691</b>	<b>(319)</b>	<b>2,378</b>								
FTEs associated with the integration of NEMG and LMPA are excluded in the incremental column. Please refer to the Medical Group CDH to reference the corresponding additional FTEs																						
<b>E. VOLUME STATISTICS*</b>																						
1	Inpatient Discharges	17,286	17,243	211	17,464	17,051	393	17,474	16,900	674	17,474	16,783	768	17,508								
2	Outpatient Visits	865,966	810,843	4,864	823,997	820,364	11,080	832,244	821,813	16,830	837,643	821,913	16,558	840,471								
3	<b>TOTAL VOLUME</b>	<b>883,252</b>	<b>828,086</b>	<b>5,075</b>	<b>841,461</b>	<b>837,415</b>	<b>12,273</b>	<b>849,718</b>	<b>838,723</b>	<b>17,504</b>	<b>855,117</b>	<b>838,626</b>	<b>17,286</b>	<b>857,979</b>								

\*Total amount should equal the total amount on each line "Net Patient Service Revenue" Row 14.

\*Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

\*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

NON-PROFIT  
 APPLICANT: LHM Hospital  
 Financial Worksheet(A)

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with, the COA proposal in the following reporting format:

LINE	Total Entity	FY 2016		FY 2017		FY 2018		FY 2019		FY 2020		FY 2021		FY 2022		FY 2023	
		Actual Results	Projected	Unrestricted	Restricted	Unrestricted	Restricted	Unrestricted	Restricted	Unrestricted	Restricted	Unrestricted	Restricted	Unrestricted	Restricted	Unrestricted	Restricted
<b>A. OPERATING REVENUE</b>																	
1	Total Gross Patient Revenue	\$755,237,000	\$1,024,000	\$1,024,000	\$74,277,000	\$894,530,000	\$32,852,000	\$832,050,000	\$830,374,000	\$53,320,000	\$883,634,000	\$55,938,000	\$932,692,000	\$55,938,000	\$932,692,000	\$55,938,000	\$1,024,000
2	Less: Allowances	\$450,257,000	\$5,292,000	\$5,292,000	\$495,526,000	\$527,252,000	\$72,480,000	\$525,062,000	\$552,773,000	\$52,740,000	\$566,033,000	\$43,332,000	\$569,741,000	\$43,332,000	\$569,741,000	\$43,332,000	\$524,667,000
3	Less: Charity Care	\$5,449,000	\$0	\$0	\$5,449,000	\$9,375,000	\$0	\$9,375,000	\$9,375,000	\$0	\$9,375,000	\$0	\$9,375,000	\$0	\$9,375,000	\$0	\$7,668,000
4	Net Patient Service Revenue	\$299,531,000	\$197,000	\$197,000	\$223,202,000	\$357,903,000	\$147,183,000	\$307,503,000	\$259,226,000	\$27,580,000	\$299,226,000	\$27,580,000	\$307,503,000	\$27,580,000	\$307,503,000	\$27,580,000	\$478,333,000
5	Net Patient Service Revenue	\$118,164,000	\$1,974,000	\$1,974,000	\$126,656,000	\$129,659,000	\$1,974,000	\$127,685,000	\$129,659,000	\$1,974,000	\$127,685,000	\$1,974,000	\$127,685,000	\$1,974,000	\$127,685,000	\$1,974,000	\$46,033,000
6	Medicaid	\$36,748,000	\$600,000	\$600,000	\$36,700,000	\$39,084,000	\$1,555,000	\$37,529,000	\$36,365,000	\$2,146,000	\$38,511,000	\$2,146,000	\$37,529,000	\$2,146,000	\$37,529,000	\$2,146,000	\$17,663,000
7	CHAMPUS & Tricare	\$10,481,000	\$182,000	\$182,000	\$10,299,000	\$11,673,000	\$4,665,000	\$12,144,000	\$11,709,000	\$5,410,000	\$14,410,000	\$5,410,000	\$12,144,000	\$5,410,000	\$12,144,000	\$5,410,000	\$0
8	Other Government	\$2,059,000	\$0	\$0	\$2,059,000	\$18,202,000	\$0	\$18,202,000	\$18,202,000	\$0	\$18,202,000	\$0	\$18,202,000	\$0	\$18,202,000	\$0	\$0
9	Compassionate Care	\$13,714,000	\$2,704,000	\$2,704,000	\$16,418,000	\$15,169,000	\$4,398,000	\$19,567,000	\$15,483,000	\$9,874,000	\$25,357,000	\$9,874,000	\$15,483,000	\$9,874,000	\$15,483,000	\$9,874,000	\$183,276,000
10	Unrecovered	\$0	\$0	\$0	\$0	\$18,489,000	\$0	\$18,489,000	\$18,489,000	\$0	\$18,489,000	\$0	\$18,489,000	\$0	\$18,489,000	\$0	\$0
11	Self Pay	\$5,132,000	\$5,490,000	\$5,490,000	\$5,448,000	\$5,458,000	\$0	\$5,458,000	\$5,458,000	\$0	\$5,458,000	\$0	\$5,458,000	\$0	\$5,458,000	\$0	\$5,970,000
12	Programs Compensation	\$7,679,000	\$7,679,000	\$7,679,000	\$7,679,000	\$7,679,000	\$31,000	\$7,710,000	\$7,695,000	\$430,000	\$8,125,000	\$430,000	\$7,695,000	\$430,000	\$7,695,000	\$430,000	\$5,418,000
13	Other	\$7,550,000	\$0	\$0	\$7,550,000	\$7,550,000	\$0	\$7,550,000	\$7,550,000	\$0	\$7,550,000	\$0	\$7,550,000	\$0	\$7,550,000	\$0	\$5,138,000
14	Total Non-Government	\$176,784,800	\$182,484,000	\$182,484,000	\$179,694,000	\$182,484,000	\$3,004,000	\$185,488,000	\$182,484,000	\$3,004,000	\$185,488,000	\$3,004,000	\$185,488,000	\$3,004,000	\$185,488,000	\$3,004,000	\$227,150,000
<b>B. OPERATING EXPENSES</b>																	
1	Salaries and Wages	\$143,938,000	\$151,945,000	\$151,945,000	\$144,131,000	\$149,070,000	\$174,000	\$149,310,000	\$147,090,000	\$756,000	\$147,846,000	\$756,000	\$147,846,000	\$756,000	\$147,846,000	\$756,000	\$145,265,000
2	Employee Benefits	\$51,945,000	\$54,028,000	\$54,028,000	\$54,374,000	\$57,452,000	\$1,224,000	\$58,676,000	\$57,711,000	\$1,255,000	\$60,000	\$1,255,000	\$60,000	\$1,255,000	\$60,000	\$1,255,000	\$54,450,000
3	Pharmaceuticals	\$36,649,000	\$30,254,000	\$30,254,000	\$27,840,000	\$22,080,000	\$4,878,000	\$27,958,000	\$22,633,000	\$4,799,000	\$27,432,000	\$4,799,000	\$27,432,000	\$4,799,000	\$27,432,000	\$4,799,000	\$27,714,000
4	Supplies and Drugs	\$59,539,000	\$54,299,000	\$54,299,000	\$54,244,000	\$54,810,000	\$348,000	\$55,158,000	\$54,541,000	\$592,000	\$55,133,000	\$592,000	\$55,133,000	\$592,000	\$55,133,000	\$592,000	\$57,380,000
5	Medical Services	\$22,729,000	\$20,059,000	\$20,059,000	\$17,000	\$17,672,000	\$154,000	\$17,826,000	\$17,696,000	\$164,000	\$17,860,000	\$164,000	\$17,860,000	\$164,000	\$17,860,000	\$164,000	\$18,694,000
6	Provision for Bad Debts-Other	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7	Interest Expense	\$3,643,000	\$3,968,000	\$3,968,000	\$3,968,000	\$3,168,000	\$0	\$3,168,000	\$3,168,000	\$0	\$3,168,000	\$0	\$3,168,000	\$0	\$3,168,000	\$0	\$3,168,000
8	Maintenance Insurance Cost	\$4,539,000	\$4,810,000	\$4,810,000	\$4,810,000	\$4,810,000	\$0	\$4,810,000	\$4,810,000	\$0	\$4,810,000	\$0	\$4,810,000	\$0	\$4,810,000	\$0	\$4,810,000
9	Lease Expense	\$4,619,000	\$4,652,000	\$4,652,000	\$4,652,000	\$4,652,000	\$0	\$4,652,000	\$4,652,000	\$0	\$4,652,000	\$0	\$4,652,000	\$0	\$4,652,000	\$0	\$4,652,000
10	Other Operating Expenses	\$26,333,000	\$30,491,000	\$30,491,000	\$30,491,000	\$30,491,000	\$0	\$30,491,000	\$30,491,000	\$0	\$30,491,000	\$0	\$30,491,000	\$0	\$30,491,000	\$0	\$29,268,000
11	Total Operating Expenses	\$259,622,000	\$315,724,000	\$315,724,000	\$298,181,000	\$318,975,000	\$7,169,000	\$326,144,000	\$324,074,000	\$7,606,000	\$331,681,000	\$7,606,000	\$331,681,000	\$7,606,000	\$331,681,000	\$7,606,000	\$329,268,000
<b>INCOME(LOSS) FROM OPERATIONS</b>																	
		\$225,615,000	\$1,071,000	\$1,071,000	\$16,546,000	\$16,458,000	\$3,868,000	\$22,032,000	\$14,703,000	\$11,798,000	\$25,842,000	\$14,703,000	\$25,842,000	\$14,703,000	\$25,842,000	\$14,703,000	\$27,204,000
<b>NON-OPERATING REVENUE</b>																	
		\$9,789,000	\$9,283,000	\$9,283,000	\$0	\$9,283,000	\$0	\$9,283,000	\$9,283,000	\$0	\$9,283,000	\$0	\$9,283,000	\$0	\$9,283,000	\$0	\$9,283,000
<b>EXCESS(DEFICIENCY) OF REVENUE OVER EXPENSES</b>																	
		\$5,979,000	\$12,765,000	\$12,765,000	\$13,844,000	\$23,397,000	\$6,888,000	\$30,316,000	\$22,056,000	\$11,798,000	\$34,755,000	\$22,056,000	\$34,755,000	\$22,056,000	\$34,755,000	\$22,056,000	\$35,467,000
<b>Principals Payments</b>																	
		\$5,153,000	\$5,911,000	\$5,911,000	\$0	\$5,728,000	\$0	\$5,728,000	\$5,911,000	\$0	\$5,911,000	\$0	\$5,911,000	\$0	\$5,911,000	\$0	\$5,153,000
<b>C. PROFITABILITY SUMMARY</b>																	
1	Operating Profit	6.8%	13.3%	13.3%	15.5%	4.1%	48.0%	6.9%	4.8%	60.9%	6.9%	3.7%	64.9%	3.7%	64.9%	3.7%	64.9%
2	Operating Margin	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%
3	Operating Total Margin	1.7%	3.5%	3.5%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%
<b>D. FTEs</b>																	
		1,848	1,827	1,823	1,823	1,765	1,745	1,742	1,745	1,745	1,742	1,745	1,745	1,745	1,745	1,745	1,745
<b>E. VOLUME STATISTICS</b>																	
1	Inpatient Discharges	14,451	14,212	14,178	14,331	14,883	15,229	15,472	15,240	14,478	15,478	15,240	15,478	15,240	15,478	15,240	15,478
2	Outpatient Visits	458,111	455,073	454,331	458,331	455,160	458,419	458,419	455,160	458,419	458,419	455,160	458,419	455,160	458,419	455,160	458,419
	TOTAL VOLUME	472,562	469,285	468,509	472,662	470,043	473,898	473,898	470,320	473,898	473,898	470,320	473,898	470,320	473,898	470,320	473,898

\*Total amount should equal the total amount on our Net Patient Revenue Row 14.

\*Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

\*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

## Lawrence + Memorial Health System Affiliation with Yale New Haven Health System Assumptions

<u>Net Revenue Rate Increases</u>		<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
1) Government		0 - 1.4%	0 - 1.4%	0 - 1.2%	0 - 1.2%
2) Non-Government		0 - 2.5%	0 - 2.0%	0 - 2.0%	0 - 2.0%
3) Inpatient Volume		1.1%	0.1%	0.0%	0.2%
4) Outpatient Volume		1.0%	1.5%	0.8%	0.5%
<u>EXPENSES</u>		<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
A. Salaries and Fringe Benefits		1.5%	1.5%	1.5%	1.5%
B. Non-Salary					
1) Supplies and Drugs		2.0%	1.5%	1.5%	1.5%
2) Professional and Contracted Services		2.0%	1.5%	1.5%	1.5%
3) Malpractice Insurance and Lease Expense		0.0%	0.0%	0.0%	0.0%
4) All Other Expenses		1.0%	1.0%	1.0%	1.0%
5) All Other Expenses					
		<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
<u>FTEs</u>					
1) Total estimated FTEs		<u>2,641</u>	<u>2,386</u>	<u>2,378</u>	<u>2,378</u>

Note - The above increase projections reflect all changes relating to Medicare and Medicaid reimbursement regulations.

**YALE-NEW HAVEN System  
Lawrence + Memorial Affiliation  
Assumptions**

<u>Net Revenue Rate Increases</u>		<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
1) Government		1.0%	1.0%	1.0%	1.0%
2) Non-Government		1.0%	1.0%	1.0%	1.0%
3) Inpatient Volume		1.0%	1.0%	1.0%	1.0%
4) Outpatient Volume		1.0%	1.0%	1.0%	1.0%
<u>EXPENSES</u>		<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
<b>A. Salaries and Fringe Benefits</b>		3.0%	3.0%	3.0%	3.0%
<b>B. Non-Salary</b>					
1) Supplies and Drugs		3.0%	3.0%	3.0%	3.0%
2) Professional and Contracted Services		3.0%	3.0%	3.0%	3.0%
3) Malpractice Insurance and Lease Expense		3.0%	3.0%	3.0%	3.0%
4) All Other Expenses		3.0%	3.0%	3.0%	3.0%
<u>FTEs</u>		<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
1) Total estimated FTEs		14,391	14,412	14,418	14,450

## **EXHIBIT 8**

## **EXHIBIT 9**

**William W. Backus Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
Former President & CEO			\$3,357,690	\$738,636	\$666,118	\$925,503	\$645,419		
Regional President		\$858,680							
President & CEO			\$975,550	\$664,781	\$573,317	\$410,672		\$627,001	\$596,473
Regional VP, Finance		\$598,856							
Medical Affairs Regional VP	\$410,993	\$577,237							
Medical Director, Medicare Care Admin	\$552,137								
BPS Physician	\$622,339	\$558,100		\$523,896	\$497,357				
Hospitalist Physician	\$489,374								
Sr. Vice President & CFO			\$659,230	\$488,297	\$438,868	\$494,684	\$407,839	\$404,988	\$382,897
Chief of Emergency Medicine		\$495,605							\$357,592
Clinical Services Sr. VP & CMO			\$587,917						
ER Physician	\$424,203	\$414,709				\$437,095	\$415,402	\$406,279	\$345,324
Medical Director				\$479,197	\$458,448	\$407,519	\$380,678	\$366,158	
ER Physician	\$418,265	\$414,453		\$469,984	\$471,117	\$404,362	\$379,087	\$347,302	\$330,183
Vice President & COD						\$391,942	\$360,153	\$345,700	\$317,502
BPS Physician		\$551,117	\$548,961	\$400,639	\$397,513				
BPS Physician			\$504,965	\$384,636	\$377,448				
ER Physician	\$416,812								
ER Physician	\$409,255	\$405,635	\$481,414	\$380,816	\$382,452	\$369,115	\$346,575	\$339,930	\$328,021
ER Physician	\$391,415	\$396,123	\$421,693	\$372,326	\$380,316	\$362,716	\$344,000	\$336,916	\$326,419
ER Physician			\$411,993			\$358,594	\$343,575	\$332,063	\$322,176
ER Physician			\$403,912				\$342,098	\$326,881	\$320,727
Rheumatology Physician	\$407,038								
<b>Total</b>	<b>\$4,541,831</b>	<b>\$5,270,515</b>	<b>\$8,353,325</b>	<b>\$4,903,208</b>	<b>\$4,642,954</b>	<b>\$4,562,202</b>	<b>\$3,964,826</b>	<b>\$3,833,218</b>	<b>\$3,627,314</b>

**Bridgeport Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	\$1,447,989	\$1,222,022	\$1,101,139	\$764,779	\$1,352,509	\$1,702,615	\$2,543,047	\$1,021,040	\$932,810
Chief Financial Officer									\$510,450
Physician Chief								\$1,222,471	
Sr. VP of Administration	\$955,867	\$929,905	\$885,638						
Senior VP of Finance & CFO	\$941,809	\$796,077	\$741,380	\$668,999	\$687,985	\$646,716	\$572,020	\$572,249	
VP of Finance	\$778,986								
Medical Director			\$632,905	\$570,304	\$571,351	\$748,468			
Physician General Surgery								\$561,283	
Sr. VP Medical Affairs	\$582,014	\$516,861					\$640,909	\$646,930	
Senior VP of Human Resources				\$468,241	\$494,194	\$464,453	\$449,781	\$445,356	\$425,297
Surgeon in Chief & Chairman of Surgery Dept								\$518,721	
Senior VP & CDO				\$458,001	\$529,615	\$514,318	\$475,065	\$477,510	\$416,311
Chief, ER Physician									\$353,048
Chief, Section of Cardiology								\$504,253	
Chief, Maternal Fetal Medicine								\$488,249	
VP				\$452,611					
Senior VP, Planning & Marketing	\$522,220	\$487,114	\$460,560		\$465,508				\$328,370
ER Physician	\$481,515	\$457,886	\$455,310		\$409,341	\$414,117	\$386,542		\$327,312
ER Physician	\$466,707	\$433,118		\$402,984	\$404,703	\$375,929	\$353,626		\$315,697
VP of Performance Management	\$436,837								
Sr. VP of Quality Control and Risk Management			\$412,762	\$397,219	\$396,540	\$355,398	\$331,960		
ER Physician	\$393,898	\$403,033	\$397,495	\$391,752	\$366,594	\$354,567	\$337,643		\$308,417
ER Physician		\$399,524	\$393,302	\$365,621		\$351,726	\$334,460		\$307,444
ER Physician		\$381,032	\$392,410						
<b>Total</b>	<b>\$7,007,842</b>	<b>\$6,026,572</b>	<b>\$5,872,901</b>	<b>\$4,940,511</b>	<b>\$5,678,340</b>	<b>\$5,928,307</b>	<b>\$6,425,053</b>	<b>\$6,458,062</b>	<b>\$4,225,156</b>

**Bristol Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	\$756,841	\$659,742	\$605,526	\$495,299	\$441,821	\$368,985	\$358,071	\$301,300	\$145,757
Interim CEO/CFO									\$250,043
Chief Operating Officer									\$236,857
Senior Vice President, Chief Medical Officer	\$395,340	\$375,135	\$368,261	\$392,474	\$353,187	\$307,376			
Vice President of Admin Services								\$202,603	
Oncology Physician						\$327,712	\$280,817		
Senior Vice President, Patient Care Services & CNO	\$318,668	\$308,975	\$304,551	\$237,201		\$212,105			
Senior Vice President/CFO		\$328,273	\$268,516		\$331,856	\$287,078		\$134,945	
Vice President/CFO	\$348,020					\$200,460	\$186,930		
Vice President, Human Resources and Support Services	\$221,100	\$207,363	\$204,326						
Clinic Physician						\$197,383	\$202,405	\$199,016	
Vice President of Operations					\$227,176	\$195,850			
Occupational Health Physician	\$179,366	\$177,125	\$176,987			\$157,692	\$213,798	\$216,973	\$186,222
Assistant Vice President, Information Services	\$215,018	\$210,272	\$198,613	\$197,149	\$180,780				
Assistant Vice President/In House Counsel								\$166,354	\$146,325
Vice President of Patient Care Services				\$195,892			\$196,267		\$143,244
Assistant Vice President, Human Resources & Support				\$181,069	\$146,022	\$142,091			
Director of Physician Recruitment									\$140,180
Controller			\$168,117	\$174,159					
Director of Revenue Cycle		\$157,556							
Staff Psychiatrist				\$168,640	\$206,727		\$189,381	\$200,513	
Psych Physician								\$143,448	\$194,500
Psych Physician									\$140,095
Assistant Vice President, Chief Development Officer	\$193,117	\$186,781	\$169,549	\$168,198	\$149,114				
Director, Clinical Operations	\$168,848		\$165,578	\$168,106					
Director, Diagnostic Imaging	\$167,114								
Biomedical Technician							\$149,554		
Director of Perioperative Services							\$148,407		
Manager of Applications & Programming		\$156,752			\$145,775		\$147,965	\$139,438	
Psychologist								\$138,061	\$135,572
Clinical Staff Pharmacist					\$143,422				
<b>Total</b>	<b>\$2,963,432</b>	<b>\$2,767,974</b>	<b>\$2,630,024</b>	<b>\$2,378,187</b>	<b>\$2,325,880</b>	<b>\$2,396,732</b>	<b>\$2,073,595</b>	<b>\$1,842,651</b>	<b>\$1,718,795</b>

**Hospital of Central Connecticut**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>
President & CEO	\$2,325,846	\$999,354	\$1,499,546	\$2,764,505	\$609,893	\$2,851,220	\$1,110,502	\$852,338
Physician, Private Practice								\$625,058
Executive Vice President and CMO		\$849,179	\$776,392	\$736,855	\$603,486			
Senior VP of Medical Affairs						\$652,298	\$498,636	
Chief of Pediatrics						\$563,571	\$401,551	\$360,656
Hospitalist	\$763,388			\$568,564				\$395,449
Chief Emergency Room Physician	\$728,973	\$663,474	\$550,999	\$497,610	\$499,051	\$475,774	\$400,568	\$379,873
Chief Operating Officer						\$454,785	\$473,762	\$445,037
Chief of Medicine	\$664,689	\$555,465	\$500,547	\$480,323	\$474,233	\$411,214		\$374,604
Neurosurgeon		\$542,218						
Director of Cardiology	\$476,866	\$463,175			\$459,292	\$382,490	\$377,094	\$360,863
Director Hospitalist Medicine	\$438,866							
Hospitalist		\$598,728	\$491,528		\$450,815	\$415,460	\$439,224	
Director Surgical Oncology	\$712,251	\$645,121	\$487,581					
Chief of Psychiatry		\$498,562	\$484,686		\$440,082		\$360,201	
Medical Director of Quality					\$420,419			
Vice President Human Resources		\$644,445		\$461,731				
Vice President Patient Services				\$455,425				
Vice President Finance			\$598,466	\$458,671				
VP Analytics & Decision Report	\$604,754							
Oncologic Surgeon				\$439,374	\$376,249			
Chief Financial Officer					\$309,038	\$547,595	\$604,747	\$479,362
Medical Director BMH ED	\$461,593		\$447,047			\$364,789	\$356,421	\$337,862
Medical Director NBG ED	\$474,401		\$438,419	\$418,618				
<b>Total</b>	<b>\$7,651,627</b>	<b>\$6,459,721</b>	<b>\$6,275,211</b>	<b>\$7,281,676</b>	<b>\$4,642,558</b>	<b>\$7,119,196</b>	<b>\$5,022,706</b>	<b>\$4,611,102</b>

**Charlotte Hungerford Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Physician Surgeon	\$784,306	\$748,423	\$661,640	\$619,607	\$378,765				
Pathologist Medical Director	\$498,959	\$511,240	\$520,852	\$530,760	\$536,040	\$499,855	\$473,687	\$455,147	\$249,074
CEO President	\$625,107	\$522,445	\$503,491	\$504,603	\$540,443	\$476,023	\$456,011	\$413,138	\$358,641
Physician Surgeon	\$745,495	\$659,650	\$581,148	\$473,947					
Cardiologist	\$459,094	\$443,487	\$515,457						
VP Medical Affairs	\$409,022		\$400,445	\$368,032	\$427,464	\$447,908	\$363,622	\$340,417	\$309,144
Physician Surgeon	\$592,094	\$640,888	\$498,646	\$365,008					
Cardiologist	\$450,788	\$430,722	\$483,052						
Cardiologist	\$433,352	\$430,225	\$441,292						
Cardiologist		\$422,353	\$435,124						
Psychiatrist Medical Director				\$349,331	\$372,589	\$356,994	\$312,884	\$293,876	\$278,137
CFO					\$330,796	\$375,568	\$288,650	\$300,901	\$251,468
Orthopedic Surgeon	\$724,504			\$343,470	\$285,223				
Physician Hospitalist				\$289,357	\$312,841	\$303,332	\$213,128		
VP Administration						\$292,016	\$220,139	\$240,948	\$195,225
Physician Surgeon				\$279,548	\$308,569				
Pathologist						\$254,361	\$243,633	\$233,915	
VP Human Resources						\$252,639			
Physician Hospitalist						\$249,054			
Walk in Physician									\$211,324
Physician Walk In Med Director							\$217,483	\$218,017	
Psychiatrist							\$212,833	\$215,421	\$208,815
Psychiatrist									\$204,676
VP Patient Care									\$201,576
Medical Physicist								\$181,556	
Hospitalist Med Director		\$546,781			\$288,930				
<b>Total</b>	<b>\$5,722,721</b>	<b>\$5,356,214</b>	<b>\$5,041,147</b>	<b>\$4,123,663</b>	<b>\$3,781,660</b>	<b>\$3,507,750</b>	<b>\$3,002,070</b>	<b>\$2,893,336</b>	<b>\$2,468,080</b>

**CT Children's Medical Center**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
Physician in Chief		\$460,190	\$512,905	\$468,345	\$468,999	\$388,964	\$513,586	\$366,915	\$380,057
Former President & CEO									\$735,259
Executive VP & CFO		\$426,289	\$478,476	\$429,575	\$443,284	\$352,157			
Senior VP & CFO							\$485,969	\$354,737	\$388,977
EVP & COO	\$444,836	\$420,424	\$468,676						
Chief Operating Officer				\$336,211	\$375,179	\$339,764	\$399,608	\$282,887	
President & CEO	\$618,181	\$516,728	\$748,347	\$315,696	\$480,870	\$336,532	\$490,926	\$368,969	
Senior VP and General Counsel	\$413,375	\$367,734	\$391,769	\$299,663					
General Council					\$338,238	\$250,232	\$308,223	\$251,259	\$264,825
VP Clinical Services & Chief RN Officer		\$286,793	\$250,382		\$285,981	\$237,795	\$292,464	\$239,987	\$251,280
Senior VP Quality Improvement & Patient Safety	\$548,936	\$469,599	\$253,456	\$277,035	\$391,164	\$264,622			
Executive VP Community & Child Health	\$506,930								
VP Quality Improvement & Patient Safety							\$248,438	\$231,484	\$189,791
Interim CFO	\$315,779								
CIO	\$299,080	\$292,330	\$300,302	\$266,623					
President, Specialty Group			\$267,602						
Chief Medical Information Officer	\$335,252	\$293,608							
VP Human Resources	\$292,022			\$229,430	\$262,535	\$211,180	\$266,708	\$233,645	
Director, Human Resources									\$175,107
Director of IT					\$210,421	\$185,045			
VP Marketing & Business Development	\$334,482	\$323,482							
VP Strategy & Regional Development					\$191,027		\$402,005	\$326,282	\$323,556
Staff Nurse - Operating Room						\$167,452			\$213,405
Staff Nurse - Emergency Department								\$197,469	\$169,796
Mid-Level Practitioner NICU							\$204,601		
Professional Practice RN IV				\$221,543					
Director, Perioperative Services			\$235,505	\$173,491					
<b>Total</b>	<b>\$4,108,873</b>	<b>\$3,857,177</b>	<b>\$3,907,420</b>	<b>\$3,017,612</b>	<b>\$3,447,698</b>	<b>\$2,733,743</b>	<b>\$3,612,528</b>	<b>\$2,853,634</b>	<b>\$3,092,053</b>

**Danbury Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	\$1,173,053	\$1,056,889	\$955,838	\$1,075,078	\$1,867,610	\$6,445,204	\$1,010,458	\$957,098	\$734,223
Executive VP/CEO					\$862,137	\$475,935			
VP Human Resources	\$820,052	\$948,869	\$836,281	\$872,756	\$838,535	\$726,912	\$2,050,637	\$470,470	\$400,817
Chief Information Officer	\$412,631	\$377,700		\$570,359	\$362,411	\$312,899	\$318,742		\$355,439
Chief Financial Officer	\$672,565	\$616,267	\$614,912	\$562,520	\$555,894	\$309,028	\$4,650,958	\$839,689	\$496,428
Chief Operating Officer	\$475,605	\$428,450	\$456,821	\$399,887			\$550,628	\$513,664	\$452,822
Executive VP, Medical Education									\$413,029
Medical Director Southbury Geriatric								\$331,878	
VP IT								\$323,281	
VP Planning	\$338,621	\$307,327							\$387,954
Chief Nursing Officer	\$389,086	\$363,505	\$366,115	\$368,420	\$439,491	\$373,122	\$347,111		
VP Marketing				\$327,799	\$384,914	\$343,416		\$300,910	
Medical Director Community Health Center					\$362,936	\$362,935	\$333,882	\$278,085	
Senior VP Operations					\$349,398	\$309,492			\$333,766
Cardiac Perfusionist								\$272,516	\$256,225
VP Operations							\$279,730		
General Counsel	\$410,471	\$385,527	\$318,627						
VP Compliance							\$273,892		
Executive Medical Director			\$324,499	\$319,748					
Director Education and Research	\$380,708	\$368,511	\$317,847	\$316,265					
VP Facilities	\$322,491	\$311,890	\$288,360	\$314,273	\$326,248	\$318,800	\$308,571	\$311,928	\$316,438
Chief Compliance Officer			\$269,435						
<b>Total</b>	<b>\$5,395,283</b>	<b>\$5,164,935</b>	<b>\$4,748,735</b>	<b>\$5,127,105</b>	<b>\$6,349,574</b>	<b>\$9,977,743</b>	<b>\$10,124,609</b>	<b>\$4,599,519</b>	<b>\$4,147,141</b>

**Day Kimball Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	\$516,452	\$513,986	\$514,375	\$474,666	\$560,836	\$411,409	\$507,590	\$345,096	
Interim President & CEO									\$216,080
Director, OBS/GYN									\$354,236
Director, ICU									\$323,919
DB/GYN Physician			\$411,489	\$407,455	\$336,629	\$313,335	\$338,181	\$331,018	\$299,684
ICU Physician	\$300,114	\$296,501							
Chief Nursing Officer/COD	\$258,269								
VP Philanthropy/Corp. Communications								\$274,810	
VP Information Technology							\$414,745	\$227,892	
Director Informatics		\$224,605							
Pulmonary Physician		\$376,468	\$349,728	\$346,213	\$296,573	\$256,479			
VP Medical Affairs	\$344,214	\$336,971	\$364,114	\$339,071	\$306,047	\$294,738	\$305,808		
Senior VP Human Resources							\$273,219		\$230,147
Primary Care Physician		\$345,634	\$310,908	\$303,899					
Sr. VP of Finance/CFO	\$223,937	\$224,475					\$269,690	\$248,725	\$264,433
Corporate Controller	\$188,798								
Director, Pulmonary Services									\$242,043
Clinical Coordinator	\$165,232								
Psychiatric Physician	\$257,275	\$368,447	\$285,299	\$282,325	\$315,466	\$334,821			
Senior VP, M.I.S.									\$240,796
Director, Pediatric Center									\$238,397
Pulmonary Physician		\$261,912					\$263,369	\$233,040	
OB/GYN Physician			\$233,012	\$230,477	\$300,832				
Psychiatric Physician	\$250,064	\$260,024							
Psychiatric Physician	\$232,919								
Cardiologist			\$309,121		\$266,480	\$253,808	\$263,028	\$240,878	
OB/GYN Physician					\$230,630	\$237,022		\$301,577	
Pediatrician			\$228,861	\$226,361	\$230,070	\$210,606		\$236,100	
Pediatrician			\$225,507	\$223,035	\$226,780	\$209,303			
Pediatrician				\$221,314					
Director of Diagnostic Imaging							\$262,389		
Sr. VP of Patient Services						\$204,924	\$241,376	\$220,463	\$232,287
<b>Total</b>	<b>\$2,737,274</b>	<b>\$3,209,023</b>	<b>\$3,232,414</b>	<b>\$3,054,816</b>	<b>\$3,070,343</b>	<b>\$2,726,445</b>	<b>\$3,139,395</b>	<b>\$2,659,599</b>	<b>\$2,642,022</b>

**Essent-Sharon**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
Chief Executive Officer	\$277,021	\$314,605	\$736,907	\$259,785	\$270,070	\$317,324	\$474,064	\$283,984	\$262,966
General Surgeon								\$306,608	\$325,221
Hospitalist								\$259,673	\$239,511
Chief Financial Officer	\$244,320	\$268,966	\$149,605	\$243,219	\$223,506	\$218,844	\$210,290	\$154,111	\$157,443
Chief Nursing Officer	\$169,868		\$189,966	\$166,424	\$173,838	\$170,212	\$216,423	\$195,159	\$136,670
Hospitalist								\$183,785	\$191,623
Registered Nurse	\$145,966			\$168,971	\$164,087				\$147,995
Registered Nurse, Operating Room		\$141,012						\$129,873	
Director of Clinical Services, RN		\$134,126							
Director, Rehab Services	\$148,054	\$140,011	\$134,254						
Radiology Technician							\$150,220	\$120,207	\$141,799
Registered Nurse, ICU							\$150,198	\$119,137	
Associate Administrator/Director HR	\$178,790	\$176,514	\$168,637	\$165,449	\$156,926	\$151,963			
Director, Human Resources							\$139,260	\$118,928	
Registered Nurse, Surgical Services							\$136,772		
Chief Quality Officer				\$154,903	\$149,086	\$145,354			
Assistant Chief Financial Officer					\$141,916	\$136,640			
Director Information Management		\$151,335					\$133,325		
Director					\$141,526				
Director Cardiology							\$131,238		
Director, OB/OR									\$133,378
Ultrasound Technician					\$131,927	\$126,922			
Corp. Compliance/Director HIM	\$154,697			\$140,648		\$139,163			
Director ICU/Medical Floor						\$137,798			
Registered Nurse			\$130,821	\$138,152					\$124,818
Director				\$132,448	\$136,750				
Director, Facilities	\$137,605	\$134,220							
Director Surgical Services			\$132,286	\$130,566		\$123,914	\$121,299		
Director, Emergency Services	\$140,971	\$137,453	\$132,012						
Registered Nurse			\$130,196						
Director, Quality	\$137,992	\$136,886	\$130,009						
<b>Total</b>	<b>\$1,735,284</b>	<b>\$1,735,128</b>	<b>\$2,034,693</b>	<b>\$1,700,565</b>	<b>\$1,689,632</b>	<b>\$1,668,134</b>	<b>\$1,863,089</b>	<b>\$1,871,465</b>	<b>\$1,861,424</b>

**Greenwich Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President & CEO	\$1,357,317	\$1,523,283	\$1,530,629	\$1,712,494	\$5,220,127	\$1,370,221	\$1,197,091	\$1,043,126	\$967,072
Executive VP & COO	\$854,537	\$687,992	\$791,085	\$773,054	\$2,249,823	\$697,391	\$606,122	\$561,225	
Senior VP & CFO	\$794,818	\$772,022	\$716,899	\$717,888	\$749,638	\$701,024	\$613,265	\$580,578	
CFO									\$555,583
COO									\$538,885
Physician - Emergency Medicine				\$600,733					
Director, Pathology	\$630,556	\$594,309	\$602,825	\$588,104	\$637,971	\$633,638	\$530,313	\$653,882	\$568,169
Pathologist	\$586,829	\$568,771	\$592,050	\$566,033	\$591,098	\$599,523	\$571,407	\$543,299	\$505,003
Breast Cancer Surgeon							\$487,387	\$493,628	
Pathologist		\$543,930	\$567,963	\$562,933	\$568,572	\$570,470	\$518,699	\$538,592	\$485,429
Pathologist		\$484,800	\$538,472	\$555,083	\$550,747	\$568,928	\$452,651	\$521,624	\$474,045
Pathologist	\$483,016	\$433,270		\$548,782	\$501,860	\$464,975	\$431,605		\$449,961
Sr VP of Medical Services	\$545,816							\$476,104	
Perinatologist								\$469,742	\$444,738
VP YNHH/COO Greenwich			\$546,303						
SVP - Health System Development	\$564,526	\$524,668	\$504,529	\$510,007	\$520,234	\$501,699	\$429,141		
Pathologist	\$564,333					\$451,166			\$419,929
Chief Quality Officer		\$513,401	\$506,060		\$500,206				
Chief Safety Officer/Director OPC	\$392,587								
<b>Total</b>	<b>\$6,774,335</b>	<b>\$6,646,446</b>	<b>\$6,896,815</b>	<b>\$7,135,111</b>	<b>\$12,090,276</b>	<b>\$6,559,035</b>	<b>\$5,837,681</b>	<b>\$5,881,800</b>	<b>\$5,408,814</b>

**Griffin Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	\$557,181	\$499,284	\$558,543	\$489,758	\$547,978	\$411,802	\$454,181	\$443,596	\$395,345
Chief, Psychiatric Physician	\$291,115	\$320,377	\$314,419	\$291,232	\$296,341	\$299,790	\$308,476	\$303,398	
Chief Financial Officer	\$296,929	\$256,683		\$289,096	\$346,302	\$244,324	\$268,883	\$262,323	\$219,846
Chair, Preventative Medicine		\$337,159							
Director, Preventative Medicine		\$282,169	\$308,557	\$277,693	\$301,503	\$273,033	\$240,111	\$217,064	
Chief, Pulmonary Physician	\$287,582	\$280,819	\$279,175	\$272,275	\$307,978	\$246,624	\$241,934	\$234,407	\$187,340
Psychiatric Physician	\$280,396	\$310,078	\$303,559	\$269,168	\$332,866	\$257,518	\$249,306		\$229,293
Chief Medical Director		\$244,481	\$271,028	\$255,557	\$344,552				
Vice President Ancillary Services	\$255,685	\$227,218	\$255,880	\$233,095					
Vice President Communication			\$244,003	\$224,973	\$301,463	\$237,288	\$240,378		
Vice President Support Services		\$219,892							
Emergency Room Physician					\$261,883	\$309,873		\$232,257	\$293,228
Chief, Emergency Room Physician					\$265,122	\$320,932	\$316,904	\$308,016	
Emergency Room Physician						\$239,993	\$299,902	\$273,151	\$246,891
Emergency Room Physician							\$237,606	\$208,609	\$230,109
Emergency Room Physician									\$215,742
Emergency Room Physician									\$215,163
Vice President, Facilities	\$218,056							\$215,178	
Vice President, Nursing	\$255,126		\$231,317	\$211,004					
Psychiatric Physician	\$231,109		\$225,621						\$206,328
Psychiatric Physician	\$215,966								
<b>Total</b>	<b>\$2,889,145</b>	<b>\$2,978,160</b>	<b>\$2,992,102</b>	<b>\$2,813,851</b>	<b>\$3,305,988</b>	<b>\$2,841,177</b>	<b>\$2,857,681</b>	<b>\$2,697,999</b>	<b>\$2,439,285</b>

**Hartford Hartford**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Director of Arrhythmia Center	\$493,748				\$1,900,259				\$481,940
VP, Medical Affairs								\$1,820,511	
VP Academic Affairs & Chief Academic Officer	\$659,689		\$3,351,507						
VP Physician Relations	\$775,366		\$2,975,037						
President and CEO			\$917,623	\$1,738,078	\$1,730,709	\$1,200,432	\$1,037,800	\$1,225,925	\$1,129,631
Director of Maternal & Fetal Medicine			\$1,198,676						
President and CEO (former)					\$1,176,466	\$7,222,700	\$1,271,472		
VP Finance and CFO (former)						\$2,183,659	\$732,281		
Executive VP and COO (former)							\$686,910		
VP, Support Services (former)							\$691,664		
VP, Human Resources						\$1,946,399	\$672,239		
Executive VP and COO		\$1,023,714		\$770,537	\$718,644	\$916,347		\$820,361	\$632,172
SVP & Chief Strategy Officer		\$662,244							
SVP & Treasurer		\$647,196							
Director of Nuclear Cardiology						\$863,309			
VP, Finance and Admin Services								\$731,102	\$663,234
Director of Surgery	\$807,330	\$735,506	\$687,588	\$708,508	\$637,627	\$623,888	\$587,306	\$582,937	\$552,460
Chair, Cancer Institute	\$673,632								
VP, Psychiatry		\$3,235,078	\$736,656	\$705,069	\$726,491				
VP Behavioral Health		\$747,573							
Director of Cardiology	\$599,205	\$694,590	\$1,694,841	\$694,379	\$671,144	\$635,051	\$602,750	\$571,217	\$522,269
Director of Electrophysiology	\$532,089								
Director of Critical Care	\$511,264								
Director of Medicine	\$466,270								
Executive VP and CFO		\$879,820	\$783,046	\$673,245	\$642,618				
VP, Academic Affairs		\$724,793	\$705,560	\$660,035	\$840,004	\$1,838,533	\$601,862	\$592,607	\$563,150
VP, HR and Support Services								\$575,835	\$539,645
SVP & Chief Medical Officer		\$821,632	\$663,431						
Chief Medical Officer				\$615,860					
Director of Emergency Med. & Trauma Svcs.				\$604,599	\$601,875	\$638,169	\$704,026	\$680,234	\$627,615
Director of OB/GYN	\$693,448							\$522,364	\$495,873
Director of Women's Health Services				\$594,607					
<b>Total</b>	<b>\$6,212,041</b>	<b>\$10,172,146</b>	<b>\$13,713,965</b>	<b>\$7,764,917</b>	<b>\$9,645,837</b>	<b>\$18,068,487</b>	<b>\$7,588,310</b>	<b>\$8,123,093</b>	<b>\$6,207,989</b>

**John Dempsey Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
CFO					\$423,912	\$467,571	\$433,800		
Professor/Clinical Operation/CEO								\$366,377	\$226,139
Assistant Professor/Clinical/ ER	\$302,012	\$305,075	\$270,370	\$336,160	\$298,171	\$282,759	\$323,057	\$339,593	\$340,415
Assistant Professor/Clinical/ ER	\$300,619	\$297,040	\$264,648	\$280,994	\$280,062	\$282,087	\$287,737	\$284,186	\$272,033
Assistant Professor/Clinical/ ER	\$297,959	\$291,942	\$258,459	\$279,646	\$279,395	\$281,404	\$281,933		\$247,466
Assistant Professor/Clinical/ ER	\$263,242	\$289,832	\$226,433	\$256,709	\$278,719		\$255,721		
Assistant Professor/Clinical/ ER		\$268,015		\$256,097	\$273,502				
Associate VP/Quality Assurance				\$255,248					
Associate Vice President/Nursing		\$264,858	\$261,801						
Associate VP/Clinical Operation					\$239,014	\$280,309	\$245,858	\$358,640	\$229,110
Associate VP/Clinical Operation								\$239,070	
Professor/Clinical Operation						\$227,704	\$266,034		
Assistant Professor/Clinical/ ER				\$246,747		\$260,249		\$235,231	
Assistant Professor/Clinical/ ER				\$224,026					
Instructor/Clinical					\$235,563			\$273,965	\$219,033
Director of Nursing/Clinical/COO								\$268,125	\$257,788
Director/Nursing	\$320,187								
Director/Nursing	\$294,743								
Assistant VP/Application Development									\$219,585
Professor, Clinical Care Improvement									\$256,050
Professor/Clinical Operation								\$263,030	
CEO	\$332,520	\$613,215	\$477,518		\$228,363	\$122,728	\$427,968		
Chief Operating Officer/Finance/CFO								\$171,946	\$274,404
COO		\$322,932	\$309,737		\$143,634	\$288,884	\$278,220		
Staff Nurse		\$258,118							
Pharmacist	\$264,600		\$249,078						
Chief Perfusionist			\$235,662						
Director/Care Coordination	\$258,829								
Medical Physicist/Clinical Radiology				\$243,983		\$237,831	\$230,310		
Associate VP/Quality Assurance				\$231,828					
Associate Professor/Clinical/ ER	\$363,522	\$357,331	\$322,819						
<b>Total</b>	<b>\$2,998,233</b>	<b>\$3,268,358</b>	<b>\$2,876,525</b>	<b>\$2,611,438</b>	<b>\$2,680,335</b>	<b>\$2,731,526</b>	<b>\$3,030,638</b>	<b>\$2,800,163</b>	<b>\$2,542,023</b>

**Johnson Memorial Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President	\$198,324	\$477,819	\$483,070	\$439,647			\$605,558	\$682,469	\$236,771
Vice President Medical Affairs			\$176,895	\$365,673	\$409,004	\$405,455	\$392,694	\$314,833	\$230,598
VP Human Resources	\$169,393				\$159,122	\$193,937			
Chief Financial Officer	\$311,922	\$309,070	\$313,450	\$277,196					
Medical Director of Emergency Medicine					\$142,788	\$416,901			
Emergency Room Physician					\$132,475	\$362,056		\$322,870	\$541,108
Chief of Pathology					\$121,619	\$297,052	\$279,230	\$238,786	
Emergency Room Physician					\$119,808	\$338,007	\$381,418	\$285,669	\$310,265
Emergency Room Physician					\$119,592	\$308,800	\$342,751	\$274,052	\$305,792
Emergency Room Physician					\$118,828	\$305,737	\$331,902	\$244,867	\$274,657
Emergency Room Physician					\$91,680		\$291,416	\$222,387	\$267,637
Pathologist					\$19,825	\$265,952			
Vice President Operations	\$144,662							\$231,870	
Emergency Room Physician						\$213,194	\$288,524		\$257,326
Vice President, Patient Care Services	\$184,847	\$205,683	\$208,759	\$189,280					
Vice President Finance							\$268,980	\$297,447	\$215,515
Emergency Room Physician							\$267,113		\$245,908
Director, Perioperative Services		\$129,118	\$130,075	\$155,610					
RN	\$170,448	\$178,553	\$154,463	\$153,493					
Corporate Director, Information Technology				\$153,090					
Corporate Director, Physical Therapy			\$155,226	\$150,314					
Corporate Controller	\$152,428	\$147,108	\$145,680						
RN	\$148,565	\$147,631	\$145,058	\$147,917					
Corporate Director, Pharmacy				\$143,925					
RN		\$142,565	\$143,158						
RN, Nursing Administration	\$150,823	\$125,578							
RN, Med Surg Unit	\$148,549	\$143,973							
<b>Total</b>	<b>\$1,779,961</b>	<b>\$2,007,098</b>	<b>\$2,055,834</b>	<b>\$2,176,145</b>	<b>\$1,434,741</b>	<b>\$3,107,091</b>	<b>\$3,449,586</b>	<b>\$3,115,250</b>	<b>\$2,885,577</b>

**Lawrence and Memorial Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President, CEO	\$761,873	\$694,776	\$761,734	\$743,210	\$723,845	\$682,508	\$607,001	\$506,695	\$521,633
President, CEO								\$413,795	\$488,744
VP, Medical Staff								\$351,265	\$323,290
Chair, Amb. Services									\$411,637
VP, COO		\$456,567			\$434,976		\$382,094	\$342,528	
Executive Vice President/COO									\$323,371
Neonatologist								\$313,122	
Chair, Dept. of Medicine								\$304,762	\$303,344
Chief Operating Officer	\$455,107		\$484,902	\$448,642		\$426,450			
Chair, Department of Surgery			\$428,327	\$392,627	\$329,508				
Vice President, CFO		\$375,843	\$431,702	\$409,269	\$390,983	\$384,955	\$363,470	\$292,612	
Vice President of Strategic Planning	\$305,928	\$301,458	\$347,841	\$328,400	\$317,427				
Vice President, Chief Transformation Officer	\$370,291								
Chief Legal Officer	\$314,655	\$291,513	\$324,214	\$307,829	\$298,788				
Vice President, Human Resources				\$303,273					
Chief Information Officer	\$279,344	\$263,482	\$300,811	\$291,003					
Vice President, Patient Care	\$289,965	\$268,052	\$307,103	\$287,396					
Vice President, Physician Practice Mgmt	\$571,419	\$259,091	\$287,114						
Vice President, Development	\$259,338	\$227,889							
ER Physician					\$293,348	\$292,898	\$318,715	\$459,149	\$339,944
ER Physician					\$292,410	\$292,249	\$280,475	\$282,018	\$334,402
ER Physician					\$281,359	\$288,100	\$269,065		\$308,049
ER Physician						\$283,183	\$268,588		\$296,538
ER Physician						\$267,590	\$267,500		
ER Physician						\$266,996	\$266,945		
ER Physician							\$265,510		
Neonatologist								\$280,617	
Medical Director Physician	\$237,574	\$260,900	\$269,719	\$280,326	\$305,139	\$351,937			
<b>Total</b>	<b>\$3,845,494</b>	<b>\$3,399,571</b>	<b>\$3,943,467</b>	<b>\$3,791,975</b>	<b>\$3,667,783</b>	<b>\$3,536,866</b>	<b>\$3,289,363</b>	<b>\$3,546,563</b>	<b>\$3,650,952</b>

**Manchester Memorial Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
CEO	\$683,398	\$558,098	\$560,793	\$730,743	\$475,878	\$509,190	\$433,628	\$430,334	\$386,610
CFO				\$416,311	\$306,482	\$335,082	\$323,493	\$301,441	\$285,916
Behavioral Health Director, MD									\$314,757
Senior VP of Medical Affairs	\$375,056	\$333,973		\$376,267	\$304,418				
Medical Director ED	\$486,729	\$347,998	\$377,339	\$304,562	\$286,005	\$315,238	\$331,415		
Emergency Room MD	\$411,993	\$407,087	\$410,390	\$280,429	\$262,183	\$361,900	\$359,032	\$339,513	\$296,890
Emergency Room MD	\$384,580	\$401,584	\$378,568	\$302,168	\$260,466	\$331,476	\$309,185	\$321,084	\$296,661
Emergency Room MD	\$374,550	\$372,004	\$374,663	\$274,218	\$255,360	\$330,931	\$311,748	\$334,337	\$293,784
Psychiatrist							\$317,634		
Treasurer/Exec VP		\$338,414	\$342,391						
Emergency Room MD	\$371,405	\$363,455	\$359,568	\$272,895	\$259,570	\$321,268	\$305,500	\$304,625	\$286,261
Emergency Room MD	\$362,526	\$355,113	\$340,878	\$267,058	\$247,008	\$316,460	\$305,252	\$290,023	\$285,301
Medical Director ED	\$396,992		\$336,920						
Emergency Room MD		\$370,834	\$334,601	\$258,061	\$235,264	\$327,577	\$288,101	\$287,442	\$264,082
Emergency Room MD						\$316,051		\$284,711	
Medical Director MD	\$383,624							\$281,648	\$275,259
<b>Total</b>	<b>\$4,230,853</b>	<b>\$3,848,560</b>	<b>\$3,816,111</b>	<b>\$3,482,712</b>	<b>\$2,892,634</b>	<b>\$3,465,173</b>	<b>\$3,284,988</b>	<b>\$3,175,158</b>	<b>\$2,985,521</b>

**Middlesex Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President/CEO	\$1,059,523	\$1,047,527	\$1,022,460	\$855,550		\$1,377,566	\$1,894,107	\$1,933,120	\$1,884,150
President/CEO (11 mos), Retired 8/31/10					\$1,698,891				
Sr. VP, Finance & Operations (11 mos), Pres/CEO (1mo)					\$713,168				
VP, Quality and Patient Safety	\$552,948	\$514,956	\$495,392						
Sr. VP/COO						\$583,273	\$568,734		
VP, Clinical Affairs	\$639,942	\$712,317	\$692,616	\$527,592	\$522,169	\$425,075			
VP, Nursing					\$515,525	\$455,108	\$589,921	\$422,093	
Chairman, Emergency Medicine	\$465,412	\$457,572	\$437,030	\$458,361	\$437,785	\$414,514	\$407,600	\$530,229	\$359,355
VP, Finance/CFO/Treasurer	\$507,273	\$491,453	\$472,027	\$443,841	\$420,113	\$366,834			\$476,898
VP, Human Resources	\$407,633	\$485,999	\$458,638					\$771,255	\$571,732
Sr. VP, Finance & Operations								\$688,373	
Sr. VP, Strategic Planning & Operations	\$410,991	\$398,871							
Associate Director, Family Practice									\$326,086
VP, Operations				\$437,276			\$345,141	\$398,682	
Chairman, Dept. of Medicine					\$402,393	\$383,550	\$355,939		
Physician, Emergency Department	\$404,116	\$438,794	\$410,969	\$412,833	\$383,357	\$359,933	\$380,476		\$313,468
Physician, Emergency Department			\$382,622				\$342,129		\$302,881
Physician, Emergency Department							\$333,436		
Chief, Dept. of Psychiatry								\$480,747	\$319,133
Medical Director/MMC Shoreline									\$306,084
Clinical Director of Infectious Disease		\$393,196	\$384,870	\$397,220	\$399,022	\$373,789		\$471,634	
Clinical Director, Family Practice								\$385,914	
Chief, Department of Medicine & Secretary	\$410,301	\$395,704	\$387,577	\$391,924	\$398,797				
ED Physician, Shoreline								\$383,310	
Former President/CEO				\$390,210					
Medical Director/Emergency Department	\$396,768			\$385,161		\$354,820	\$363,313		\$305,760
<b>Total</b>	<b>\$5,254,907</b>	<b>\$5,336,389</b>	<b>\$5,144,201</b>	<b>\$4,699,968</b>	<b>\$5,891,220</b>	<b>\$5,094,462</b>	<b>\$5,580,796</b>	<b>\$6,465,357</b>	<b>\$5,165,547</b>

**Midstate Medical Center**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President/CEO		\$943,218	\$958,020	\$903,186	\$852,851	\$856,294	\$818,081	\$724,372	\$583,640
CFO				\$500,859	\$472,514	\$417,879	\$370,141	\$325,521	\$318,218
Hospitalist Physician Director				\$402,481	\$384,467	\$362,957	\$334,211		
Hospitalist	\$389,707	\$450,232							
Hospitalist	\$347,566	\$383,916							
Hospitalist	\$336,773	\$372,952							
Hospitalist	\$324,813	\$365,712							
Hospitalist	\$320,553	\$359,039							
Hospitalist	\$316,325	\$348,383							
Hospitalist	\$257,561	\$347,761							
Per Diem Hospitalist	\$314,391								
Medical Director Mediquick	\$365,164								
Vice President			\$390,197	\$361,186					
Physician/ED Physician			\$409,553	\$357,013	\$523,033	\$515,538	\$452,689	\$454,104	\$416,177
Physician/ED Physician			\$409,432	\$338,014	\$392,805	\$426,115	\$410,223	\$395,225	\$368,814
Physician/ED Physician			\$351,649	\$327,442	\$373,523	\$366,218	\$354,336	\$345,308	\$336,495
CMO		\$538,417	\$419,637	\$324,801					
Senior VP Operations	\$362,653								
Vice President				\$317,948					
COO		\$418,703						\$418,216	\$372,092
Physician/ED Physician			\$348,160	\$310,134	\$359,090	\$352,368	\$319,583	\$341,842	\$316,487
Physician/ED Physician			\$340,888		\$352,973	\$343,935	\$319,411	\$329,998	\$311,835
Physician/ED Physician			\$340,517		\$345,949	\$336,351	\$310,987	\$323,821	\$311,615
Physician/ED Physician			\$339,775		\$343,328	\$331,467	\$310,000	\$322,437	\$305,567
<b>Total</b>	<b>\$3,335,506</b>	<b>\$4,528,333</b>	<b>\$4,307,828</b>	<b>\$4,143,064</b>	<b>\$4,400,533</b>	<b>\$4,309,122</b>	<b>\$3,999,662</b>	<b>\$3,980,844</b>	<b>\$3,640,940</b>

**Milford Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President	\$875,081	\$596,448	\$579,475	\$409,804	\$369,792	\$368,100	\$584,198	\$564,048	\$542,425
Physician, Dir. ICU						\$435,314	\$436,656	\$366,809	\$311,211
Vice President Finance							\$367,778	\$359,990	\$335,416
Physician, Chief Operating Officer	\$824,032	\$556,742	\$538,527	\$390,015	\$451,013				
Hospitalist		\$363,430	\$351,489	\$358,094	\$370,807		\$308,051		
Pathologist	\$369,566	\$344,700	\$345,094	\$350,286					
ER Physician	\$274,722	\$373,044	\$341,173	\$333,021	\$337,610	\$341,036	\$332,309	\$324,830	\$313,159
ER Physician	\$246,745	\$359,350	\$341,090	\$332,969	\$337,610	\$350,539	\$331,769	\$324,668	\$311,318
ER Physician		\$339,255	\$340,882	\$331,803	\$327,796	\$335,078	\$330,092	\$321,487	\$306,348
Physician, Dir., ER				\$329,567	\$334,377			\$319,726	\$318,225
Hospitalist			\$346,959	\$329,539	\$318,975	\$332,513			
House Physician	\$373,895							\$294,558	\$269,738
House Physician	\$357,857								
House Physician	\$346,822								
House Physician	\$286,221								
House Physician	\$267,192								
ER Physician		\$339,099	\$339,691	\$322,711	\$327,783	\$325,638	\$326,820	\$320,258	
ER Physician		\$335,714	\$332,195		\$323,799	\$326,493	\$307,639	\$291,567	\$241,487
ER Physician		\$335,209				\$322,325			\$234,035
ER Physician						\$315,317			
Vice President Finance							\$301,943		
<b>Total</b>	<b>\$4,222,133</b>	<b>\$3,942,991</b>	<b>\$3,856,575</b>	<b>\$3,487,809</b>	<b>\$3,499,562</b>	<b>\$3,452,353</b>	<b>\$3,627,255</b>	<b>\$3,487,941</b>	<b>\$3,183,362</b>

**New Milford Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
VP Human Resources				\$598,225					
President/CEO	\$240,264	\$216,471	\$195,774			\$579,769	\$551,928	\$378,612	\$510,994
SVP Operations	\$305,899	\$390,795	\$399,446						
Controller	\$175,328	\$169,748	\$187,679						
Director, Finance	\$202,764	\$197,173	\$187,168						
Ex-President						\$504,699	\$520,642	\$556,305	
Director, Patient Experience	\$185,544	\$181,583							
PVT-Physician				\$524,365	\$415,363	\$388,286		\$314,473	\$294,239
PVT-Physician					\$402,659				
PVT-Physician					\$372,602				
Lab-Physician			\$480,036	\$433,162	\$458,129	\$444,620	\$431,352	\$393,499	\$395,072
Dir., Emergency Services				\$425,241	\$455,760	\$442,595	\$493,692	\$391,352	\$397,819
Ear, Nose & Throat Physician						\$393,109	\$419,422		
Chief Medical Physicist	\$241,166	\$236,050	\$236,050						
Manager, Cancer Center	\$172,631								
Radiology-Physician			\$237,151	\$388,596	\$463,809	\$453,172	\$452,354	\$409,046	\$390,278
ER-Physician				\$324,724	\$356,520		\$357,558	\$333,064	\$303,683
VP, Finance				\$304,635	\$320,582	\$1,574,460	\$332,954	\$286,657	\$291,461
ER-Physician				\$296,090	\$325,727	\$341,992	\$324,888	\$301,257	\$301,090
ER Physician								\$296,044	\$297,204
ER Physician									\$290,550
VP, Nursing, COO			\$206,897	\$279,629	\$335,896	\$379,013	\$377,312		
PVT-Physician				\$268,123					
Director, Nursing	\$169,779	\$213,871							
Director, Medical Affairs & Quality	\$199,888	\$197,694							
Director, Planetree			\$180,756						
Director, Employee Health	\$171,529	\$173,850	\$180,359						
Mgr, Pharmacy Operations		\$157,679							
MIS Officer			\$178,965						
<b>Total</b>	<b>\$2,064,792</b>	<b>\$2,134,914</b>	<b>\$2,670,281</b>	<b>\$3,842,790</b>	<b>\$3,907,047</b>	<b>\$5,501,715</b>	<b>\$4,262,102</b>	<b>\$3,660,309</b>	<b>\$3,472,390</b>

**Norwalk Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
VP & Chief Medical Officer				\$810,916	\$911,520				
President & CEO	\$1,268,795	\$1,050,930	\$901,148	\$797,727		\$941,545	\$947,473	\$753,038	\$712,447
COO									\$624,360
President & CEO (through April 2010)					\$2,769,742				
VP & Chief Operating Officer/President & CEO					\$631,222				
VP & Chief Operating Officer						\$580,806			
VP Quality				\$651,642					
Physician, Emergency Department	\$590,305	\$626,548	\$685,615	\$644,978	\$598,761	\$546,877	\$571,541	\$581,690	
Chairman, Dept. of Emergency Medicine		\$568,977	\$585,218	\$582,032		\$520,710	\$499,071	\$471,022	\$530,410
VP Planning/VP and Chief Operating Officer					\$495,864				
Chairman, Dept. of OB/GYN				\$576,298		\$787,458	\$510,698	\$469,596	\$458,545
Sr. VP & COO			\$535,681	\$534,321			\$715,282	\$475,350	
Physician, Emergency Department	\$516,291	\$475,854	\$519,445	\$518,578	\$616,208	\$539,434	\$508,100	\$555,721	\$464,069
Chairman, Dept. of Medicine				\$499,713	\$545,236	\$827,220	\$708,223	\$574,213	\$564,770
VP & Chief Financial Officer	\$664,111	\$610,069	\$489,543				\$461,558		
VP Nursing Patient Care Services						\$436,783			
VP Planning and Business Development						\$407,117			\$358,054
Sr. VP Strategy & System Development	\$601,931								
Sr. VP & COO		\$560,049					\$413,961		
VP, Human Resources	\$926,697	\$472,049							
Chairman, Dept. of Surgery				\$478,153	\$437,306		\$400,520	\$436,043	
Chief Pulmonary/Critical Care					\$495,115				
Director, Real Estate								\$411,611	
Physician, Emergency Department	\$501,242		\$478,304		\$392,756	\$392,120		\$380,719	\$401,936
Chief Financial Officer									\$399,721
VP & Chief Nursing Officer			\$472,525						
Chairman, Psychiatry		\$454,227							\$395,655
Physician, Emergency Department	\$473,446	\$420,766	\$442,639						
Physician, Emergency Department	\$472,663	\$411,006	\$412,040						
Physician, Emergency Department	\$455,025								
<b>Total</b>	<b>\$6,470,506</b>	<b>\$5,650,475</b>	<b>\$5,522,158</b>	<b>\$6,094,358</b>	<b>\$7,893,730</b>	<b>\$5,980,070</b>	<b>\$5,736,427</b>	<b>\$5,109,003</b>	<b>\$4,909,967</b>

**Rockville General Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
CEO	\$269,844	\$239,511	\$240,340	\$313,176	\$203,947	\$218,224	\$185,155	\$184,429	\$165,690
Medical Director	\$338,865	\$353,700	\$324,458						
Medical Director		\$279,461	\$267,332						
Emergency Room Staff MD						\$298,633	\$288,830	\$316,140	\$284,842
Urgent Care MD	\$311,021	\$237,773							
Urgent Care MD	\$256,590	\$198,751							
Urgent Care MD	\$237,577								
OB/GYN				\$296,847	\$287,075	\$253,645	\$134,771		
VP Patient Care Services	\$224,341	\$194,226	\$168,500						
Infection Control Director MD	\$264,351			\$267,035	\$213,063	\$231,082	\$231,252	\$251,377	
Emergency Room Staff MD						\$156,625	\$286,392	\$308,333	\$279,951
Emergency Room Staff MD								\$233,212	\$275,186
Infectious Disease MD									\$250,121
Emergency Room Staff MD									\$227,994
Psychiatrist	\$261,240	\$226,768							
CFO				\$178,419	\$131,350	\$143,386	\$140,036	\$129,190	\$122,535
Senior VP of Medical Affairs				\$161,257	\$131,123	\$134,648			
RN - Amb Surg					\$144,581				
VP Quality							\$151,625		\$153,245
Emergency Room Staff MD									\$135,879
Senior Director									\$128,113
RN Supervisor		\$174,125	\$167,806	\$144,695	\$126,755				
RN Supervisor		\$185,757							
Registered Nurse	\$176,954		\$148,917						
Treasurer/Exec VP			\$146,739						
Admin Director				\$147,232	\$140,026	\$139,004	\$131,485		
Medical Director MD		\$149,601	\$144,450					\$120,706	
Staff Nurse Practitioner								\$119,658	
Registered Nurse			\$126,837						
Senior VP/Medical Director			\$124,441						
Clinician	\$155,922								
Admin Director							\$134,895		
RN-ICU				\$146,783	\$135,200	\$132,657			
RN-ICU					\$128,826				
Medical Director ED				\$130,526		\$135,102	\$142,034	\$117,224	
Pharmacist								\$126,810	
Medical Imaging Director				\$149,607					
<b>Total</b>	<b>\$2,496,705</b>	<b>\$2,239,673</b>	<b>\$1,859,820</b>	<b>\$1,935,577</b>	<b>\$1,641,946</b>	<b>\$1,843,006</b>	<b>\$1,826,475</b>	<b>\$1,907,079</b>	<b>\$2,023,556</b>

**Saint Francis Hospital and Medical Center**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President	\$3,135,570	\$1,697,418	\$1,521,090	\$1,422,730	\$1,534,640	\$1,225,460	\$1,295,178	\$1,161,713	\$1,052,791
Retired President									\$842,802
Senior Vice President and CFO			\$715,743		\$820,051	\$764,883	\$782,085	\$592,563	\$525,978
Executive Vice President						\$776,959	\$732,722	\$624,226	\$553,559
Executive Vice President and COO	\$635,702	\$898,975	\$731,103	\$693,126	\$629,960	\$506,142			
Executive Vice President, Chief Admin Officer	\$785,531	\$843,425							
Senior Vice President and General Counsel			\$395,262			\$739,382	\$543,618	\$436,409	
Department Chairman, Surgery	\$731,925	\$667,064	\$627,085			\$433,126			
Executive Vice President and CPO		\$823,171	\$564,996						
President - Saint Francis Foundation				\$568,974	\$475,818	\$480,084			
Senior Vice President, Chief Academic Officer	\$505,762	\$522,703	\$497,259	\$515,074	\$498,851	\$453,270			
Senior Vice President, Chief Dev. Officer	\$483,872	\$487,359							
Section Chief - Pathology					\$489,166	\$434,053	\$487,549	\$473,932	\$455,029
President, JMMC	\$442,406								
Vice President, Financial Planning		\$380,990	\$495,310						
Department Chairman - Pathology					\$467,804		\$471,696	\$460,763	\$442,915
Senior Vice President - Nursing		\$441,176	\$419,088						
Program Director - Pathology					\$442,922		\$440,671	\$428,034	\$409,916
Vice President - Interim CFO				\$436,565		\$494,094			
Department Chairman - Emergency				\$427,080	\$410,602		\$473,425	\$433,598	\$415,766
Senior Vice President - Planning	\$415,876	\$412,053	\$413,512	\$426,075	\$444,464		\$418,495		
SVP, Human Resources	\$376,149								
SVP, Chief Information Officer	\$374,456								
Staff Physician - Emergency				\$417,086			\$398,410		\$422,436
Staff Physician - Emergency				\$419,896					\$348,989
Staff Physician - Emergency				\$394,466				\$397,797	
Psychiatrist								\$388,889	
<b>Total</b>	<b>\$7,887,249</b>	<b>\$7,174,334</b>	<b>\$6,380,448</b>	<b>\$5,721,072</b>	<b>\$6,214,278</b>	<b>\$6,307,453</b>	<b>\$6,043,849</b>	<b>\$5,397,924</b>	<b>\$5,470,181</b>

**St. Mary's Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President & CEO	\$913,009	\$853,512	\$791,256	\$649,453	\$599,134			\$765,051	\$764,919
Medical Director Cardiology									\$314,576
Vice President & CFO former								\$306,178	\$166,517
Executive Vice President						\$593,749	\$404,367		
Vice President and CFO	\$334,247	\$266,887	\$218,577	\$479,091	\$363,355	\$392,216	\$424,741	\$199,564	\$299,653
Vice President & CNO	\$256,164	\$338,629							
Vice President & CNO, former		\$265,011							
Vice President Patient Services			\$560,617	\$284,285	\$293,715	\$296,546	\$343,210	\$259,189	\$228,563
VP, Marketing & Business Development								\$224,306	\$172,878
Former President & CEO							\$305,243		
Vice President Human Resources	\$303,346	\$280,376	\$290,284	\$255,565	\$240,600	\$246,038	\$247,611		\$163,764
Physician Hospitalist Program Internal Med.									\$190,874
Chairman, Department of Medicine		\$275,582							
Vice President & Chief Medical Officer	\$435,298	\$245,516	\$425,825	\$432,762	\$475,162	\$270,057			
Chief Information Officer		\$228,524	\$244,993	\$240,094	\$200,300	\$178,502	\$181,117	\$152,782	
Chief Marketing Officer	\$257,678	\$240,125	\$226,403	\$221,048	\$201,173	\$178,752	\$159,775		
Vice President Surgical Services			\$353,905	\$318,435	\$201,394				
Vice President Surgical Services, Former	\$372,127								
Vice President Operations	\$349,154	\$325,082	\$333,779	\$296,349	\$241,116		\$284,820	\$222,746	\$167,537
Chief Operating Officer	\$307,756								
Critical Care Nurse						\$162,859			
Div. Dir. Perioperative and Invasive Services							\$168,939	\$161,555	
Divisional Director, Clinical Quality			\$185,905	\$185,753		\$173,009	\$163,605	\$158,061	
Director of Pharmacy								\$151,739	
Director, Operating Room					\$178,178	\$162,039			\$146,949
Executive Director Revenue Cycle	\$219,286								
<b>Total</b>	<b>\$3,748,065</b>	<b>\$3,319,244</b>	<b>\$3,631,544</b>	<b>\$3,362,835</b>	<b>\$2,994,127</b>	<b>\$2,653,767</b>	<b>\$2,683,428</b>	<b>\$2,601,171</b>	<b>\$2,616,230</b>

**St. Raphael**

Position Title	2012	2011	2010	2009	2008	2007	2006
President	\$1,803,605	\$1,043,560	\$911,333	\$4,282,605	\$1,013,140	\$903,330	\$890,725
Former President			\$2,168,074				
Senior Vice President, COO & CFO		\$734,111	\$987,313	\$635,609			
Senior Vice President, CMO (MD)	\$724,139	\$705,420	\$773,004	\$651,886			
Clinical Chair, Surgery (MD)			\$680,736	\$713,955	\$648,922	\$624,624	\$527,845
Clinical Chair, Emergency Medicine (MD)	\$460,733	\$630,934		\$629,011	\$516,934	\$437,898	
Vice President - Medical Services							\$488,498
Clinical Chair, Medicine (MD)	\$541,652	\$595,195		\$714,365	\$534,595	\$503,169	\$483,632
Former Sr. Vice President, CMO (MD)			\$635,338				
Cardiologist (MO)	\$514,489	\$524,696				\$501,371	\$325,398
Clinical Chair, Women's/Children's Services (MD)	\$472,267			\$580,409	\$621,357	\$613,674	\$545,164
Associate Clinical Chair, Surgery (MD)						\$400,079	\$387,694
Director, Cardiology Fellowship/CDU (MD)	\$503,734	\$510,919	\$515,784				
Director, Surgical Intensive Care Unit (MD)	\$478,876	\$487,030			\$439,540	\$405,821	\$384,802
Section Chief, Thoracic Surgery (MD)	\$564,767	\$484,735	\$486,810	\$468,291	\$493,505		
Section Chief, Cardiology (MO)			\$447,832	\$420,950	\$397,602	\$621,619	\$386,114
Associate Clinical Chair, Medicine (MD)	\$368,478	\$387,201	\$377,221	\$360,560	\$348,214	\$340,498	
Directors, McGivney Cancer Center (MD)							\$308,371
Medical Information Officer (MD)					\$345,612		
<b>Total</b>	<b>\$6,432,740</b>	<b>\$6,103,801</b>	<b>\$7,983,445</b>	<b>\$9,457,641</b>	<b>\$5,359,421</b>	<b>\$5,352,083</b>	<b>\$4,728,243</b>

**St. Vincent's Medical Center**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
Chief Executive Officer	\$1,076,770	\$984,669	\$2,394,278	\$1,484,755	\$1,485,490	\$1,275,826	\$922,813	\$954,683	\$813,986
Former Chief Executive Officer		\$1,110,833							
President/Chief Academic Officer			\$978,878						
Chairperson Medicine					\$771,879				
Senior Vice President			\$929,797						
CMO/Clinical VP Cardiology							\$715,872	\$815,402	\$588,172
Chief, Cardiothoracic Surgery						\$714,299	\$688,391	\$470,873	
Clinical Chair Oncology						\$659,205	\$567,940	\$562,094	
Corp. Sr. VP Marketing/Govt Relations						\$624,541	\$575,899	\$497,550	\$640,952
Sr. VP Chief Clinical/Chief Medical Officer	\$921,307	\$910,454			\$717,509				
Clinical Chair Oncology/Chief Medical Officer				\$837,791					
Clinical Vice President Cardiac Services			\$774,448	\$634,145					
Clinical Vice President Surgical Services		\$894,493	\$778,042	\$630,797	\$587,507	\$594,139		\$561,609	\$562,403
Senior Vice President/Chief Financial Officer	\$688,869	\$673,021	\$747,134	\$567,478	\$527,089				
Clinical Vice President Medicine	\$675,890	\$643,993	\$613,539	\$554,058		\$622,403	\$624,660	\$602,937	\$732,012
Vice President/Chief Legal Counsel	\$534,713	\$513,004							
Sr. VP/Chief Nursing Officer/COO	\$497,600	\$482,467							
Senior VP, Corporate Affairs	\$390,699	\$354,899							
Chairperson, Department of Surgery	\$481,159								
Director, Cardiothoracic Surgery						\$536,707	\$582,197		
General Surgeon						\$506,107	\$622,697		
Trauma Surgeon								\$491,733	
Chair Neonatology							\$505,356		
Chairperson Emergency Care	\$443,244		\$592,032	\$525,145	\$626,929		\$454,732	\$457,191	\$476,961
Vice Chairperson Emergency Care				\$491,021	\$527,678				\$354,263
ED Physician						\$443,302		\$378,793	\$331,842
ED Physician						\$435,153			\$313,453
Chief Financial Officer									\$420,933
Senior Vice President				\$456,215	\$653,854				
Sr. VP/Chief Administrative Officer			\$590,696		\$427,992				
Chairperson, Obstetrics & Gynecology	\$376,404				\$390,454				
Sr. VP/Chief Human Resources Officer		\$454,673	\$477,436						
Vice President CHRO Employee Council				\$455,920					
<b>Total</b>	<b>\$6,086,655</b>	<b>\$7,022,506</b>	<b>\$8,876,280</b>	<b>\$6,637,325</b>	<b>\$6,716,381</b>	<b>\$6,411,682</b>	<b>\$6,260,557</b>	<b>\$5,792,865</b>	<b>\$5,234,977</b>

**Stamford Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President & CEO	\$2,402,748	\$2,222,554	\$1,532,094	\$2,241,639	\$1,695,727	\$2,399,609	\$1,552,751	\$1,424,969	\$1,505,731
Sr. VP Finance CFO									\$1,177,667
Sr. VP of Medical Affairs	\$929,239	\$779,389	\$681,212	\$1,080,817	\$911,568	\$844,466	\$1,084,950	\$916,043	\$827,193
VP of Physician Network Development		\$873,017							
Surgery Physician									\$707,094
Pediatric Physician									\$612,001
Chief of Cardiac Surgery	\$898,824	\$996,839	\$1,180,752	\$992,541					
Chief of Surgery	\$857,348		\$768,216	\$906,571	\$716,968	\$677,257	\$718,271	\$603,072	
Exec. VP and Chief Operating Officer	\$1,316,300		\$784,363	\$756,653	\$586,964	\$556,035	\$669,998	\$555,285	
Sr. VP Operations COO		\$807,104							\$531,798
Sr. VP of Strategy & Marketing	\$721,788	\$649,400	\$663,125	\$740,648	\$584,749	\$555,766	\$702,165	\$560,141	\$516,754
VP of Finance & Chief Financial Officer	\$1,008,955	\$816,687	\$735,596	\$720,187					
Chief Information Officer					\$572,108			\$659,960	
Chief Financial Officer					\$538,917	\$584,026	\$685,468	\$642,151	
VP Ambulatory Services			\$662,001	\$656,204	\$537,897				
Chief of Cardiology		\$619,201	\$608,165	\$580,278					
Chair, Dept. of Pediatrics						\$535,091	\$599,219	\$596,484	
Cardiac Surgeon			\$604,033						\$526,501
Director of Cardiology					\$577,961	\$527,830	\$567,360	\$533,258	
Chief of Bariatric Surgery	\$719,194	\$616,054							
Sr. VP Patient Services					\$523,138				\$608,443
VP and Chief Information Officer	\$688,889								
Chief Financial Officer								\$527,027	
Dept. of Medicine Physician									\$500,240
Sr. VP of Talent & Culture						\$507,757	\$560,848		
Chief, Dept Medicine							\$489,451		
Chair, Dept. of Obstetrics	\$1,063,073	\$673,597		\$579,437		\$579,607			
<b>Total</b>	<b>\$10,606,358</b>	<b>\$9,053,842</b>	<b>\$8,219,557</b>	<b>\$9,254,975</b>	<b>\$7,245,997</b>	<b>\$7,767,444</b>	<b>\$7,630,481</b>	<b>\$7,018,390</b>	<b>\$7,513,422</b>

**Waterbury Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
COO			\$285,001	\$372,533	\$349,800	\$346,933	\$336,115		\$303,422
President	\$700,205	\$663,566	\$520,298		\$559,086	\$557,177	\$543,225	\$497,412	\$495,175
Medical Director ICU							\$429,416	\$404,073	\$368,600
Chief Financial Officer	\$412,354								
Chief Information Officer	\$390,922	\$343,254							
Physician, Director of ED			\$220,141			\$434,224	\$419,545	\$385,225	\$360,832
VP Medical Affairs		\$168,103	\$200,000		\$401,415	\$399,001	\$386,234	\$361,690	\$356,362
VP Patient Care/CNO	\$277,791	\$246,766							
Vice President Operations		\$182,207							
Medical Director Internal Medicine						\$406,881	\$390,191	\$374,049	\$363,491
Psychiatrist	\$241,985		\$206,039						
Medical Director ICU						\$401,214			
ED Physician						\$375,695	\$347,516	\$301,684	\$292,832
Staff Pharmacist		\$183,278							
Physician Assistant Director of Surgery									\$337,710
Associate Director of Surgery							\$350,943	\$342,946	
Attending Faculty Surgeon						\$351,552	\$340,601	\$354,404	
Physician, Director of ED								\$357,059	
CFO			\$174,602	\$366,538	\$342,259	\$340,322			\$304,167
Chief Medical Information Officer: MD				\$279,141	\$241,679				
Chief Medicaid Information Officer		\$235,757							
Medical Director Behavioral Health	\$250,037	\$235,528	\$204,736	\$245,009	\$253,710				
Medical Director Behavioral Health	\$234,438		\$193,939	\$234,970	\$234,482				
Medical Director Adolescent Services	\$230,941								
Psychiatrist		\$189,684	\$200,840	\$240,995	\$242,964				
VP Human Resources	\$272,995	\$249,234	\$177,500	\$224,139	\$213,388				
Psychiatrist	\$238,483			\$237,376	\$237,430				
ED Physician						\$327,404	\$334,097	\$313,796	\$282,454
COO				\$214,294					
VP Finance				\$191,630					
<b>Total</b>	<b>\$3,250,151</b>	<b>\$2,697,377</b>	<b>\$2,383,096</b>	<b>\$2,606,625</b>	<b>\$3,076,213</b>	<b>\$3,940,403</b>	<b>\$3,877,883</b>	<b>\$3,692,338</b>	<b>\$3,465,045</b>

**Windham Community Memorial Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer				\$545,243	\$585,128	\$520,920	\$469,982	\$367,447	\$368,288
Director of ER									\$454,329
Associate Director Emergency Department							\$323,865	\$434,562	
Physician/Hospitalist		\$288,962	\$463,270	\$441,376	\$376,126				
Medical Director			\$347,208	\$359,517	\$290,378				
Chief Financial Officer/VP Finance			\$249,090	\$337,633	\$341,410	\$318,624	\$293,324	\$241,639	
Chief Financial Officer									\$242,778
Emergency Department Physician							\$293,059	\$414,618	\$376,809
Emergency Department Physician							\$246,715	\$366,186	\$345,570
Emergency Department Physician							\$242,264	\$352,725	\$302,407
Emergency Department Physician							\$214,742	\$315,865	\$289,138
Emergency Department Physician							\$206,331	\$312,993	\$273,434
Emergency Department Physician							\$143,862	\$306,390	\$226,486
Emergency Department Physician								\$247,438	\$178,510
Physician/Hospitalist	\$378,887	\$436,964	\$433,682	\$269,810	\$221,757				
Physician/Hospitalist	\$296,315	\$320,462	\$284,341	\$265,443					
Physician/Hospitalist	\$279,557	\$305,674	\$279,696	\$264,125					
Physician/Hospitalist	\$264,022	\$269,719							
Physician/Hospitalist	\$261,230								
Vice-President Operations		\$263,290	\$257,531	\$245,308					
Physician/Hospitalist	\$250,041	\$301,846	\$245,831						
Physician/Hospitalist	\$233,954								
Medical Director			\$223,976	\$229,559	\$222,030				
Vice President Patient Care		\$255,343			\$237,440	\$292,675	\$190,886		
Vice President Human Resources	\$198,295	\$349,509			\$199,093	\$183,859			
IT Director		\$248,557							
Registered Nurse	\$232,524		\$257,641			\$193,937			
Registered Nurse	\$212,515			\$214,202	\$196,156	\$165,936			
Director Inpatient Nursing						\$162,875			
Registered Nurse						\$160,759			
Registered Nurse						\$160,524			
Registered Nurse					\$192,973	\$158,314			
<b>Total</b>	<b>\$2,607,340</b>	<b>\$3,040,326</b>	<b>\$3,042,266</b>	<b>\$3,172,216</b>	<b>\$2,862,491</b>	<b>\$2,318,423</b>	<b>\$2,625,030</b>	<b>\$3,359,863</b>	<b>\$3,057,749</b>

**Yale-New Haven Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO (YNHH & YNHHS)	\$3,520,872	\$3,263,758	\$2,803,228	\$2,592,381	\$2,547,699	\$2,612,895	\$2,022,544	\$1,798,621	\$1,488,980
Exec. VP, COO (YNHH & YNHHS)	\$2,143,135	\$1,942,688	\$1,680,133	\$1,636,424	\$1,643,996	\$1,625,653	\$1,516,169	\$1,403,271	\$350,233
SR VP, Chief of Staff (YNHH & YNHHS)	\$1,593,847	\$1,482,123	\$1,673,612	\$1,383,291	\$2,713,552	\$1,339,602	\$1,234,724	\$1,115,331	
SR VP Finance, CFO (YNHH & YNHHS)	\$1,806,166	\$1,597,211	\$1,432,214	\$1,359,691	\$1,345,514	\$1,260,656	\$1,114,791	\$1,083,817	\$1,124,783
SVP, Med. Aff/Chief									\$1,102,233
Sr. VP of Quality & Safety	\$909,375								
Senior VP HR (YNHH & YNHHS)	\$1,078,184	\$1,002,344	\$945,388	\$963,800	\$954,346	\$976,093		\$725,218	\$656,327
Senior VP Administration				\$920,989	\$924,331	\$870,911	\$726,378	\$636,947	\$577,249
VP of Legal Services	\$1,100,951	\$998,877	\$903,335	\$802,811	\$780,372				
VP & Exec Dir of Childrens Hospital		\$853,117				\$739,113	\$594,779		
Sr. VP of OPS/Children	\$875,071								
Senior VP Patient Services		\$703,474	\$769,813	\$736,309	\$724,577	\$729,091	\$1,093,847	\$565,102	\$528,715
Senior VP, CIO (YNHH & YNHHS)	\$1,133,727	\$1,003,592	\$895,982	\$687,019	\$902,132	\$985,608	\$739,064	\$686,872	\$676,045
Vice President, Administration									\$508,390
Vice President, Administration									\$486,639
SVP OPS/Smilow	\$898,353	\$800,103	\$647,666						
VP Finance					\$726,759	\$718,587	\$574,932	\$539,790	
VP Ambulatory Services			\$622,898	\$654,217			\$601,502	\$562,377	
<b>Total</b>	<b>\$15,059,681</b>	<b>\$13,647,287</b>	<b>\$12,374,269</b>	<b>\$11,736,932</b>	<b>\$13,263,278</b>	<b>\$11,858,209</b>	<b>\$10,218,730</b>	<b>\$9,117,346</b>	<b>\$7,499,594</b>

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July 1, 2016

**Via Email and Hand Delivery**

Kimberly Martone, Director of Operations  
Kevin Hansted, Hearing Officer  
Office of Health Care Access  
Department of Public Health  
State of Connecticut  
410 Capitol Avenue  
Hartford, CT 06106



**Re: Certificate of Need Applications,  
OHCA Docket No. 15-32032-CON, Merger of L & M Physicians Association and  
Northeast Medical Group, Inc. and,  
OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial  
Corporation and Yale New Haven Health Services Corporation**

Dear Ms. Martone and Mr. Hansted:

Attached please find originals and two copies of pre-file testimony submitted by the  
Intervenors in the above captioned matters. Thank you.

Very truly yours,

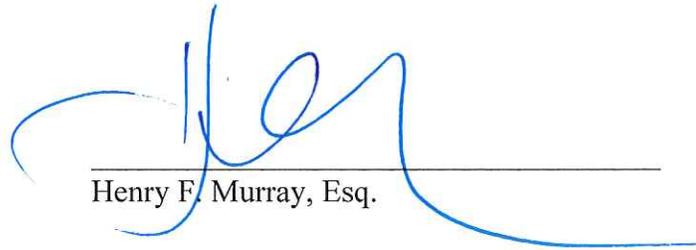
Henry F. Murray

HFM:vds  
Enclosure

## CERTIFICATION

This certifies that the Intervenor's pre-file testimony was sent via email and First Class Mail, pre-paid on July 1, 2016, to the following counsel of record:

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TESTIMONY to the Office of Health Care Access  
July 1, 2016

**Re: CON application regarding acquisition of Lawrence & Memorial Hospital and its physicians' group by Yale-New Haven Health System**

Ellen Andrews, PhD, Executive Director

My name is Ellen Andrews. I reside at 49 Wilkins St., Hamden Connecticut. I am Executive Director of the Connecticut Health Policy Project. I'm here today to urge OHCA not to approve the application of Yale-New Haven Health System to take over Lawrence and Memorial Health.

We are in the midst of enormous transition in our health care system. The Affordable Care Act has enabled 16 million Americans to gain health insurance coverage, and covered thousands of Connecticut's previously uninsured residents. The ACA offers ongoing incentives and supports to help our state get coverage for the remaining 250,000 uninsured that live in Connecticut.

But not all the news is good. The continued consolidation of providers and insurers is driving an ongoing cost spiral that threatens to undo much of the positive change that we've seen in the past few years. . Dr. Hyde has described the overwhelming body of research demonstrating that as competition is drained from our health care system, costs inevitably go up, and consumers lose choice.

The Connecticut Health Policy Project is particularly concerned about the impact of these trends on low income and underserved communities, the state budget and the growing trend of underinsurance among those with private coverage.

Connecticut has received national recognition for its work reining in Medicaid costs.<sup>1</sup> We are the only state to take back Medicaid recipients from private managed care plans and negotiate provider rates ourselves. That decision and resulting reforms has reduced per member costs, increased the number of physicians participating in the Medicaid program, and reduced emergency room visits. More people covered for less money seen by more providers and better quality care in the appropriate setting. Sounds like a win.

But it hasn't been enough. Underlying provider prices are destroying access to care for many in our state. Due to budget constraints, 11,677 working parents are losing HUSKY coverage at the end of this month. Medicaid beneficiaries in high cost areas like New Haven still struggle to get appointments. HUSKY families "transitioning" to coverage in AccessHealthCT insurance plans, our state's health insurance exchange, are expected to meet a \$500 deductible and spend 10-12% of their income on health care. Enrollees in AccessHealthCT plans face enormous

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<sup>1</sup> Melinda Beck, "Connecticut Moves Away From Private Insurers to Administer Medicaid Program," *Wall Street Journal*, March 18, 2016. <http://www.wsj.com/articles/connecticut-moves-away-from-private-insurers-to-administer-medicaid-program-1458325696>

deductibles as subsidies decrease up the income scale. Even workers with decent jobs are increasingly stuck in cost-prohibitive plans. Nearly a quarter of workers are in high deductible plans, up from just 4% in 2006. According to the Kaiser Family Foundation deductibles have increased at nearly seven times the rate of workers' earnings.

Some policymakers insist that high cost sharing is necessary to reduce excess utilization. But utilization isn't really our main problem. Despite progress, Medicaid members, the remaining uninsured and the growing ranks of underinsured state residents still struggle to access recommended care. The US has the highest health care costs by far in the world – we spend twice as much per person on average as the rest of the world, and nobody spends even three quarters as much as we do. Except for Switzerland, we already have the highest out of pocket costs. So if out of pocket costs are the solution, why isn't the problem solved?

As Dr. Hyde's literature review shows, our problem is price, not utilization, and monopoly creates a disaster for prices. Jason Pelletier's testimony contains a shocking fact – workers at a corporate cafeteria run by a global food service company serving food to workers at one of the most profitable companies in the world are forced to go without health insurance or be covered by state assistance programs because their premium share is too high. Shame on those employers, but let's not kid ourselves. Employers are fighting with workers over premiums because underlying provider prices are forcing them to.

And when you lose your coverage, or your deductible goes up to five thousand dollars, what happens? You go to the doctor, and, now that the hospitals are buying up all the doctors, you get charged a facility fee for the privilege of seeing a new sign on your doctor's office door. You find yourself choosing between rent, food, and the electric bill for your family or going to the doctor for yourself.

To approve this CON, OHCA must look the public in the eye and say "Yale is different." Unlike all the other giant monopolies, Yale will throw away its monopoly bargaining advantage and keep prices low. Or you must say "New London County is different." For some reason Yale won't buy up all the doctors the way they have in the New Haven area.

No one can take those arguments seriously. One of the few things that Yale's proposed \$300 million investment clearly identifies as a specific priority is physician recruitment. To most of us, that suggests recruiting neurologists to move to New London so that telemedicine visits or an hour's drive to New Haven aren't patients' only options. But Yale's past behavior in the New Haven area suggests that money is earmarked for physician practice acquisitions – which means more market power, more facility fees, higher prices and people skipping needed care because of cost.

Perhaps the most telling passage in the CON can be found on page 34. Asked how "low income persons, racial and ethnic minorities, disabled persons and other underserved groups" will benefit from the proposal, YNHHS replies that L+M and YNHHS provide services to the uninsured, underinsured and all patients regardless of race, ethnicity, income or ability to pay. "That will not change as a result of this proposal."

The proposal offers no visions for improvement of services to underserved populations save for the general clinical benefits presumed to accrue to all patients. One must assume that this, like so many other specifics, would be left to the post-acquisition strategic planning process to decide. The rest of us are supposed to wait and hope.

As a member of the Governor's Health Care Cabinet, I view this proposal as the leading example of one of the most dangerous trends in health care, and one of the few key issues we must grapple with to set Connecticut on course

for an accountable 21<sup>st</sup> Century health care system. I urge you not to rule on this application until my colleagues and I, and our counterparts on the Certificate of Need Task Force have completed our recommendations. If you must rule before that, you must deny the application. Without dramatic changes to address the issues of access, price and quality within a framework of true accountability to the community and protections for underserved and at-risk residents, you must deny it whenever it ripens for decision. There is no public need for this deal and very great risk to state residents and the state's budget.

Pre-file testimony from Stephen R. Smith, M.D., M.P.H.

My name is Stephen R. Smith, M.D. I am a professor emeritus of family medicine at the Warren Alpert Medical School of Brown University. I live in New London.

I am a family physician working at the Community Health Center of New London. I also speak on behalf of the National Physicians Alliance in Connecticut. This group includes physicians from a variety of different specialties who serve on the medical staff and/or work as community-based physicians who refer their patients to either Yale/New Haven Hospital or Lawrence and Memorial (L+M) Hospital.

I am also speaking on behalf of the Universal Health Care Foundation of Connecticut in my capacity as a member of the board of directors of the Connecticut Health Advancement and Research Trust (CHART), the parent organization of the foundation.

I am a lifelong resident of New London residing at 899 Montauk Avenue and have served on the medical staff at Lawrence and Memorial Hospital in the past.

The initial position that the Office of Health Care Access should take when considering any hospital merger or acquisition is that such mergers are not in the best interest of the public and should be denied. As our testimony has previously shown, hospital mergers are, by their very nature, anti-competitive and generally lead to higher prices without concomitant improvements in efficiency, quality, accessibility, or accountability. Mergers and acquisitions should be permitted *only* when convincing evidence has been presented demonstrating that no other means is available to achieve the purported goals of the merger that would serve the community's interests in preserving high-quality, affordable, and accessible health services.

The proposed acquisition of L+M by Yale/New Haven Health Services Corporation does not demonstrate any compelling public interest, or evidence suggesting a public good.

Close clinical coordination and cooperation is already achieved between the two institutions and with health care providers in the community without the benefit of formal acquisition.

As a family physician working in an independent community health center in New London, I already have instant access to the L+M computers to obtain laboratory data, x-ray reports, emergency room reports, and hospital discharge summaries on my patients. If a patient of our health center is seen in the emergency room at L+M, procedures already exist that allow the emergency physician to schedule a visit for the patient with us within 24 hours. Yet our community health center and L+M are separate, independent entities.

I already have excellent relationships with the specialists at Yale/New Haven, many of whom have office hours at L+M for the convenience of our patients. Yale/New Haven specialists have often called me on the telephone to discuss mutual patients with serious vascular problems and pulmonary conditions. At their behest, I have seen the patients and ordered tests and managed their conditions in between visits to the specialists in New Haven. All of this is done without the need for one hospital to “own” the other, especially given all of the bad results from such ownership.

The neonatal intensive care unit at L+M is already staffed by Yale/New Haven neonatologists. The NICU staff already arrange for babies to be seen within 24 hours at our community health center following their discharge. This occurs without the necessity of L+M being owned by Yale/New Haven.

This and other evidence demonstrates that close clinical coordination and cooperation already exists between L+M and Yale/New Haven. This clinical coordination already exists between Yale/New Haven personnel and community health providers in the New London area. The formal acquisition of L+M by Yale/New Haven is neither required nor justified to achieve clinical goals—that is, to serve our patients.

Should the Office of Health Care Access nevertheless consider approval of such an acquisition, it must condition such an acquisition on agreement by both parties to stipulations that would safeguard health care services in Southeastern Connecticut. These stipulations should be in force for at least 10 years and would include:

- Retaining existing health services in the New London community and not outsourcing them to other Yale hospitals or relocating them to more affluent communities in the L+M service area
- Freezing the prices charged and negotiated by L+M to existing levels with annual increases no greater than the Consumer Price Index
- Ensuring help with any transportation for health care that has to be delivered at another hospital
- Expanding health services to Southeastern Connecticut by fully funding and implementing all the recommendations emanating from the 2016 Community Health Needs Assessment conducted by L+M and the Ledge Light Health District
- Requiring that L+M and Yale/New Haven negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs
- Assuring that L+M Hospital remains under the control of a locally controlled and locally elected Board of Directors with decision making authority and accountability to the community.

The Office of Health Care Access must consider this proposed acquisition in the context of the entire state's health care system. Consolidation of the health care system is not in the best interests of patients or communities. Consolidation weakens accountability to the communities these hospitals serve. Consolidation erodes competition and innovation, increase costs, and provides little or no additional benefits in terms of quality, safety, or accessibility.

I urge the Office of Health Care Access to deny the proposals to transfer ownership of L+M to Yale/New Haven Health Services Corporation and the merger of L&M Physician Association, Inc. into Northeast Medical Group, Inc.

Stephanie Johnson, RPSGT  
President, AFTCT Local 5051 LPN/Technologists  
43 Converse Pl.  
New London CT  
(c) 860-961-1635

Pre-filed Testimony  
July 1, 2016  
Office of Health Care Access

My name is Stephanie Johnson and I am the president of AFTCT Local 5051 which represents more than 270 LPN's and Technologists at Lawrence Memorial Hospital. I am a 15 year employee, the last 13 years being in my current position as a polysomnographic technologist and a resident of East Lyme. Today I am here to ask you, Office of Health Care Access, to follow Governor Malloy's directive to hold off on this takeover of Lawrence Memorial Hospital by Yale New Haven Hospital.

As a caregiver in the hospital and as president of the union, I have seen many changes and understand that sometimes change is necessary. In this instance I would say that not only is this change for the sake of change but also the changes that are made can be devastating to our community. I have reservations about many things but primarily I am concerned about access to the quality care that we provide. I think it is irresponsible for a community hospital to not be there for the region we are supposed to be here to care for. The story has already played out in Windham, how long before it reaches New London and Westerly?

I was at a meeting held jointly by L&M and Yale recently and heard for myself from Bruce Cummings, CEO of L&M Hospital that Westerly Hospital does not have the physical footprint that the hospital needs to do inpatient and outpatient services. As an employee of the New London hospital, which is also land locked and has constraints that might prevent future growth, how long until we are told that the services we provide are not going to continue. How far will our patients have to travel to receive care? I am not just a care giver but I also utilize the hospital for my care. I was born at Lawrence and Memorial Hospital, gave birth to my son there and have said final good byes to close relatives who died there. I cannot imagine having to drive to Yale to visit a sick family member and more importantly, I cannot imagine how our patients who may not have the benefit of transportation and rely on public transportation will get there.

Decisions about which services will be kept at both campuses will be made by Yale. We are asking for assurances that services for our patients will not be made by a board that seeks to fatten the already large pocket of Yale New Haven's system, as there will no longer be any viable competition which. That means reduced patient's choice to seek care at a lower cost. I have personally read the bylaws changes in the Certificate of Need and have seen the handover of control to Yale. When I asked about it, I was not taken seriously and told "Oh those are just words written in the contract." Luckily, I know how to read contracts.

We were surprised to see Yale and L+M say that L+M lacks the financial and clinical resources to run the programs necessary to take care of our community. We've watched management spend \$17 million dollars that could have gone to take care of people in Greater New London on strikebreakers, lawyers

and other expenses to lock their workers out of their jobs. We've watched management spend \$35 million dollars to buy an unprofitable hospital out of bankruptcy. We've watched management spend more \$78 million of our hospital's profits subsidizing the growth of its physician practice, and now Yale-New Haven says the combined NEMG/LMPA practice will run \$70 million a year in losses.

All of that money could have, and should have gone to strengthening our hospital's clinical programs. Instead, we see staffing cuts, the first of what may be many. In the CON, Yale-New Haven says it doesn't have any planned service cuts, but it may reduce "duplicate" services in the future. We are concerned that the duplicate services may simply be the profitable services, which will be extracted from the hospital and placed far from New London, where poorer patients and those who need help with transportation will struggle with access.

When you look at this proposal, make sure you ask what Yale's goals will be. We've already lived under management that thought they were building a small empire. Now the biggest empire in the state wants to take over.

We are asking that services be made available to this community in this community. We are asking that the community be made aware of who will be in control of these services. We are asking that any promises be guaranteed, in writing, with enforcement and oversight by the community. We are asking for you, Office of Healthcare Access to slow down this process. If, after all is said and done, and the bodies that Governor Malloy put in place to look into the laws that govern deals like this find that our concerns are not necessary, we can start a new conversation about the future of L+M, Yale and our health care system. Please allow the process to be followed, and give us time so that all questions can be asked and answered—truthfully.

Pre-filed testimony of Jason Pelletier

Office of Health Care Access

Docket #s 15-30233 CON and 15-30233, Acquisition of L+M Health Care by Yale-New Haven Health Services Corporation and Merger of Lawrence and Memorial Physicians Association into Northeast Medical Group

June 30, 2016

My name is Jason Pelletier. I live at 28 E Street, Groton Connecticut. I am a cook in the cafeteria at Pfizer in Groton, and a shop steward for UNITE HERE Local 217.

I am now almost 49 years old and have always been in great health until last year, when I contracted Lyme disease. After a run of antibiotics, all was well until symptoms started to recur this year.

My health care coverage is very important in order to cover costs of recurring doctor visits and prescriptions. I am also concerned about having adequate health coverage as I get older and have more health issues.

We are in in contract negotiations with our employers. So are 7 other corporate cafeterias in Connecticut that are operated by Compass, including our brothers and sisters at Electric Boat. We pay 20% of our premiums now, and are trying to reduce that percentage at the bargaining table.

The cost of employees' share of the premiums went up by 10% last October. That means that everyone who had coverage had a big bite taken out of the raises that we negotiated with our employer. We have a really good health plan and have fought to keep costs down, but I have coworkers who are uninsured or on state assistance because they can't afford the premiums.

Before I talk about Yale taking over our hospital, I want to tell you how hard our union works on health care costs. Our health plan, UNITE HERE Health, is run jointly by our union and employers in our industries. Workers in our union take leave from their jobs for several weeks to educate their coworkers and help them sign up for a primary care doctor and get their biometric tests so that they can work with our health plan to improve their health and avoid going the hospital. We have run a union-wide education program to educate our coworkers on how to tell the difference between a health care problem and a real emergency, and to use Urgent Care or see their doctors instead of the Emergency Room, unless they really need to go. As a steward, I'm trained to help my coworkers use health care the right way, and to help them connect with our health plan if they have problems.

But that won't matter if prices for hospitals and doctors go up because Yale takes over our hospital. Even if we convince our employer to lower the percentage of the premiums that we pay, if the care itself gets more expensive, premiums will go up and we'll be paying what we paid before. Please stop this takeover, or, if it is approved, make Yale-New Haven guarantee in writing that they won't raise prices.

We don't make a lot of money. As a cook, I make \$16.44 an hour, and I'm one of the better paid people in our workplace. I'm fortunate to have full-time hours and a steady paycheck. But none of us can afford

to pay more for health care. Affordable health insurance has always been important to me, but where I'm at in my life now, I can't do without it. Thank you.

**Pre-filed Testimony  
July 1, 2016**

Fred Hyde, M.D.  
57 Main Street  
Ridgefield, CT 06877

**A. General Background**

- (1) The proposed acquisition of L+M Health Corporation (L+M) by Yale-New Haven Health Services Corporation (YNHHSC) comes at an important moment in the American and Connecticut health care systems.
- (2) The Patient Protection and Affordable Care Act (PPACA) has failed to control the ongoing growth of health care costs.
- (3) In the five years since passage of the PPACA, private sector health care insurance premiums grew at three times the rate of general inflation, faster in relation to inflation than during the five years prior to passage.
- (4) A portion of this increase in health and hospital expense can be *directly attributable to the consolidation of hospitals and health systems*. These consolidations result in:
  - (a) Higher prices through monopoly market position;
  - (b) Inflated expenses resulting from more complex and more generously compensated management, with hospital administration now accounting for 1.43% of the nation's Gross Domestic Product; and
  - (c) Compromise to the integrity of physician judgment when such hospital and health system consolidations include physician practices.
- (5) The burden of these costs falls on the patient, the patients' families, and society, through higher health insurance premiums, higher out-of-pocket payments and compromises to choice and freedom. The Kaiser Family Foundation reports that insurance deductibles grew nearly seven times faster than worker earnings in the five years following PPACA passage.
- (6) This is the background against which OHCA is called upon to evaluate yet another attempt at monopoly acquisition (another hospital by a health system) and consolidation of institutional control over professional judgment through hospital-sponsored medical groups.
- (7) *OHCA's task is non-delegable*. Legal redress opposing or attempting to remedy hospital monopolies has proven to be unreliable: even when "after-the-merger" remedies or checks are in place, inevitable cost increase occurs.

The FTC has allowed the Hart-Scott-Rodino review period to lapse, and the federal government continues to struggle to win cases under antitrust laws.

- (8) OHCA awards a Certificate of Need "franchise" to private corporations which are engaged in publicly funded services: the *award must be based on the public good*, not on private gain.

One state with challenges parallel to those of Connecticut is Massachusetts. Testimony is offered on the applicability of findings from that state to the challenge facing OHCA in this and similar Certificate of Need applications.

B. The Applicants assert these arguments in support of Docket No. 15-32033-CON (**affiliation of Lawrence + Memorial Corporation with Yale-New Haven Health Services Corporation**), and Docket No 15-32032, (**merger of L&M Physician Association and Northeast Medical Group**):

(1) Lawrence + Memorial as a system *does “not have the clinical and financial resources” to “integrate service delivery and assume responsibility for achieving specific quality, cost and service outcomes.”*<sup>1</sup>;

a. Lawrence + Memorial only lacks financial resources as a result of empire building and other imprudent management decisions, including:

(i) Expensive attempts to outsource services, and to “lock out” unionized employees performing those services, about which other members of the coalition will provide more detailed testimony;

(ii) The acquisition of the bankrupt Westerly Hospital for a reported price of \$35 million; and

(iii) The extraordinary subsidy of physician practices. The **first attachment** to this document shows the extent to which hospital revenues are generating adequate margins to support operations and maintenance, but are subsidizing physician practice and other “system” losses. Those losses amount to \$78 million over the past five years. The combined new NEMG practice is expected to lose \$70 million per year.

b. In general, not-for-profit hospitals are doing well financially.<sup>2</sup> In fiscal year 2015 Moody’s reports that not-for-profit hospitals had median annual growth rate of 7.4% and median three-year revenue compounded annual growth rate of 5.6%.

(2) If acquired by Yale-New Haven Health Services Corporation, Lawrence + Memorial as a system would *achieve efficiencies through economies of scale*, and patients will receive *“the right care at the right time and in the most cost effective setting.”*

a. However, evidence provided here (the **second attachment**, a list of peer-reviewed journal articles provided electronically) shows that such economies have not been achieved in similar health system acquisitions in the past, and that consolidation leads to significant price increases and resulting systemic cost growth. Consider these critical examples from a body of literature that grows daily:

i. A comprehensive study by the Massachusetts Health Policy Commission found that market power is the primary determinant of prices in the state,

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<sup>1</sup> OHCA Docket 15-32033-CON, p. 25

<sup>2</sup> Health Care Policies and Trends, *Healthcare Financial Management*, June 2016, Page 18

and that community hospitals provide the same care at much lower price as the dominant system.

- ii. Cooper<sup>3</sup> et al studied nearly 4 billion private sector claims nationwide and found that the primary determinant of health care costs is the price of provider services, and that the most powerful determinant of provider price is market power – not quality, not size, not academic status or reputation. Parenthetically, these authors noted that one area of the country with *both* high Medicare and high private commercial health insurance costs is New Haven, CT.
- iii. Gowrisankaran<sup>4</sup> et al studied data on post-merger pricing and found that separately negotiated prices do not negate the impact of a system's market power. Newly purchased hospitals still gain a price premium.

A new study of leverage in California hospitals<sup>5</sup> indicates that monopolist health systems took active advantage of their status, leading to steadily increasing price differentials, separating them from non-monopolist hospitals by as much as \$4,000 per discharge.

- iv. The Applicant's own evidence makes this point. The Health Care Cost Institute's report submitted with the application notes that the primary driver of health care cost increases is provider and pharmaceutical pricing.
- b. Despite OHCA's request and the urging of legislators, the Applicants flatly refuse to provide comparative price data between L+M and the YNHHS hospitals. However, original analysis of Medicare payments submitted as part of this testimony shows that, almost uniformly, payments for services at Yale-New Haven (including low acuity services) are significantly higher than those at Lawrence + Memorial and much higher than other currently independent hospitals.

The **third attachment** to this testimony is excerpted from 2013 CMS records of billing and payment by DRG by hospital for the top 100 DRGs in Connecticut hospitals.

No evidence has been offered by applicants to demonstrate that past acquisitions or affiliations (Bridgeport, Greenwich) have produced economies similar to those predicted in the current application. To the contrary, these hospitals remain among the most expensive in Connecticut;

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<sup>3</sup> Cooper, Z. et al, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," NBER Health Care Pricing Project, December 2015

<sup>4</sup> Gowrisankaran, G., et al, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *The American Economic Review*, March 2013

<sup>5</sup> Melnick, G. and K. Fonkych, "Hospital Price Increases in California, Especially Among Hospitals in the Largest Multi-hospital Systems," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, Volume 53: 1-7, 2016

- c. A report by members of the intervenor coalition from December of last year, submitted as the **fourth attachment**, demonstrates that this acquisition will lead to extreme market concentration in the L+M service area, and intensify Yale-New Haven's market power from New York to the Rhode Island border. If this acquisition is consummated, Yale-New Haven Health Systems will account for 83% of discharges in L+M's primary service area, and nearly 60% of all inpatient discharges in the southern half of the state. Using the federal government's standard measure, the growth in market concentration in each of those areas would be presumed to create excessive market power.
- d. Consolidation can alter financial and referral relationships to create a "death spiral" for community hospitals. The Massachusetts Health Policy Commission, in its comprehensive study of community hospitals and the effect of monopolist systems, has concluded that the provision of *routine* hospital care at academic medical centers and teaching hospitals leads to lower total and commercial inpatient volume at community hospitals.

This sequence of events, in turn, leads to lower prices at community hospitals, poor hospital financial performance, limited ability to invest, and barriers to adoption of new technology. This cycle reinforces patient preferences for academic medical centers and teaching hospitals, even for routine hospital care.

For patients left behind in communities like Windham and New London, especially those (i) without transportation to the central hospital, (ii) good health insurance, or (iii) well-connected doctors, this practice results *in patient red-lining*, leaving the poor and aged to be served by inferior hospitals, made inferior as their patients are drawn out of local services, and into the central "name-brand" academic medical center.

The initial and understandable community "rapture" at being part of a larger, more exciting, more capable health system becomes, in short order, the recognition that the community hospital has been "left behind."

- e. The Applicants have offered no evidence that the acquisition of Lawrence + Memorial Physicians Association, L+M's 70-physician group medical practice, will create efficiencies with any meaningful return to patients and payers. Extensive bibliographic evidence of studies in academic, professional and public service literature, submitted as the **fifth attachment**, indicates that such efficiencies will not result.
- f. For example, Robinson<sup>6</sup> et al, found that physician practices in California that were owned by local community hospitals had costs 10% higher than physician-owned organizations. Practices owned by regional multi-hospital systems generated costs 20% higher than physician-owned practices.
- g. **Excessive bureaucracy** will increase expenses, including (a) more layers of management between the physician and the patient, (b) attempts to conform

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<sup>6</sup> Robinson, J. and K. Miller, "Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California," *JAMA*, October 22/29, 2014;312(16):1663-1669

physician behavior to purchasing, referral or other financial direction, (c) hospital-oriented -- that is, institutional and hospital revenue cycle-oriented -- information systems.

- h. OHCA should view with skepticism the idea that installation of the EPIC electronic medical record system will generate efficiency or improve quality. The Partners system in Massachusetts spent \$1.2 billion to go live in 2015, double the original budgeted \$600 million. Auditors for Southcoast Health hospitals in Massachusetts attribute a \$30 million 2014 operating loss and 105 layoffs in part to the cost of EPIC.<sup>7</sup> Southcoast (and other Massachusetts hospitals) are attempting to “keep up” with the highest priced system, Partners, as Partners attempts to meet its own budget requirements by electronic steering of patients from distant corners of that State.

Moreover, “efficiencies” or quality improvements resulting from the use of one or another brand of electronic health record systems are purely speculative. There is no generalizable data showing that EHRs are actually helping control health costs, and EPIC is an extraordinarily expensive product.

- (3) If acquired by Yale-New Haven Health Services Corporation, Lawrence + Memorial would achieve *higher quality* in care provided.
  - a. The recent comprehensive study of all hospitals in Massachusetts by the Health Policy Commission (HPC), cited above, reveals that spending at community hospitals is lower for low acuity inpatients and “is not associated with any difference in quality.”
  - b. In fact, the HPC study showed that “Most community hospitals provide care at a lower cost per discharge, without significant differences in quality,” nearly \$1,500 less per inpatient according to that study. This HPC study is **the sixth attachment** to this testimony.
  - c. The **fifth attachment** (as also noted above) is a list of peer-reviewed journal articles that report, among other findings, no evidence that consolidation of large and small hospital systems produces higher quality care. There is, to the contrary, some evidence that care improvements and patient safety both become victims of bureaucratic inertia and indifference.
  - d. Extensive bibliographic evidence of studies in academic, professional and public service literature indicates that the “quality” of physician services will not increase, and may, in fact, be compromised.

(4) That *access to primary and advanced specialty care will be greatly enhanced* for the citizens of the Lawrence and Memorial hospital service area through the acquisition. This argument is contradicted by:

- a. The example of Windham Hospital’s acquisition by Hartford HealthCare, to which testimony will be given by others.

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<sup>7</sup> Akanksha Jayanthi, “8 Epic EHR implementations with the biggest price tags in 2015,” *Becker’s Health IT and CIO Review*, 7/1/2015

- b. Compromise to physician resistance achieved through acquisition of medical practices. Doctors will ordinarily be fighting for their patients' rights, with insurance companies, vendors and even with hospitals. When the doctor is owned by the hospital, judgments may be altered concerning necessary services, referrals and costs. See the **fifth attachment** for journal studies in this area;
- c. Changing governance and control will render local officials and L+M itself incapable of protecting local services. The hearing notice makes clear that OHCA rejects the notion that this is not an acquisition. Upon consummation, the deal will leave all relevant decision-making authority in the hands of Yale-New Haven Health System.
- d. **Patient choice** will be severely compromised, if not eliminated. The Massachusetts Health Policy Commission study indicated that, as the result of consolidation in that state, "Patients often mentioned that they did not feel they had a choice of hospitals because their primary care provider or insurance plan determined where they could go for care."

In fact, insurance carriers are driven by the financial impact of monopolist pricing to develop narrow networks of providers. This results in limited or non-existent flexibility for the patient and the patient's treating physician. Insurers are compelled to this strategy as a means of attempting to secure discounted prices from price-gouging monopolist systems, in return for assurance of increased volume.

- e. **Physician integrity** may be compromised. Since patients rarely evaluate the quality of medical care, instead valuing the recommendations of physicians, those recommendations become very important.

Contracts involving "owned" physicians reveal requirements for which service to use, what imaging center, what laboratory, what pharmaceutical products have been included in the formulary of the monopolist system, all of these limitations on the ability of the practicing physician to put their patients' interest first.

Many physicians in independent practice face overwhelming bureaucracy and micro-regulation. These bureaucratic challenges are complicated by the extraordinary difficulty of actually being paid for work done. Many therefore have thrown in this particular "towel," resigned to doing the best they are able under the constraints of monopolist systems. By way of recompense, physicians who have ceded such freedoms now have salaries or practice income guarantees supported by double billing and price-gouging associated with large health systems.

- f. Applicants' submission of misleading data about the flow of patients to out-of-state providers, obscuring a potential reduction in the diversity of providers. The applicants break out discharges from New York and Massachusetts providers, but neglect discharges from Rhode Island Hospital. RIH, the affiliated hospital of Brown University Medical School, is the most obvious competitor for subspecialty care to Yale-New Haven Hospital – the two hospitals are exactly equidistant from New London.

OHCA must ask the Applicants what mechanism they will use to shift patient flows from "distant" competitors. Why should an acquisition change referral patterns? Without reviewing all provider employment, affiliation and practice management

agreements between YNHHS, NEMG and all employed physicians and/or affiliated group practices, OHCA cannot fairly evaluate the impact on access. If doctors are contractually bound to refer to YNHHS, patients – especially those in towns west of the Thames River – will lose choice and will incur higher costs due to monopoly pricing effects.

The cancellation of L+M's affiliation with the Dana Farber Institute offers an ominous foreshadowing of this effect. There is no reason L+M can't allow its doctors and their patients access to two brand-name cancer hospitals. Patients should have their choice of providers when their care requires subspecialty services only available outside New London.

- g. The terms of the supposed **\$300 million investment** in health in Southeastern Connecticut. The applicants refuse to offer specifics about how much they will really invest, what they will invest in, or where the money will come from.

All of the hypothetical \$300 million appears to be contingent on future programs being consistent with the YNHHS strategic plan, mutually agreed upon (between YNHHS and L+M), and *displaying a positive return on investment*. In other words, there would be no new investment in the Greater New London community's health unless that investment earns Yale-New Haven Health System a profit.

The proposed expenditures for "physician and clinical recruitment" require scrutiny. The system spent \$54.5 million in cash to buy PriMed LLC in 2014. If by "recruitment," Yale actually means "buying up the physician practices that L+M hasn't already purchased," patients will not benefit.

In fact some or all of the \$300 million is supposed to come from efficiencies that lead to lower expenses in L+M's future operations, or perhaps from the other YNHHS hospitals. The application assumes that L+M will eliminate more than 200 jobs and more than \$130 million in wage and benefit expense *during the first three years*. (See **attachment seven**, excerpts from the application.) Over seven to ten years, L+M could generate its own \$300 million in funds to invest, and have control over how they would be invested. Of course, these may be needed jobs for the delivery of patient services.

- h. **Financial pressure on patients** will be increased, perhaps intolerably so, as evidenced by these examples:

There is a well-known history of abusive bill collection practices at Yale-New Haven. These abuses were investigated by the then-Attorney General;

Approximately 35% of the accounts receivable of the nation's hospitals is now categorized as "patient responsibility." Articles in the hospital field call the patient the "new payer." Pressure on hospital revenue cycle performance will, of necessity, be addressed now more directly and forcefully to patients;

Also, narrow networks allow referral only to "approved" doctors, leading to "surprise" bills (for out-of-network services, specialties not covered, services in other parts of Connecticut, other states).

## Hospitals Owning Doctors

The shift of physician practices from 70% physician-owned in 2003 to less than 55% physician-owned by the end of 2010 (Mathews, A., “When the Doctor Has a Boss,” *The Wall Street Journal*, November 8, 2010) was accompanied by extraordinary increases in the cost of medical care, even by the standards of high prices and inflation in the health care field.

**Who benefits?** If these proposals before OHCA will not produce efficiency, improvement in quality or control of cost, but will, to the contrary, lead to bureaucratic inefficiency, decline in physician integrity and accountability, and increase in cost, why then do their sponsors put them forward?

## Hospitals and the Public Interest

Put simply, executives prosper. At Yale-New Haven, for example, **attachment eight** demonstrates that compensation of the top ten most highly compensated executives has increased by 100% in the time period (2006-2014) when smaller and independent hospitals have had increases of 20 – 25%.

Moreover, the doubling of administrative cost has an impact on the perception of those less handsomely compensated, such as practicing doctors. The surge of doctors seeking to become administrators has spawned extraordinary growth in schools of business, public health and hospital administration. Doctors see the lavish compensation of executives, the unhurried hours, and quickly deduce the market strategy (get bigger, earn more). Of course, all of this affects the patient.

A study published in *Health Affairs* and summarized by the Commonwealth Fund compared hospital administrative costs in eight countries and found that such costs accounted for 25% of hospital spending in the United States, twice the proportion seen in other advanced nations.

*The hospital administration share of gross domestic product for the entire country rose from .98% to 1.43% between 2000 and 2011. Moreover, “There was no apparent link between higher administrative costs and better-quality care.”*

This anomaly—societal concern and even outrage over health prices, yet skyrocketing compensation for hospital administrators—is made possible by the financial insulation enjoyed by members of those hospital boards.

In short, public agencies—not private boards or conflicted executives—will have to “stand in” for governance, if public interests are to be served.

## C. Summary

In summary, the applicants have failed to successfully address these issues identified by OHCA:

### (1) Public need:

- a. There is no “public need” demonstrated for this proposal;
- b. To the contrary, the public good (preservation of the lowest possible rates for health services and health insurance; the guarantee of local autonomy concerning decisions involving access to services; measures preserving the independence and integrity of physicians) argues against this proposal;

- (2) **Impact on residents**, including how access to services (including specialty care) will be maintained or improved:
- a. The applicants have failed to provide evidence that the access to specialty services will be improved. To the contrary, evidence has been presented that in other acquisitions by market-leading health systems in Connecticut (e.g., Hartford HealthCare acquisition of Windham Hospital), services have diminished. In that example, specialty and hospital care has been transferred incrementally to centrally-located specialists with Hartford.
  - b. Similar migration of specialty services has been demonstrated in a comprehensive study of community hospitals in Massachusetts by the Massachusetts Health Policy Commission.

(3) **Benefits achieved** in the Bridgeport/Greenwich Hospitals service areas:

- a. There is no evidence that has been presented that either financial stability or enhanced programs or services have taken place in the Bridgeport and/or Greenwich Hospital services areas, beyond whatever trends and factors have applied to the hospital industry as a whole.
- b. Neither OHCA nor the applicants have produced complete records of the “before” and “after” assessment of “financial stability or enhanced programs or services.” The submission of incremental and selected information by the applicants more than six months after the beginning of the CoN process indicates that demonstration of the benefits of previous hospital acquisitions has not been a priority.

These applications fail to meet the standards in PA 14-168 Section 7(a)(3), (4), (5), (11) and (12).

(3) Applicants have not demonstrated a clear public need.

(4) By refusing to provide price data, applicants have failed to adequately demonstrate how the proposal will impact the financial strength of the health care system, particularly if one views patients and payers as part of the system.

(5) Applicants have not satisfactorily demonstrated how the proposal will improve the quality, accessibility, and cost effectiveness of health care. Intervenors have presented a large volume of evidence to the contrary.

(11) Applicants have not satisfactorily demonstrated that the proposal will *not* negatively impact the diversity of health care providers and patient choice in the geographic region. This is a new and much higher burden of proof for both OHCA and the Applicants. Intervenors have raised a series of questions about the vague generalities in the application, without answers to which OHCA cannot plausibly certify having met this standard.

(12) Applicants have failed to provide any evidence that the consolidation from the proposal will *not* adversely affect health care costs or accessibility to care. Again, this is a new standard, enacted by the General Assembly specifically to address the circumstances currently under review. When OHCA pressed the applicants to say whether any of the supposed cost savings from the acquisition would be passed on to consumers, they simply refused.

These proposals should not be ruled on until January 15, 2017 or until the Governor's Task Force makes its recommendations. If forced to rule by the statutory calendar, OHCA must deny them. Regardless of Executive Order 51, the applications as written fail the relevant statutory tests and must be denied whenever they ripen for decision.

The only possible scenario under which a proposed takeover of L+M by YNHHS or any other major system could proceed is with permanent, concrete written guarantees on access, cost, quality and workplace standards, all negotiated directly with a representative cross-section of the community and with ongoing enforceable community oversight. We have attached our coalition's "Vision and Values Statement" which includes details of our vision for the future of the Southeastern Connecticut health care system.

Thank you for your attention.

# **EXHIBIT 1**

YNHHS and L+M, Holding Company Profit and Loss, Hospital Profit, Physician Subsidy

	2015	2014	2013	2012	2011
<b>Yale New Haven Health System</b>					
Holding Company Profit (Loss)	\$144,091,000	\$204,301,000	\$168,660,000	\$130,416,000	\$71,016,000
Hospital/Hosp + Sub Profit	\$105,816,000	\$160,785,000	\$178,722,000	\$130,609,000	\$67,162,000
Physician Subsidy	\$53,931,000	\$45,621,000			
<b>Lawrence + Memorial</b>					
Holding Company Profit (Loss)	\$1,536,369	(\$3,388,068)	\$2,253,354	\$7,721,331	\$15,902,773
Hospital Profit	\$14,522,752	\$5,979,688	\$10,767,187	\$17,549,573	\$16,766,396
Physician Subsidy	\$20,061,502	\$20,865,372	\$15,724,357	\$12,069,947	\$9,263,443

Source: audited financial statements

## **EXHIBIT 2**

**Exhibit One**  
**Monopoly Prices in Health Care, The Result of Hospital Consolidation**

Abelson, R., "Health Care Companies in Merger Frenzy," *The New York Times*, October 29, 2015

Abelson, R., "Regulators Tamp Down on Mergers of Hospitals," *The New York Times*, December 18, 2015

Advocate Health Care Network, et al, Complaint, Docket No. 9369, Federal Trade Commission, December 17, 2015

Auer, D. and N. Petit, "Two-Sided Markets and the Challenge of Turning Economic Theory into Antitrust Policy," *The Antitrust Bulletin*, 2015, Vol. 60(4), 426-461

Bai, G. and G. Anderson, "A More Detailed Understanding Of Factors Associated With Hospital Profitability," *Health Affairs*, No. 5 (May 2016): 889-897

Brennan, J., "Sixth Circuit Reinstates Antitrust Challenge to Hospital Joint Operating Agreement," *AHLA Weekly*, April 8, 2016

Brill, J., "Competition in Health Care Markets," Transcript of Keynote Address by Julie Brill, Commissioner, Federal Trade Commission, 2014 Hal White Antitrust Conference, June 9, 2014, Washington, DC

Brown, M., "Mergers, network, and vertical integration: Managed care and investor-owned hospitals," *Health Care Management Review*, 1996, 21(1), 29-37

Cabell Huntington Hospital, Inc. et al, Complaint, Docket No. 9366, Federal Trade Commission, November 5, 2015

Canback, S., "Limits of Firm Size, An Inquiry into Diseconomies of Scale," Doctoral Thesis, Henley Management College, September 11, 2000

Capps, C., et al, "Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?," NBER, August 2010

Commins, J., "Another Study Links Hospital Mergers to Higher Prices," *HealthLeadersMedia*, March 28, 2016

Cooper, Z. et al, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," NBER Health Care Pricing Project, December 2015

Cutler, D. and F. Morton, "Hospitals, Market Share, and Consolidation," *JAMA*, Volume 310, Number 18, November 13, 2013

Dafny, L., et al, "The Price Effects of Cross-Market Hospital Mergers," NBER, March 18, 2016

Daly, R., "Insurer Role Underscored in FTC Hospital M&A Reviews." HFMA Healthcare Business News, December 15, 2015

Dranove, D. and A. Sfekas, "The Revolution in Health Care Antitrust: New Methods and Provocative Implications," *The Millbank Quarterly*, Vol. 87, No. 3, 2009, pp. 607-632

Ellison, A., "FTC moves to block Advocate, NorthShore merger," *Becker's Hospital Review*, December 18, 2015

Ellison, A., "NorthShore CEO: FTC gerrymandered hospital market to oppose merger," *Becker's Hospital Review*, January 6, 2016

Ellison, A., "Penn State Hershey, PinnacleHealth will fight FTC to merge," *Becker's Hospital Review*, December 17, 2015

Evans, M., "Hospital consolidation drives prices for privately insured, data suggest," *Modern Healthcare*, December 21/28, 2015

Federal Trade Commission, "FTC and Pennsylvania Office of Attorney General Challenge Penn State Hershey Medical Center's Proposed Merger with PinnacleHealth System," Press Release, December 8, 2015

Federal Trade Commission, "FTC Challenges Proposed Merger of Two Chicago-area Hospital Systems," Press Release, December 18, 2015

Fuse Brown, E.C. and J. King, "The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control," Georgia State University College of Law, Legal Studies Research Paper No. 2016, 1. 92 Ind. L.J. (forthcoming 2016-2017)

Federal Trade Commission, "FTC Staff: Proposed Health Care Legislation in West Virginia Would Likely Be Anticompetitive and Harm Consumers," Press Release, March 10, 2016

Federal Trade Commission and Department of Justice, "Improving Health Care: A Dose of Competition," July 2004

Federal Trade Commission and Department of Justice, Joint Statement on Certificate-of-Need Laws and South Carolina House Bill 3250, January 11, 2016

Feller, H., "A Primer on Antitrust Law Fundamentals," Association of Corporate Counsel National Capital Region Program Presentation, May 18, 2015

Fifer, J., "The consolidation conundrum: time to reframe," *Healthcare Financial Management*, January 2016

Gaynor, M., et al, "A Structural Approach to Market Definition With an Application to the Hospital Industry," NBER, March 14, 2012

Gaynor, M. and R. Town, "The impact of hospital consolidation – Update," Robert Wood Johnson Foundation, Synthesis Report, June 2012

Ginsburg, P., "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," Center for Studying Health System Change, No. 16, November 2010

Gold, Jenny, "Health Reform Roils Downton Abbey," *Kaiser Health News*, February 17, 2016

Gowrisankaran, G., et al, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *The American Economic Review*, March 2013

Haas-Wilson, D. and C. Garmon, "Two Hospital Mergers on Chicago's North Shore: A Retrospective Study," Federal Trade Commission Bureau of Economics Working Paper No. 294, January 2009

Havighurst, C. and B. Richman, "The Provider Monopoly Problem in Health Care," *Oregon Law Review*, Vol. 89, 847, March 31, 2011

Herzlinger, R., et al, "Market-Based Solutions to Antitrust Threats – The Rejection of the Partners Settlement," *NEJM*, 372;14, April 2, 2015

Hiltzik, M., "Mergers in the healthcare sector: why you'll pay more," *Los Angeles Times*, May 27, 2016

Howard, P. and Y. Feyman, "Keeping Score: How New York Can Encourage Value-Based Health Care Competition," Manhattan Institute Report 4, March 2016

Investing Answers, Herfindahl Index definition, [www.investinganswers.com](http://www.investinganswers.com), December 11, 2015

Krugman, P., "Robber Barron Recessions," *The New York Times*, April 18, 2016

Lewis, J., "'Oh help me, please doctor, I'm damaged' – What does the Future Hold for Hospital-Physician Acquisitions?", BakerHostetler, [www.antitrustadvocate.com](http://www.antitrustadvocate.com), February 12, 2015

Mathews, A., "When the Doctor Has a Boss," *The Wall Street Journal*, November 8, 2010

Meier, M., et al, "Overview of FTC Actions in Health Care Services and Products," Health Care Division, Bureau of Competition, Federal Trade Commission, Washington, DC, May 2016

Meier, M., et al, "Topic and Yearly Indices of Health Care Antitrust Advisory Opinions by Commission and by Staff," Health Care Division, Bureau of Competition, Federal Trade Commission, Washington, DC, May 2016

Melnick, G. and K. Fonkych, "Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-hospital Systems," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, Volume 53: 1-7, 2016

Modern Healthcare, "FTC moves to block proposed Advocate-NorthShore merger," *Modern Healthcare*, December 21/28, 2015

Pear, R., "F.T.C. Wary of Mergers, by Hospitals," *The New York Times*, September 17, 2014

Penn State Hershey Medical Center and PinnacleHealth System, Complaint, Docket No. 9368, Federal Trade Commission, December 7, 2015

Pope, C., "How the Affordable Care Act Fuels Health Care Market Consolidation," The Heritage Foundation Backgrounder, No. 2928, August 1, 2014

Ramirez, E., "Antitrust Enforcement in Health Care – Controlling Costs, Improving Quality," *The New England Journal of Medicine*, 371;24, December 11, 2014

Rangers Renal Holding, et al, Complaint, Federal Trade Commission, December 30, 2016

Richman, B., "Antitrust and Nonprofit Hospital Mergers: A Return to Basics," *University of Pennsylvania Law Review*, Vol. 156, 2007

Scheffler, R., et al, "Differing Impacts Of Market Concentration On Affordable Care Act Marketplace Premiums," *Health Affairs*, 35, No. 5 (May 2016): 880-888

Singer, T. and N. Harris, "Federal Judge Denies Health First's Motion to Dismiss Suit by Physicians Alleging Unlawful Exclusion," AHLA Antitrust Practice Group News, February 2, 2015

Stuck, T., "Tomblin signs bill with antitrust exemption for hospital deal," *The Herald-Dispatch*, March 19, 2016

United States Government Accountability Office, "Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform," GAO-16-189, Report to Congressional Requesters, December 2015

Xu, T., et al, "The Potential Hazards of Hospital Consolidation; Implications for Quality, Access and Price," *JAMA*, Vol. 314, Number 13, October 6, 2015

## **EXHIBIT 3**

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Septicemia or Severe Sepsis W MV 96+ Hours

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	81	\$310,648	\$85,235	\$74,434	\$10,801
St. Francis Hospital & Medical Center	29	\$158,137	\$60,347	\$48,067	\$12,280
Bridgeport Hospital	15	\$158,715	\$57,016	\$53,003	\$4,013
Hospital of Central Connecticut	28	\$124,601	\$52,428	\$41,063	\$11,365
Hartford Hospital	33	\$139,676	\$52,283	\$46,420	\$5,863
Manchester Memorial Hospital	16	\$174,226	\$50,655	\$49,772	\$883
William W. Backus Hospital	11	\$91,957	\$48,128	\$38,732	\$9,396
Saint Mary's Hospital	19	\$72,890	\$45,681	\$42,864	\$2,817
Lawrence & Memorial Hospital	15	\$93,194	\$44,932	\$44,211	\$721
Waterbury Hospital	25	\$143,911	\$43,622	\$39,899	\$3,723
Middlesex Hospital	16	\$161,074	\$43,016	\$41,385	\$1,631
MidState Medical Center	12	\$71,954	\$38,774	\$38,038	\$736

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Infectious & Parasitic Diseases W O.R.  
Procedure W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	12	\$140,156	\$68,723	\$62,636	\$6,087
Yale-New Haven Hospital	120	\$202,690	<b>\$63,477</b>	\$56,019	<b>\$7,458</b>
Norwalk Hospital Association	15	\$214,160	\$62,501	\$56,386	\$6,115
Bridgeport Hospital	23	\$156,619	<b>\$54,100</b>	\$43,510	<b>\$10,590</b>
Stamford Hospital	34	\$178,845	\$51,370	\$49,450	\$1,920
St. Francis Hospital & Medical Center	34	\$128,416	\$51,080	\$44,622	\$6,458
Waterbury Hospital	25	\$200,489	\$50,593	\$46,907	\$3,686
Hartford Hospital	98	\$114,399	\$48,902	\$43,311	\$5,591
Saint Mary's Hospital	25	\$78,892	\$44,855	\$42,893	\$1,962
St. Vincent's Medical Center	22	\$108,916	\$43,810	\$36,102	\$7,708
Griffin Hospital	15	\$111,374	\$41,967	\$40,039	\$1,928
Lawrence & Memorial Hospital	37	\$86,724	<b>\$41,567</b>	\$39,538	<b>\$2,029</b>
William W. Backus Hospital	37	\$83,688	\$41,302	\$36,969	\$4,333
Danbury Hospital	16	\$86,609	\$40,480	\$38,556	\$1,924
Middlesex Hospital	27	\$152,242	\$39,522	\$37,910	\$1,612
Hospital of Central Connecticut	42	\$78,346	\$38,158	\$34,812	\$3,346
Greenwich Hospital Association	11	\$123,456	<b>\$38,080</b>	\$36,732	<b>\$1,348</b>
Manchester Memorial Hospital	30	\$112,079	\$37,533	\$36,745	\$788
MidState Medical Center	26	\$71,300	\$35,872	\$33,463	\$2,409
Charlotte Hungerford Hospital	17	\$53,134	\$31,503	\$30,075	\$1,428

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Major Small & Large Bowel Procedures W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	11	\$130,340	\$63,059	\$58,620	\$4,439
Yale-New Haven Hospital	90	\$174,277	<b>\$58,706</b>	\$52,041	<b>\$6,665</b>
Stamford Hospital	24	\$205,005	\$50,763	\$48,905	\$1,858
Norwalk Hospital Association	17	\$161,687	\$49,798	\$46,130	\$3,668
Bridgeport Hospital	14	\$183,169	<b>\$49,112</b>	\$45,626	<b>\$3,486</b>
St. Francis Hospital & Medical Center	34	\$138,873	\$48,929	\$45,632	\$3,297
Danbury Hospital	26	\$122,442	\$47,977	\$42,206	\$5,771
St. Vincent's Medical Center	22	\$168,701	\$46,987	\$43,328	\$3,659
Hartford Hospital	42	\$99,028	\$42,729	\$39,399	\$3,330
Middlesex Hospital	21	\$172,377	\$42,616	\$41,002	\$1,614
Lawrence & Memorial Hospital	12	\$96,118	<b>\$40,832</b>	\$35,154	<b>\$5,678</b>
Saint Mary's Hospital	11	\$96,824	\$40,716	\$38,949	\$1,767
Greenwich Hospital Association	12	\$125,846	\$38,204	\$36,592	\$1,612
Bristol Hospital	16	\$118,331	\$37,414	\$36,530	\$884
Waterbury Hospital	15	\$136,953	\$37,140	\$35,004	\$2,136
Hospital of Central Connecticut	27	\$88,070	\$36,713	\$35,055	\$1,658
MidState Medical Center	27	\$75,716	\$36,492	\$33,697	\$2,795
Manchester Memorial Hospital	13	\$89,343	\$34,247	\$29,579	\$4,668
William W. Backus Hospital	14	\$61,329	\$32,713	\$31,709	\$1,004
Charlotte Hungerford Hospital	14	\$57,485	\$31,433	\$30,673	\$760

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Respiratory System Dx W Ventilator Support  
96+ Hours

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	60	\$202,775	\$60,818	\$56,656	\$4,162
Bridgeport Hospital	13	\$176,297	\$56,366	\$52,897	\$3,469
Norwalk Hospital Association	26	\$185,081	\$54,524	\$52,202	\$2,322
Hartford Hospital	28	\$176,005	\$52,351	\$47,429	\$4,922
Manchester Memorial Hospital	14	\$145,965	\$52,058	\$40,189	\$11,869
Danbury Hospital	13	\$123,626	\$50,969	\$36,085	\$14,884
St. Francis Hospital & Medical Center	24	\$142,835	\$50,483	\$47,648	\$2,835
St. Vincent's Medical Center	12	\$169,032	\$47,863	\$39,396	\$8,467
Saint Mary's Hospital	14	\$72,570	\$42,707	\$33,796	\$8,911
Lawrence & Memorial Hospital	20	\$72,632	\$42,362	\$35,254	\$7,108
William W. Backus Hospital	14	\$94,899	\$42,219	\$35,684	\$6,535
Hospital of Central Connecticut	24	\$102,087	\$40,720	\$38,574	\$2,146
Waterbury Hospital	11	\$133,217	\$38,140	\$34,802	\$3,338
MidState Medical Center	13	\$84,483	\$37,188	\$36,733	\$455
Middlesex Hospital	21	\$127,717	\$35,824	\$34,429	\$1,395
Charlotte Hungerford Hospital	13	\$58,770	\$34,149	\$32,069	\$2,080

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Spinal Fusion Except Cervical W/O MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	107	\$88,003	\$41,497	\$35,917	\$5,580
John Dempsey Hospital	55	\$54,387	\$40,845	\$37,805	\$3,040
Bridgeport Hospital	23	\$100,121	\$37,203	\$31,497	\$5,706
Hartford Hospital	78	\$57,900	\$34,783	\$27,294	\$7,489
Norwalk Hospital Association	29	\$100,576	\$34,032	\$32,417	\$1,615
Danbury Hospital	54	\$72,815	\$33,594	\$27,322	\$6,272
Stamford Hospital	17	\$129,246	\$32,690	\$29,709	\$2,981
Saint Mary's Hospital	25	\$81,847	\$32,119	\$25,184	\$6,935
St. Vincent's Medical Center	21	\$70,481	\$32,054	\$30,560	\$1,494
Greenwich Hospital Association	28	\$158,360	\$31,394	\$27,047	\$4,347
St. Francis Hospital & Medical Center	70	\$42,545	\$31,302	\$27,700	\$3,602
Lawrence & Memorial Hospital	16	\$75,241	\$30,013	\$28,832	\$1,181
Waterbury Hospital	26	\$144,435	\$29,952	\$25,218	\$4,734
Hospital of Central Connecticut	29	\$79,744	\$29,488	\$28,308	\$1,180
New Milford Hospital	13	\$36,857	\$28,916	\$24,487	\$4,429
Middlesex Hospital	19	\$110,939	\$28,693	\$25,097	\$3,596
MidState Medical Center	12	\$72,749	\$27,806	\$26,627	\$1,179
William W. Backus Hospital	72	\$47,418	\$27,151	\$24,440	\$2,711
Rockville General Hospital	29	\$45,887	\$24,461	\$22,523	\$1,938
Charlotte Hungerford Hospital	33	\$21,714	\$23,945	\$21,278	\$2,667

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Other Vascular Procedures With MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Middlesex Hospital	12	\$174,250	\$38,456	\$36,551	\$1,905
Yale-New Haven Hospital	79	\$135,606	\$38,296	\$35,731	\$2,565
Stamford Hospital	12	\$159,728	\$34,254	\$32,540	\$1,714
Danbury Hospital	22	\$96,541	\$32,267	\$25,353	\$6,914
Hartford Hospital	73	\$83,857	\$29,041	\$26,612	\$2,429
St. Francis Hospital & Medical Center	30	\$83,915	\$26,624	\$25,165	\$1,459
St. Vincent's Medical Center	16	\$76,358	\$25,618	\$24,552	\$1,066
Saint Mary's Hospital	13	\$52,451	\$25,068	\$24,006	\$1,062

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Hip L& Femur Procedures Except Major Joint  
W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	41	\$138,463	<b>\$38,348</b>	\$33,057	<b>\$5,291</b>
Stamford Hospital	13	\$127,169	\$29,561	\$28,118	\$1,443
Bridgeport Hospital	14	\$81,959	<b>\$28,016</b>	\$25,755	<b>\$2,261</b>
Hartford Hospital	56	\$60,199	\$25,384	\$22,919	\$2,465
Norwalk Hospital Association	13	\$79,773	\$25,255	\$23,679	\$1,576
St. Vincent's Medical Center	15	\$86,790	\$25,218	\$23,223	\$1,995
Lawrence & Memorial Hospital	16	\$46,929	<b>\$24,778</b>	\$19,022	<b>\$5,756</b>
St. Francis Hospital & Medical Center	25	\$69,793	\$24,706	\$23,328	\$1,378
Danbury Hospital	25	\$57,373	\$24,119	\$22,871	\$1,248
Hospital of Central Connecticut	25	\$64,529	\$22,876	\$21,677	\$1,199
Waterbury Hospital	15	\$79,965	\$22,327	\$20,985	\$1,342
Greenwich Hospital	14	\$101,216	<b>\$22,016</b>	\$20,670	<b>\$1,346</b>
Middlesex Hospital	20	\$78,502	\$20,670	\$19,232	\$1,438
MidState Medical Center	15	\$55,966	\$20,173	\$19,315	\$858
Charlotte Hungerford Hospital	12	\$37,816	\$18,874	\$17,996	\$878

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Major Small & Large Bowel Procedures W CC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	14	\$47,604	\$27,884	\$25,212	\$2,672
Yale-New Haven Hospital	93	\$74,952	<b>\$26,205</b>	\$21,802	<b>\$4,403</b>
Stamford Hospital	24	\$124,873	\$25,037	\$23,465	\$1,572
Norwalk Hospital Association	23	\$86,327	\$24,176	\$21,118	\$3,058
Bridgeport Hospital	20	\$74,235	<b>\$23,887</b>	\$19,380	<b>\$4,507</b>
Greenwich Hospital Association	42	\$78,156	<b>\$23,388</b>	\$17,851	<b>\$5,537</b>
Waterbury Hospital	19	\$106,740	\$23,111	\$21,013	\$2,098
Hartford Hospital	68	\$51,502	\$22,477	\$18,355	\$4,122
MidState Medical Center	25	\$53,290	\$22,143	\$13,714	\$8,429
St. Francis Hospital & Medical Center	62	\$56,193	\$21,189	\$18,850	\$2,339
Danbury Hospital	33	\$67,201	\$20,728	\$18,782	\$1,946
St. Vincent's Medical Center	32	\$52,380	\$20,438	\$17,881	\$2,557
Hospital of Central Connecticut	33	\$43,989	\$19,505	\$17,296	\$2,209
Saint Mary's Hospital	25	\$54,208	\$19,306	\$17,936	\$1,370
Griffin Hospital	13	\$67,822	\$19,135	\$17,659	\$1,476
Middlesex Hospital	31	\$86,394	\$18,870	\$17,074	\$1,796
Lawrence & Memorial Hospital	17	\$48,783	<b>\$18,657</b>	\$17,678	<b>\$979</b>
William W. Backus Hospital	45	\$39,831	\$17,888	\$15,142	\$2,746
Manchester Memorial Hospital	21	\$50,777	\$17,071	\$14,998	\$2,073
Bristol Hospital	15	\$57,521	\$16,599	\$15,813	\$786
Charlotte Hungerford Hospital	21	\$31,548	\$15,957	\$14,889	\$1,068

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Circulatory Disorders Except AMI, W Card Cath  
W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	65	\$120,592	\$28,531	\$25,275	\$3,256
Hartford Hospital	64	\$71,032	\$21,132	\$16,888	\$4,244
St. Vincent's Medical Center	26	\$79,241	\$19,916	\$16,494	\$3,422
St. Francis Hospital & Medical Center	40	\$53,805	\$18,661	\$16,819	\$1,842
Danbury Hospital	12	\$48,886	\$18,543	\$13,047	\$5,496
Lawrence & Memorial Hospital	14	\$39,395	\$15,344	\$14,496	\$848
Hospital of Central Connecticut	11	\$36,002	\$14,949	\$13,855	\$1,094

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Intracranial Hemorrhage or Cerebral Infarction  
W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	138	\$94,839	<b>\$24,649</b>	\$21,717	<b>\$2,932</b>
John Dempsey Hospital	19	\$27,682	\$20,308	\$18,596	\$1,712
Bridgeport Hospital	29	\$49,352	<b>\$19,343</b>	\$15,691	<b>\$3,652</b>
Hartford Hospital	143	\$55,092	\$17,903	\$15,145	\$2,758
St. Francis Hospital & Medical Center	86	\$57,287	\$17,058	\$15,649	\$1,409
Windham Community Memorial Hospital	13	\$19,960	\$16,147	\$15,323	\$824
Danbury Hospital	50	\$37,247	\$15,970	\$14,198	\$1,772
Norwalk Hospital Association	39	\$48,086	\$15,837	\$13,720	\$2,117
St. Vincent's Medical Center	33	\$45,394	\$15,776	\$14,137	\$1,639
Stamford Hospital	39	\$62,925	\$15,021	\$13,826	\$1,195
Saint Mary's Hospital	29	\$25,038	\$14,670	\$13,448	\$1,222
Hospital of Central Connecticut	53	\$34,972	\$14,643	\$12,615	\$2,028
Waterbury Hospital	33	\$49,025	\$14,378	\$13,132	\$1,246
Griffin Hospital	15	\$42,608	\$13,961	\$12,562	\$1,399
Greenwich Hospital Association	37	\$47,276	<b>\$13,639</b>	\$12,463	<b>\$1,176</b>
Lawrence & Memorial Hospital	41	\$30,269	<b>\$13,047</b>	\$12,207	<b>\$840</b>
Middlesex Hospital	36	\$55,045	\$12,635	\$11,568	\$1,067
William W. Backus Hospital	19	\$26,775	\$12,458	\$11,657	\$801
MidState Medical Center	31	\$32,481	\$12,041	\$11,245	\$796
Charlotte Hungerford Hospital	15	\$14,539	\$11,321	\$10,460	\$861

Source: FY2013, CMS Data

## **EXHIBIT 4**

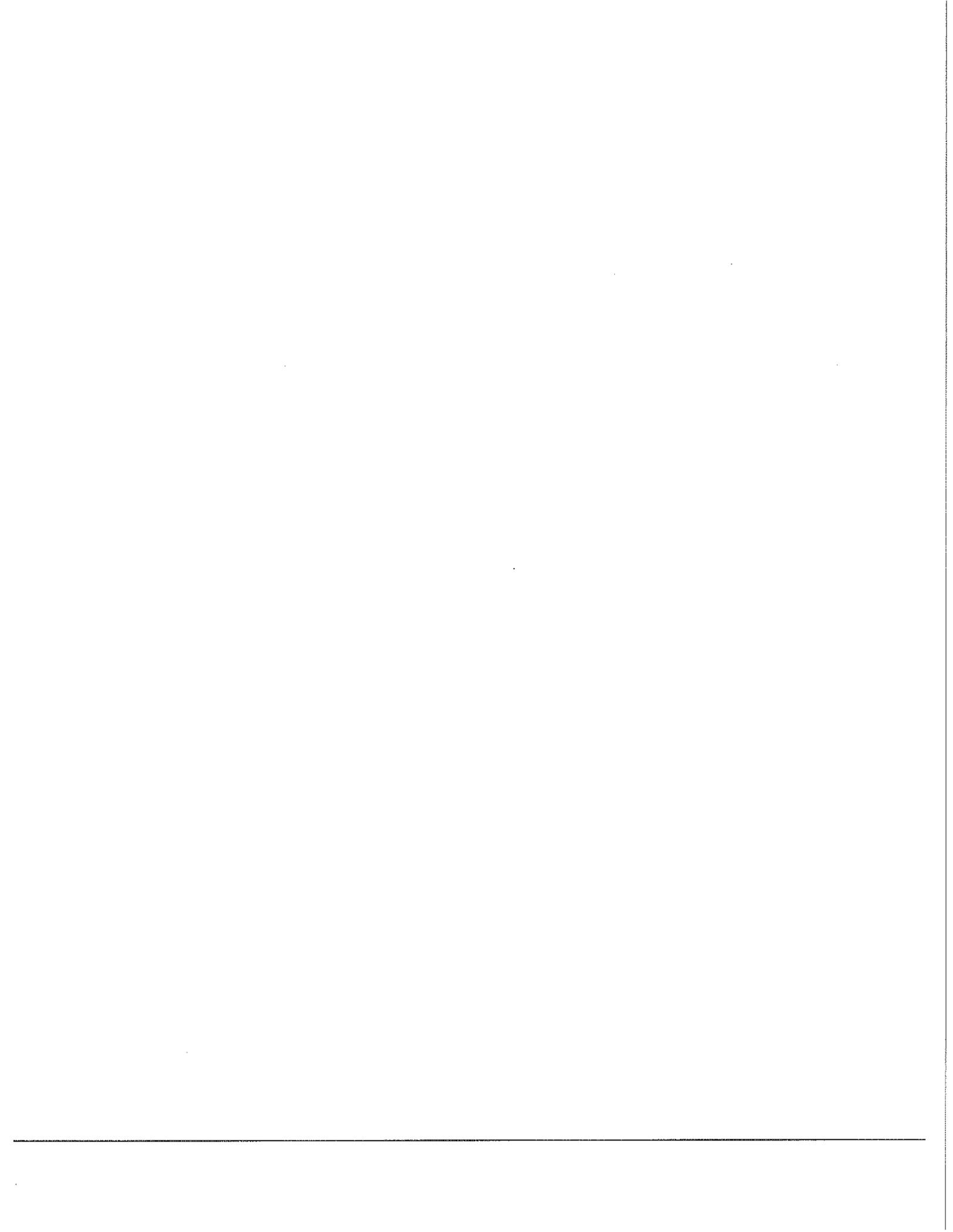
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HOSPITAL MARKET CONCENTRATION  
IN CONNECTICUT:

# The Impact of Yale-New Haven Health System's Expansion

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# EXECUTIVE SUMMARY

The last twenty years have transformed the Connecticut health care system. As recently as 1995, every hospital in the state was independent, but the era of the community hospital is over. If currently proposed mergers are completed, more than 80% of Connecticut's patients will receive care from hospitals owned by large, powerful multi-hospital systems. Driven in part by new "shared savings" reimbursement policies in the state Medicaid and federal Medicare programs, this trend is accelerating.

Connecticut now has five major acquisitions pending, including the expansion of the state's most powerful health care entity. The Yale-New Haven Health System has proposed to buy Lawrence and Memorial Health, which owns both Lawrence and Memorial Hospital in New London and Westerly Hospital in Rhode Island. At the same time, Milford Hospital was forced to shut down Labor and Delivery services when its leading Obstetrician/Gynecologists defected to Yale-New Haven Hospital. Financially distressed, Milford now leases space to Yale-New Haven Hospital for its regional inpatient rehabilitation services. A slow-motion takeover appears to be in process.

The most recent data available show that Connecticut has the 4<sup>th</sup> highest health care costs in the United States, but lags in most measures of quality. Numerous academic studies show that as providers take each other over and limit competition, prices go up without service improvement—and the more heavily concentrated the market is to begin with, the higher the price increases.

The co-authors of *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, have worked together on legislative solutions to the challenges of growing hospital monopoly for the past several years. In continuing that work, we have analyzed state inpatient hospital discharge data and mapped the potential changes to the state's health care markets if Yale-New Haven buys L+M and swallows up Milford Hospital. The report examines five geographic areas, from L+M's relatively small self-defined service area, to an area covering the southern half of the state.

The data yield three key metrics: the percentage market share held by Yale-New Haven Health, the score for each area on a standard government measure of market concentration called the Herfindahl-Hirschmann Index, or “HHI”, and the amount of change in the concentration of the hospital market in each area. The findings include:

- Though consumers already face a market with limited competitive pressure to protect them, the Milford and L+M takeovers will significantly increase the Yale-New Haven Health System’s market share in all five areas. In L+M’s primary service area, Yale-New Haven Health System will grow from 14% to 83% of inpatient discharges.
- All five geographic regions studied easily meet the federal government’s standard for a “highly concentrated” market even before the two takeovers. Highly concentrated markets lack competition and can lead to artificially excessive prices.
- In the market areas studied, the size of the increase in consolidation caused by YNHHS’s expansion would be significantly higher—by a factor ranging between 50% and 900%—than the level that requires regulators to presume that merging entities will “obtain market power,” which federal regulatory standards warn against.<sup>1</sup> Studies show that mergers in already highly consolidated markets can often lead to price increases of 20%.
- Although hospitals are consolidating across the state, the shoreline areas dominated by YNHHS are the most heavily concentrated regions in Connecticut, and thus most vulnerable to price increases. The three-hospital Yale-New Haven system claims a “local service area” comprising nearly half the state’s population. Upon full absorption of Milford and L+M, the Yale-New Haven system will account for 59% of discharges in this area.

The report’s co-authors urge public officials to take three steps before any decisions are made on whether or not, and under what conditions, the merger should proceed.

- In 2015, Connecticut passed a sweeping health care consumer protection law, SB 811. The law requires a cost and market analysis prior to regulatory action on hospital mergers. Although Yale-New Haven and L+M applied for approval before the new law took effect, state officials should conduct the cost and market analysis prior to any action on the proposed merger.
- In particular, state officials should examine the pricing impact in Greater New Haven of Yale-New Haven Hospital’s 2012 takeover of the Hospital of St. Raphael. No data will better illuminate the potential impact of Yale-New Haven’s expansion than what happened to prices after this deal, which created the 6<sup>th</sup> largest hospital in the United States.
- The L+M transaction should not be viewed in isolation. Yale-New Haven’s market power on the shoreline is expanding by leasing a wing of Milford Hospital. This adds a small but significant further increase in the extent of Yale-New Haven’s market control. State officials should include the potential absorption of Milford in their analyses.

# 1. GROWING CONCENTRATION IN THE HEALTH CARE MARKETPLACE

The last twenty years have transformed the Connecticut health care system. As recently as 1995, every hospital in the state was independent, but the era of the community hospital is over. If current proposed mergers are completed, more than 80% of Connecticut's inpatients will pass through hospitals owned by large, powerful multi-hospital systems, with few legal checks on price increases to protect them.

The Affordable Care Act has delivered health insurance to millions of people, a significant policy victory. At the same time, however, changes in reimbursement policies, mandates for technology improvements, and new regulations have tilted the market even further in favor of large, wealthy hospital systems. In Connecticut, the State Innovation Model (SIM) and "shared savings" policies for Medicare and Medicaid are creating incentives for large combinations of hospitals and doctors that can accept risk for broad patient populations. These systems are taking advantage of the new conditions to overrun their smaller competitors and build market power.

Unfortunately, the ACA contains few proven cost control measures. Congress largely left it up to states, employers, payers, municipalities, and individual patients to rein in costs as health care

systems undergo rapid consolidation. Academic studies consistently show that the main impact of hospital consolidation is increased prices without improvement in quality.<sup>2</sup> Nationally, ballooning prices threaten newly expanded access. Although increasing numbers of Americans have health insurance, out of pocket costs are rising at 3-4 times the rate of wages.<sup>3</sup> More Americans than ever report delaying needed medical care for cost reasons.<sup>4</sup> Without cost control, the long-overdue expansion of health insurance coverage will not be sustainable.

These challenges have become clear in Connecticut in recent years. Despite a dramatic growth in their market power - which will continue if the combined \$91 billion Anthem-Cigna and Aetna-Humana deals are completed - health insurers have done little to restrain costs.<sup>5</sup> Meanwhile, the rise of multi-hospital systems has created concentrated markets in the state, and the Yale-New Haven and Hartford HealthCare systems have developed a dominant grip on health care statewide. The two major health systems account for nearly half the inpatient discharges in the state, and each has even tighter regional control in its respective market. Hospital consolidation and price inflation will continue unless checked at the state level.

## Acquisition and Absorption: Yale-New Haven Expands

Yale-New Haven Hospital (YNHH) began the process of industry consolidation in Connecticut in 1995, when YNHH added Bridgeport Hospital to its network. Greenwich Hospital joined the growing system in 1998. In 2010, the health system added Northeast Medical Group, a start-up physician multispecialty group that now employs over 550 doctors and is wholly owned by the Yale-New Haven Health Services Corporation, the parent corporation of the Yale-New Haven Health System (YNHHS).

In 2012, Yale-New Haven Hospital's takeover of the Hospital of St. Raphael created the 6<sup>th</sup> largest hospital in the country.<sup>6</sup> After the merger, the Yale-New Haven Health System (YNHHS) market share rose to 98% of inpatient discharges among New Haven residents and 76% in Greater New Haven, up from 68% and 48% respectively.<sup>7</sup>

In 2014, Texas-based for-profit hospital operator Tenet Healthcare proposed purchasing five Connecticut hospitals in an equity partnership with YNHHS, with Tenet owning 80% and Yale-New Haven 20%. Adding five of its competitors to Yale-New Haven's existing market share would have meant that 37.5% of all discharges in the state were from the newly merging system, a major expansion of the Yale network. The deal fell through after the Office of Health Care Access imposed unusually strong requirements on the terms of the deal, in the face of concerns about the impact of the transaction on cost, access, services, financial burden on the uninsured, and accountability of the hospitals to local communities.

Now, YNHHS has two impending hospital takeovers that will expand its control over the health care market along Connecticut's coastline.

One is widely known. The Yale-New Haven Health System has announced a deal to purchase Lawrence + Memorial Health, a smaller system that controls: Lawrence + Memorial Hospital in New London; Westerly Hospital in Westerly, Rhode Island; L+M Physicians Association, a 72-member

multispecialty physician practice; and several other outpatient facilities.<sup>9</sup>

In a series of less publicized moves, YNHHS seems to be quietly acquiring pieces of financially struggling Milford Hospital.

Milford has reported negative operating margins in each of the last seven years. The hospital's license allows it to operate 118 beds, but due to declining patient volume, only 43 are currently staffed. Documents filed with the state Office of Health Care Access reveal that physician defections to Yale-New Haven Hospital contributed to those losses and inflicted severe competitive damage on Milford's labor and delivery service. According to these documents, in 2012, six OB/GYN doctors who accounted for a majority of Milford Hospital's deliveries told management that they would no longer deliver babies there. One had decided to stop delivering babies altogether, but the other five told Milford management that they were making Yale-New Haven Hospital their "exclusive hospital provider."<sup>10</sup>

Milford subsequently attempted to hire additional obstetricians, but could not keep them. In February of 2015, Milford applied for state approval to terminate its Labor and Delivery service. Milford's family birthing center, which occupies a large portion of the hospital's third floor, will no longer accept patients.<sup>11</sup>

Having expanded its OB/GYN network due to Milford's financial distress, Yale-New Haven Hospital announced last fall that it would open a 24-bed inpatient rehabilitation clinic on one of the three floors of Milford Hospital. The clinic would serve patients suffering from certain neurological, orthopedic, musculoskeletal, and other conditions. These patients typically have received inpatient treatment such as surgery for their conditions, and require extensive nursing care and supervision while undergoing treatments such as physical or occupational therapy.

YNHH's proposal would shift all patients who would have been treated in the current rehab unit at the St. Raphael's campus to Milford. Shortly after, YNHHS-owned Bridgeport Hospital submitted its

own paperwork to terminate its inpatient rehabilitation services as well.<sup>12</sup> In essence, YNHHS is regionalizing its inpatient rehabilitation services at its leased space at Milford Hospital, even as Milford's traditional hospital services decline and close. Taken together, these events suggest that Yale-New Haven Health System's absorption of Milford Hospital is in process. Yet state regulators have treated each submission—Milford's closure of its Labor and Delivery service, the opening of Yale-New Haven's inpatient rehabilitation unit, and the two separate YNHHS inpatient rehabilitation unit closures—as distinct, unrelated events.

In contrast to Milford Hospital, Lawrence + Memorial Hospital is a financially successful 256-bed hospital in New London that recently acquired Westerly Hospital in Rhode Island, pledging to invest \$36.5 million over five years in the new acquisition. In September, the parent company of the two hospitals and Yale New Haven Health System filed a Certificate of Need application for YNHHS to take over the L+M system. In the application, YNHHS promises to make a \$300 million capital investment in the region.<sup>13</sup> This deal is now in front of state regulators seeking approval.

## Connecticut's Growing Monopolies

Hospital consolidation is a recent and rapid phenomenon in Connecticut: twenty years ago, every hospital in the state was independent.

The trend has accelerated recently. A tally of transactions by the Universal Health Care Foundation in December 2014 reported that "between 2009 and 2013 there were thirteen attempted and seven successful hospital consolidations and/or partnerships [in Connecticut], a substantial increase from the four that occurred in the previous decade."<sup>14</sup>

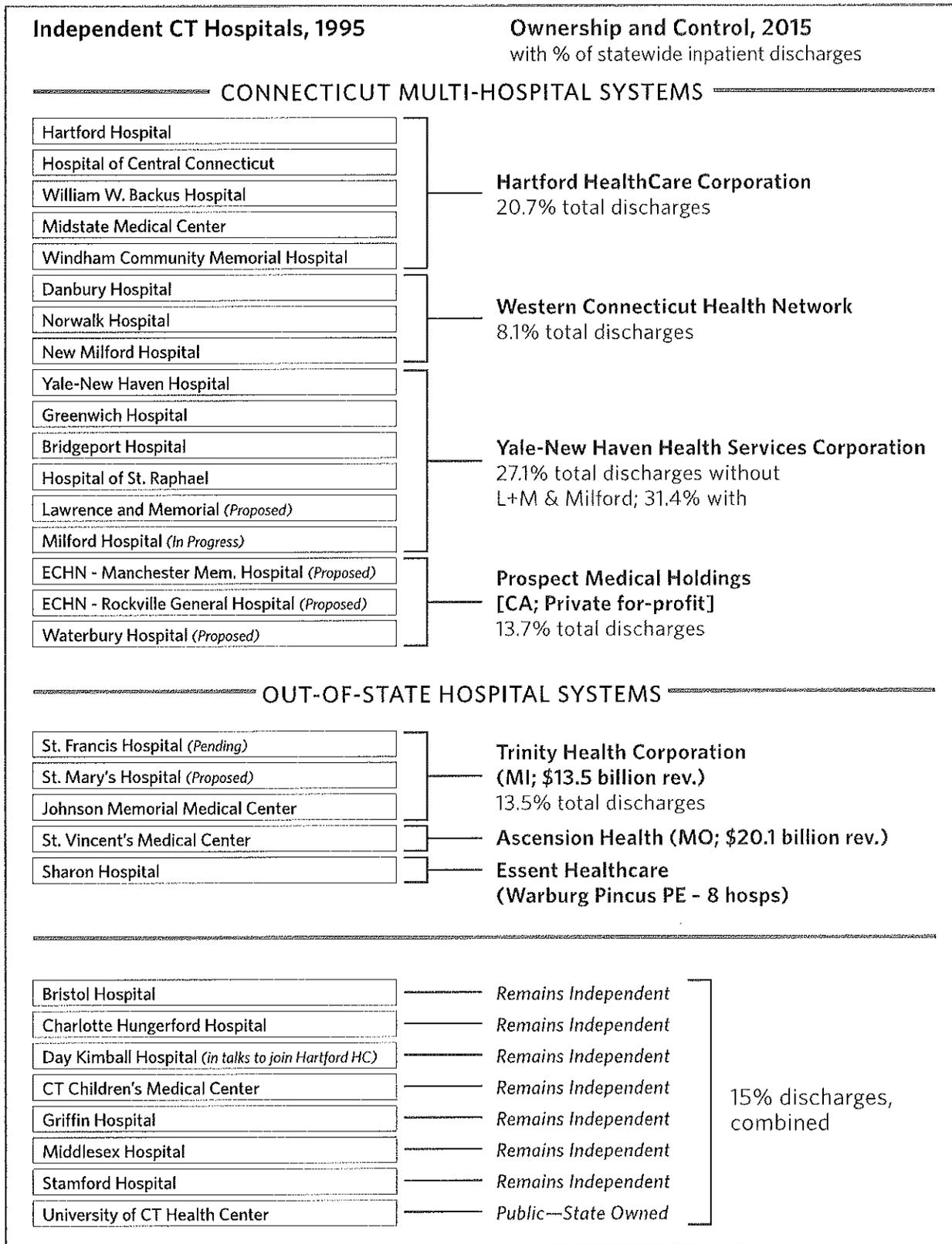
As a result of these consolidations, Hartford HealthCare accounted for 20.7% of inpatient discharges in the state in FY 2013, while Yale-New Haven Health System saw another 27.1%. The two health systems combine for nearly half of the

state's discharges, a lopsided market for Connecticut consumers.

In the year since the UHCF report, at least five major hospital affiliations or purchases have been announced or proposed: private for-profit Prospect Medical Holdings has moved to purchase the Eastern Connecticut Health Network and Waterbury Hospital; St. Francis Hospital affiliated with Trinity Health Corporation, a \$16 billion national company based in Michigan, has acquired Johnson Memorial Hospital, and has moved to acquire St. Mary's Hospital; and Ascension Health has purchased St. Vincent's Medical Center—all in addition to Yale's proposed acquisition of L+M and progressive annexation of Milford. Today, the eight hospitals that will remain independent if all pending transactions are approved provide only 15% of inpatient discharges in the state.

Unless radical change to reimbursement and support for financially distressed hospitals is on the horizon, some consolidation is inevitable. Unlike many of the other recent and proposed hospital acquisitions, however, the Lawrence + Memorial deal is not spurred by a community hospital's financial crisis. The conditions of this proposal create an opportunity for regulators to take a closer look at the growing monopolies in the state.

Figure 1: Hospital Ownership Changes, 1995-2015



## 2. THE DATA: YALE-NEW HAVEN'S LATEST MOVES INCREASE CONSOLIDATION

New data make it possible to chart the development of Connecticut's hospital systems, including the expansion of Yale's regional control in the last several years, and to anticipate how such control will grow as hospital networks expand. The authors obtained general acute inpatient care discharge data from the Office of Health Care Access, showing the number of discharges from each hospital by patients' town of residence during fiscal year 2013.

The question of how to define health care markets is highly contested and technically complex. For a detailed discussion, see Appendix A. Courts, hospitals, and regulators have disputed market boundaries for a quarter of a century while hospital systems completed 1,881 mergers.<sup>15</sup>

Recently, economists have developed improved tools to measure market boundaries, but courts are still catching up. Despite an academic consensus that hospital markets are much smaller and therefore more concentrated than courts were willing to accept a decade ago, only a handful of cases have actually seen anti-trust remedies applied to mergers.<sup>16</sup> Meanwhile, mergers are proceeding at a rate of more than 90 per year.<sup>17</sup>

For our initial analysis, we focus on market areas defined by the health systems and hospitals themselves, including concentric areas surrounding different hospitals that define smaller and larger

markets. This approach gives a thorough preliminary analysis of market concentration at varying scales. The analysis examines five areas:

- **Yale-New Haven Health System's local service area:** In the Official Statement accompanying its most recent bond offering, YNHHS defined the "local service area" for its full system as a 55-town region encompassing roughly the southern half of the state. The area includes 1.6 million people, 46% of the state's population.<sup>18</sup>
- **Yale-New Haven Hospital local service area:** A 34-town region also defined in YNHHS bond statements.<sup>19</sup>
- **Greater New Haven Area/Southern Connecticut Region Council of Governments (SCRCOG):** We use the area defined by membership in the Southern Connecticut Regional Council of Governments (SCRCOG) as a definition of Greater New Haven. SCRCOG contains fifteen towns with 16% of the state's population.
- **Lawrence + Memorial Hospital Primary Service Area:** L+M Hospital defines its primary service area as a ten-town region surrounding New London, both in the Official

Statement for its most recent bond issue and in its Certificate of Need application.

- **Lawrence and Memorial Hospital Secondary Service Area:** In the same sources, L+M also identifies as its secondary service area a twenty-town area surrounding New London.<sup>20</sup>

Within these five areas, our analysis focuses on three key metrics:

- The percentage market share for the Yale-New Haven Health System in each area prior to and after the absorption of Milford and the purchase of L+M Health.
- The Herfindahl-Hirschman Index, or “HHI,” score for each area pre- and post-acquisitions. HHI measures the degree to which a market is concentrated, and thus how likely consumers are to face anticompetitive practices. It is a standard FTC and DOJ metric, also used by the American Medical Association, Congressional Budget Office, Kaiser Family Foundation, insurance industry, and other economists and regulators for analyses.
- The change in HHI for each area before and after a transaction, a prediction of merging hospitals’ gain in market power.

In examining these metrics, we found that:

- Though consumers already face a market with limited competitive pressure to protect them, the ongoing absorption of Milford and the proposed purchase of L+M will significantly increase the Yale-New Haven Health System’s market share in all five areas we examined – by a factor of 5 or 6 in the markets surrounding New London – at the further expense of competition.
- All five geographic regions studied easily meet the federal government’s standard for a “highly concentrated” market even before the two takeovers. Highly concentrated markets can lead to artificially excessive prices.

- In the market areas studied, the size of the increase in consolidation caused by YNHHS’s expansion would be significantly higher—by a factor ranging between 50% and 900%—than the level that requires regulators to presume that merging entities will “obtain market power,” which federal regulatory standards warn against.<sup>21</sup>

- Although there is rapid consolidation across the state, the coastline areas dominated by YNHHS are the most heavily concentrated regions of the state and therefore are most vulnerable to price increases.

In each of these areas, the expansion is significant. The ultimate absorption of Milford Hospital and the L+M deal as proposed will leave YNHHS with nearly 60% of inpatient discharges in the Yale-New Haven Health System’s local service area, which covers roughly the southern half of the state, including 46% of its population. It will also add the L+M service area to the swath of coastal areas in which YNHHS dominates the market. [See Figures 3 and 4.] Yale-New Haven Hospital already treats the second highest volume of patients in L+M’s primary service area and third highest in its larger secondary service area. Combining the two hospital networks will leave YNHHS with monopoly pricing power.

When federal and state anti-trust regulators measure the degree to which a market is concentrated, they use a tool called the Herfindahl-Hirschman Index (HHI), which measures market concentration by aggregating measures of firms’ market shares.

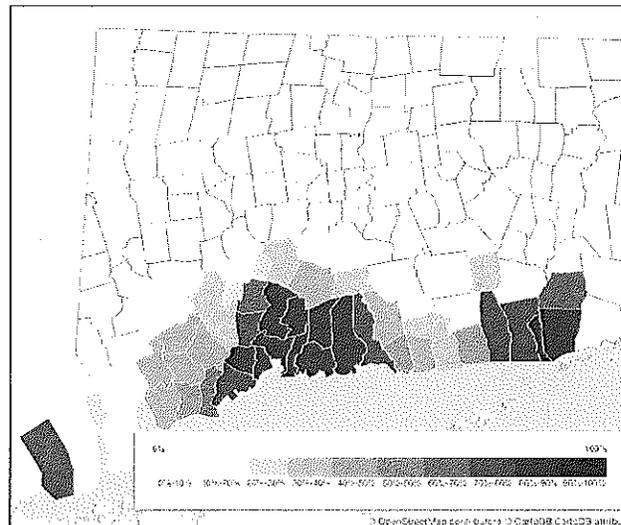
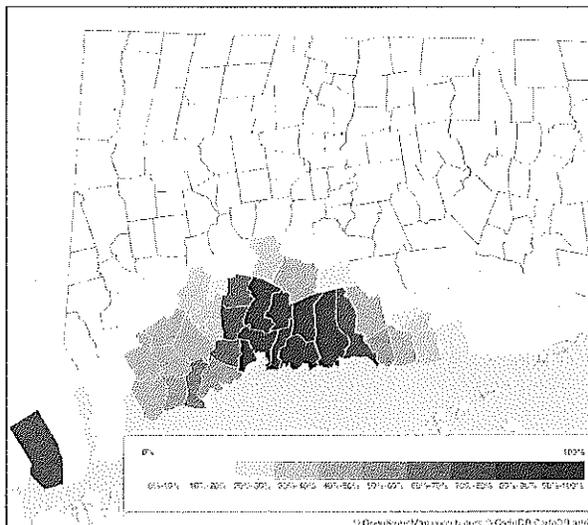
The DOJ and FTC assert that “mergers should not be permitted to create, enhance, or entrench market power or to facilitate its exercise” because of the threat to competition. When a merger increases the HHI in a highly concentrated market by 100 points, regulators expect that merger to “potentially” raise significant concerns because of an increase in market power. When it increases by 200 points or more, they “presume” that an impermissible market power increase is likely. This presumption can be rebutted only by “persuasive evidence showing that the merger is unlikely to enhance market power.”<sup>22</sup> We applied HHI to the discharge data from towns and multi-town areas to determine the health of the state’s markets.

Figure 2: YNHHS inpatient discharge share by region, before and after addition of L+M and Milford

	Population	YNHHS discharge share now	YNHHS discharge share with deals
Statewide	3,570,000	27%	31%
YNHHS local service area	1,650,000	51%	59%
YNHH local service area	1,096,135	60%	65%
GNH/SCRCOG	570,000	74%	83%
L+M primary service area	175,000	14%	83%
L+M secondary service area	362,000	12%	59%

Figures 3 and 4: YNHHS local service area market share, before and after

These maps illustrate the percentage of inpatients from each town within the Yale-New Haven Health System's local service area who were discharged from a hospital in the YNHHS, before and after the addition of L+M and Milford.



### Measuring Market Power

To calculate HHI, one adds the squares of the market shares together to get a number on a scale of 100-10,000:

- A region with a pure monopoly on a good or service would score an HHI of 10,000:  $(100\%)^2 = 10,000$ .
- A region with 10 competitors, each with equal market shares of 10% would score 1,000:  $(10\%)^2 = 100$  for each competitor.  $100 \times 10$  competitors = 1,000.
- A region with five competitors, one with 50% market share, one with 20% market share, and three with 10% market share would score 3,200 on HHI.  $(50\%)^2 = 2,500$ ;  $(20\%)^2 = 400$ ;  $(10\%)^2 = 100 \times 3$  competitors = 300.

The federal government divides markets into three categories based on HHI scores to assess the risk of monopoly:

- Less than 1,500—unconcentrated market with adequate competition
- Between 1,500 and 2,500—“moderately concentrated” market
- Above 2,500—“highly concentrated” market with an elevated risk of inefficiency and collusion to fix prices.

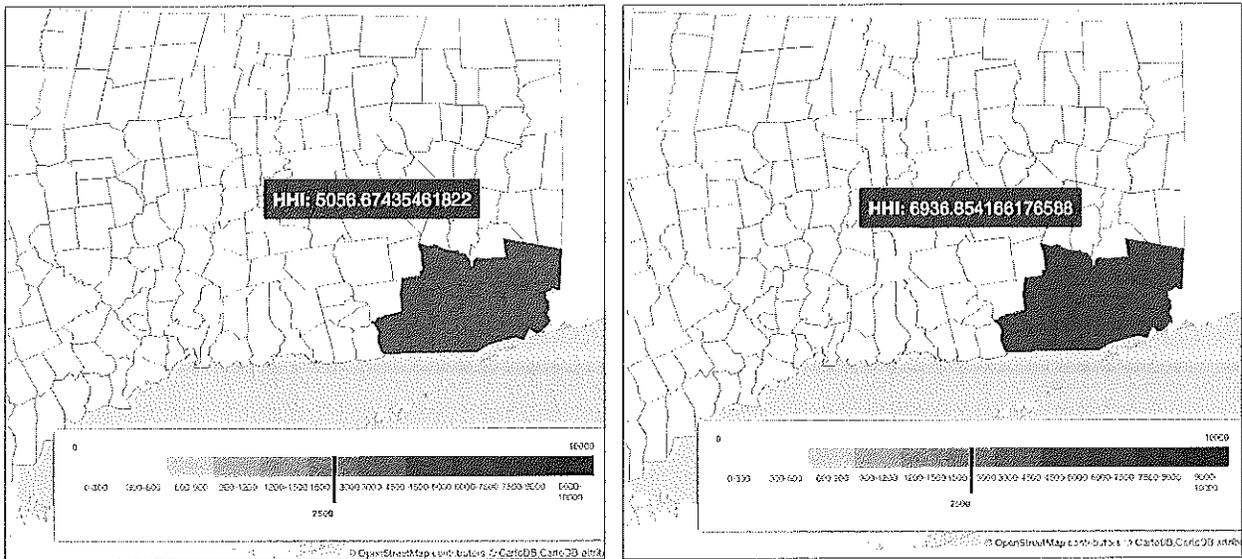
Regulators apply the strictest scrutiny to “highly concentrated” markets with scores of 2,500 or above.<sup>18</sup>

We found that every one of the five regions is already a highly concentrated hospital market to begin with. In every region, the increase in HHI was dramatic. The maps on the opposite page illustrate the HHI increase in the L+M service area. For the full table showing HHI and change in HHI for each geographic area, see Appendix B.

In every relevant local or regional area we examined, the HHI indicates that the market is already highly concentrated. When concentration is already high, increases to HHI are more concerning: federal standards indicate that the strictest scrutiny should be applied to markets like these because of the risk to competition. In every one of these markets, the magnitude of the HHI increase is far higher than the 200-point threshold at which federal regulations presume an impermissible increase to market power. In the L+M primary service area, the increase is over nine times the 200-point standard. In the YNHHS local service area—which encompasses 46% of the state’s population—the increase is more than quadruple the standard.

The state of Connecticut is far too large to consider a “market.” Even if we did consider Connecticut as a “market” of its own, however, it would already have an HHI of 1412. After these transactions, it would have an HHI of 1716—an increase of 304 points that would move it from the “unconcentrated” category to the “moderately concentrated” category. These two acquisitions constitute a substantial increase to overall market concentration in the state because they bolster the market power of its largest health system.

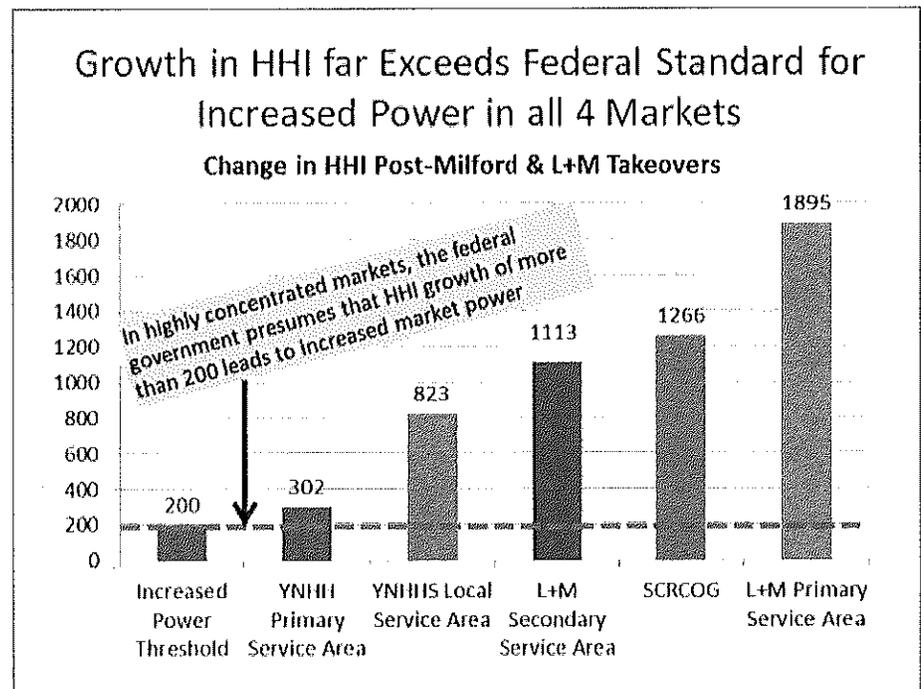
Consolidation is not equally threatening everywhere, however. We also calculated market concentration on a town-by-town basis for the entire state to demonstrate the distribution and comparative level of concentration across regions. Hartford’s expansion in northern Connecticut has been more diffuse than Yale-New Haven’s southern growth to date. In Hartford, for example, Hartford Hospital continues to face direct competition from St. Francis, which is now aligned with a multi-billion dollar national non-profit chain and is itself seeking to buy two hospitals. In the southern half of the state, highly concentrated multi-town regions clearly show the dominance of the Yale-New Haven Health System.



Figures 5 and 6: L+M Service Area HHI, before and after YNHHS takeover

This map demonstrates the dramatic increase in market concentration for the L+M Primary Service Area that will result from the potential takeovers. Because the market is already highly concentrated before the acquisition, combining YNHHS and L+MH will cause a large spike in market concentration, leaving few alternatives to the newly dominant Yale-New Haven system.

Figure 7



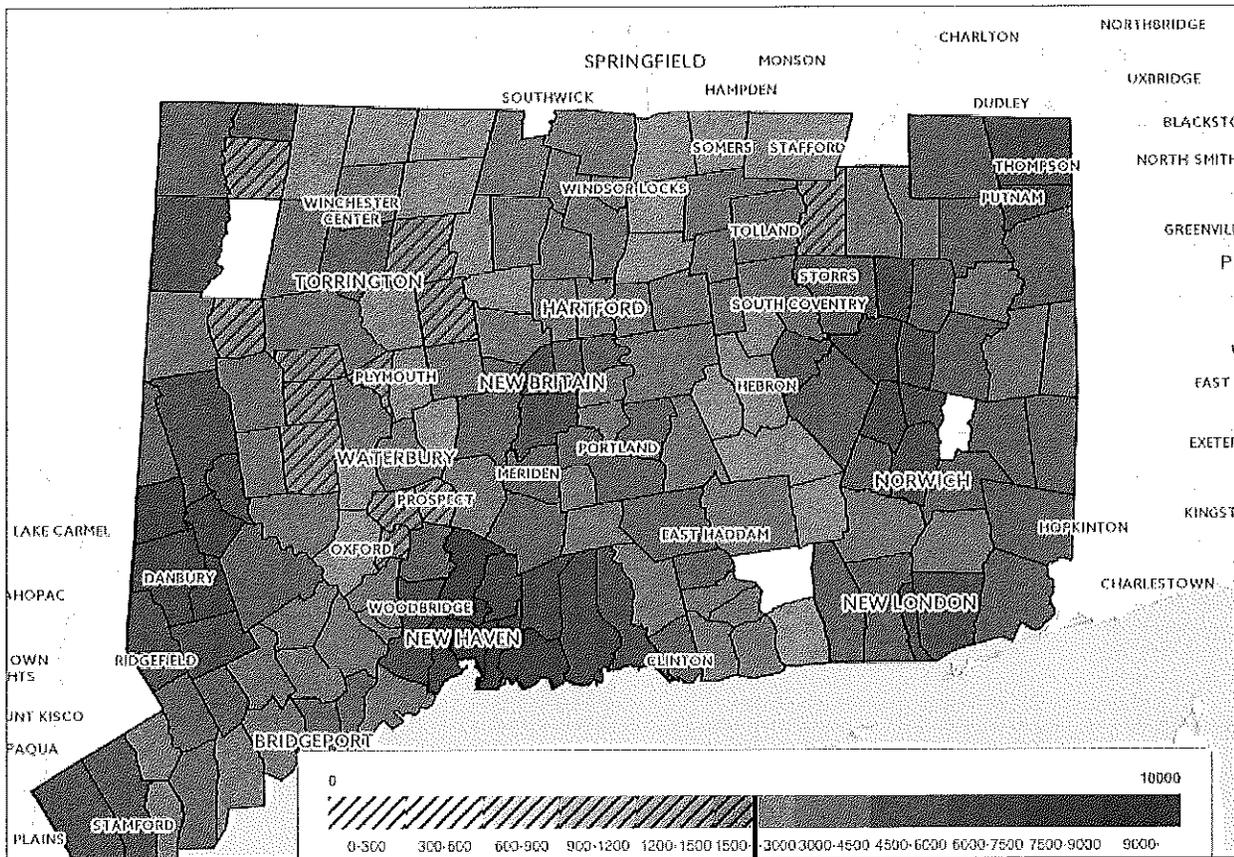


Figure 8: Town-by-town market concentration, Connecticut

This map shows the existing HHI scores for each town in Connecticut. Though discrete towns are not complete health care markets in themselves, the map shows roughly the distribution of highly and extremely concentrated markets throughout the state. Though Hartford HealthCare controls a large number of hospitals statewide, its hospitals are distributed in such a way that most towns in the north of the state exhibit comparatively lower market concentration, although most would still be defined as “highly concentrated” under federal standards. In the Yale-New Haven-controlled southern half, however, we see the highest density of towns with extremely high market concentration—above 6,000, indicating that Yale-New Haven’s control of the market is geographically consolidated. Note that the region around New London is already heavily concentrated, and will become even more so if Yale-New Haven takes over L+M.

# 3. THE UNAFFORDABLE CONSEQUENCES OF MARKET CONCENTRATION

## Prices Go Up as Hospitals Gain Market Power

Hospitals often claim that consolidation increases efficiency. There is little evidence to support this claim.

Independent comprehensive reviews of the academic literature have rejected this interpretation. Nationally, the Robert Wood Johnson Foundation reports, based on a review of five independent studies, that when hospitals “merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent.”<sup>23</sup> Locally, the Universal Health Care Foundation of Connecticut concluded in its December 2014 review that “almost all retrospective studies suggest that hospital consolidation results in concentration of market power and a rise in the price of care.”<sup>24</sup>

In Massachusetts, the Attorney General has documented that monopoly pricing, especially by the non-profit Harvard-affiliated Partners system, is the state’s most significant cost driver.<sup>25</sup> In a court ruling this year against a hospital merger involving Partners, the Massachusetts judge found that the system was able to “exercise ‘near monopoly power’ that allows it to charge prices far in excess of its competitors for the same services.”<sup>26</sup>

The fact that the dominant systems in Connecticut are nominally not-for-profit corporations does not protect Connecticut patients. A majority of U.S. acute care hospitals are structured as private, non-profit enterprises. That fact has not prevented a massive wave of mergers and skyrocketing prices.

For years, judges permitted mergers of non-profit hospitals on the theory that they would behave

charitably with greater market power. In 2007, the Federal Trade Commission studied the pricing impacts of a non-profit merger in Illinois. It found that, according to the hospitals’ own economist, managed care prices increased by 42% over four years, 12% above the market as a whole.<sup>27</sup>

With rising health care costs one of the largest drivers of perennial state budget crises, state officials are increasingly concerned about the long-term cost of consolidation to taxpayers. Comptroller Kevin Lembo, who administers the state employee health plan covering 210,000 people at a cost of \$1.4 billion annually, recently testified stating, “We’re going to be negotiating potentially with 2 or 3 large systems and that’s basically it, if things keep going the way they are going. I don’t think you need to be an actuary to know that that’s going to be a tough spot for us.”<sup>28</sup>

Non-profit hospitals claim they need surplus revenue to serve low income people. But Duke University Professor Clark Havighorst points out that the IRS allows non-profit hospitals “to spend their untaxed surpluses on anything that arguably ‘promotes health.’ Much of what hospitals count as charitable behavior or community benefit is not spent on lower income people.”<sup>29</sup> University of Illinois tax law professor John Colombo adds:

*“The standard non-profit hospital doesn’t act like a charity any more than Microsoft does—they also give some stuff away for free. Hospitals’ primary purpose is to deliver high quality health care for a fee, and they’re good at that. But don’t try to tell me that’s charity. They price like a business. They make acquisitions like a business. They are businesses.”<sup>30</sup>*

## **We're Not Getting the Quality Care We're Paying For**

Already, Connecticut has the 4<sup>th</sup> highest per capita health care costs in the nation: we paid 27% more per person than the national average for health care in 2009, the most recent year for which data are available,<sup>31</sup> and what we spend at the hospital annually nearly tripled from 1991 to 2009, from \$3.9 billion to \$9.3 billion.<sup>32</sup>

The science of measuring hospital quality is still in its infancy. No single set of metrics is backed by a wide consensus. However, we examined several federal and independent evaluations. The available data provide no evidence that Connecticut's high health care costs are correlated to high quality. On several currently available metrics, Connecticut ranks among the states with the lowest scores.

For example, Medicare penalizes hospitals if patients are frequently readmitted within a month of their discharge. Based on these readmission standards, 90% of Connecticut hospitals received penalties for the 2015-2016 fiscal year, the second highest penalty rate for any state.<sup>33</sup> These 28 penalized hospitals included all three in the Yale-New Haven Health System, and Yale-New Haven Hospital itself received the seventh most severe penalty in the state.<sup>34</sup>

Medicare also assesses hospitals based on patient satisfaction across a number of areas like communication, cleanliness, and pain management. In the most recent scores compiled from quarterly Hospital Consumer Assessment of Healthcare Providers and Systems surveys, no Connecticut hospital received the top rating of five stars. Eighteen out of twenty-five hospitals received a three star rating, including YNHHS's Bridgeport and Yale-New Haven hospitals.<sup>35</sup>

The independent Leapfrog Group assesses hospital quality nationally and grades hospitals "A" to "F" based on factors such as safe surgery practices, infection rates, and use of correct staffing and procedures to minimize mistakes.<sup>36</sup> Connecticut ranked 36<sup>th</sup> in the percentage of hospitals scoring "A" in Fall

2015.<sup>37</sup> Maine and Massachusetts were 1<sup>st</sup> and 2<sup>nd</sup> nationally. Yale-New Haven and Greenwich Hospitals received "C" grades, Bridgeport a "D". Three of Hartford HealthCare's five hospitals received "C" grades, one a "B" and one a "D".<sup>38</sup>

As the science of quality measurement improves, and analysts are better able to account for factors such as the severity of patients' conditions across populations, these scorecards may yield different results. However, the Robert Wood Johnson Foundation examined the literature on hospital consolidation in relation to currently available quality indicators, and found that "a slim majority of studies find that, at least for some procedures, increases in hospital concentration reduce quality. The strongest studies confirm this result."<sup>39</sup>

# 4. CONFRONTING CONNECTICUT'S HOSPITAL MONOPOLIES

The Affordable Care Act and new Connecticut reimbursement policy are accelerating changes in how care is delivered and measured, and how the business of health care is structured. Before our very eyes, Connecticut is being carved up by a few hospital systems. The leader is clearly Yale-New Haven, with a level of control in many areas that easily meets any definition of market power. Meanwhile, our patients and payers are carrying a heavier and heavier financial burden as their health care costs rise.

Fortunately, Connecticut's legislative leaders have acted to curb the threat of consolidation by giving more tools to public consumers and to regulators. Two hospital regulatory bills in the last two years leave Connecticut better prepared to protect its consumers from the ill effects of monopoly. These reforms have put us in the forefront of states asserting the public interest in creating a fair health marketplace that benefits all. State regulators and advocates should use those tools now.

The acquisition of Lawrence + Memorial Health by the Yale-New Haven Health Services Corporation is a pivotal opportunity for stemming the growth

of monopoly in Connecticut's health care market and limiting the ill effects of consolidation. The proposal will be reviewed under Public Act 14-168, which passed in 2014. Portions of Public Act 14-168 were quickly superseded by SB 811, which passed in 2015. However, the L+M acquisition application was submitted before the newer law took effect. Nevertheless, PA 14-168 added new standards for the Certificate of Need. In any decision to grant or refuse a CoN, the law requires the Office of Health Care Access to take into account whether the applicants have

*"satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region; and [w]hether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care."<sup>40</sup>*

The sale as proposed unquestionably poses a threat to both provider diversity and health care costs along the shoreline.

In light of this threat, state officials should

rigorously examine the likely consequences of the transaction in order to decide whether to allow it to proceed. In particular, we recommend that prior to any approval or rejection, and prior to developing any proposed conditions, regulators take the following steps:

- SB 811 requires the state to undertake a “cost and market analysis” for such mergers. Although SB 811 does not formally apply, the Attorney General retains responsibility to enforce the Connecticut Anti-trust Act, and the Office of Health Care Access now must specifically examine the impact of merger-related consolidation on cost and access. Having public market analysis was critical to the process of public comment to the judge in the case of proposed mergers by Partners Health System in Massachusetts. Accordingly, we urge regulators to conduct the cost and market analysis that our state legislators have deemed appropriate for sales like this one.
- In order to understand the likely results of these acquisitions, we also believe that a thorough analysis of potential consolidation-related cost and access impacts calls for a retrospective look at any price changes following YNHH’s acquisition of the Hospital of St. Raphael three years ago. This is a clear test of whether or not YNHHS exercises market power to artificially inflate prices: if St. Raphael’s or Yale-New Haven’s overall prices increased significantly post-merger, there is no question that the system is flexing monopoly muscle within the SCRCOG region. Understanding any changes in the two hospitals’ prices may portend similar behavior in eastern Connecticut.
- We urge OHCA and the Attorney General to view the L+M acquisition in tandem with the unannounced takeover of Milford Hospital. To date, the relationship between YNHHS and

Milford Hospital has been viewed as a series of individual transactions.

The changes to the market statewide pose high potential risks to patients. In the interest of quality and affordability in our health care marketplace, regulators must use these tools and more before they decide whether this transaction should proceed.

## APPENDIX A: DEFINING AND MEASURING HOSPITAL MARKETS

The authors have chosen to apply HHI to the five geographic areas identified in the report as an initial illustration of the challenges posed by YNHHS's slow-motion consumption of Milford Hospital and proposed acquisition of L+M Health. We are awaiting further data to allow more thorough analysis, and also expect that regulators will apply a more rigorous methodology as full information on the transaction becomes available.

The definition and measurement of hospital markets is a hotly contested legal subject. As noted in the body of the report, for many years courts tended to assume that it was appropriate to entrust not-for-profit entities with market power because of their "charitable" nature. As courts began to take the threat to competition from consolidating non-profit hospitals seriously, the prosecution of anti-trust cases foundered on the use of analytic tools that fail adequately to account for the inelasticity of hospital demand.

In 1982, the FTC and Department of Justice Guidelines adopted a test that sets the boundaries of a monopoly market at the furthest limits at which a potential cartel or monopolist can impose a small but significant non-transitory increase in price ("SSNIP"). A SSNIP is generally assumed to be a 5% increase for a year without losing market share.

To define the SSNIP boundary, economists used two tests. For hospitals, the Elzinga-Hogarty test uses "patient flow" data to determine consumers' ability to enter and exit the market boundaries. Any boundary in which 10% or more patients leave to get care elsewhere is assumed to have enough competition to preclude anti-competitive behavior. "Critical Loss Analysis" examines the ability of firms to withstand profitably the loss of customers expected under a given market definition following a price increase. Once the market was defined,

analysts would then apply a measure of market concentration such as the Herfindahl-Hirschman Index (HHI) to determine the anti-trust risk.

E-H and CLA both proved inadequate for hospital mergers. Neither accounts for factors that influence patient choice other than price (3rd party payment, role of the physician, proximity, availability of subspecialty services, etc.). Standard CLA analysis often results in "inconsistent logic and erroneous conclusions." Use of these tools allowed hospital defendants to win a series of cases between 1997 and 2004 in part by successfully defining markets as large geographic areas within which any single combination of hospitals posed a minimal threat to competition.

Gaynor, Kleiner, and Vogt estimate that these older methods overstated the elasticity of hospital demand "by a factor of 2.4 to 3.4 and were likely a contributing factor to the permissive legal environment for hospital mergers." That permissive environment allowed 1,425 mergers and acquisitions to be consummated between 1994 and 2009. Dr. Elzinga himself questioned the value of his own test on hospital markets in 2011.

In the early 2000s, economists developed the "option demand" analysis (Town and Vistnes, 2001; Capps, Dranove, and Satterthwaite, 2003) and the Differentiated Bertrand Oligopoly Model (DB). These models attacked the issue of third party reimbursement by envisioning a hypothetical health plan attempting to construct a provider network in the region of the merging competitors. "This is a reasonable characterization of managed care markets," write Gaynor, et al., of the option demand model.

The new methods yield markets far smaller and closer to economic reality than the older tests, and

lead to clearer pictures of market concentration. According to Gaynor et al, they allow analysts "to assess merger effects without a market definition."

However, they are not yet universally accepted in court, and even though the new methods are capable of assessing merger effects without a market definition, courts expect definitions and FTC guidelines for state Attorneys General insist on them as well. The new tools are powerful, and once we obtain data sufficient to apply them we will attempt to do so.

For our initial analysis, we have chosen to examine markets defined by the hospitals in their public descriptions of themselves. These analyses serve as an adequate preliminary basis for gauging the degree of concentration, and we examine several concentric markets that present analyses at varying scales of market definitions.

However, we recognize that in the policy process, any attempt at market definition will be contentious. Therefore, we urge regulators to heed the words of Kenneth Elzinga closely. In evaluating the usefulness of his original model in the context of

hospital mergers, Dr. Elzinga notes "where direct evidence of anticompetitive effects attributable to a merger is available, its use may diminish the need to rely on geographic market definition tools such as the E-H test," writes Dr. Elzinga. "Such direct evidence is most readily available in post-closing merger challenges such as the FTC's Evanston case."

Connecticut patients cannot wait until Milford and L+M are fully in the Yale-New Haven orbit to understand the potential price impact of the deals. Although there is no direct evidence, there is a useful precedent. Yale-New Haven's purchase of the Hospital of St. Raphael resulted in intense market concentration in the Greater New Haven area.

The Certificate of Need filed for that transaction in 2012 states that "YNHH has no plans to raise charges as a result of the HSR acquisition," language similar to that in the Certificate of Need for L+M. If an analysis of the market before and after that merger reveals significant price increases, there will be little question that YNHHS exerts monopoly pricing power.

**APPENDIX B:  
HHI TABLE, BEFORE AND AFTER BOTH HOSPITAL ACQUISITIONS, BY AREA**

<b>Market name</b>	<b>HHI before</b>	<b>HHI after</b>	<b>Change</b>
Lawrence + Memorial Primary Service Area	5087	6982	+1895
Lawrence + Memorial Secondary Service Area	3485	4598	+1113
YNHHS Local Service Area	2911	3735	+823
Greater New Haven (SCRCOG)	5665	6931	+1266
YNHH Primary Service Area	3920	4222	+302

**APPENDIX C:  
MARKET SHARE AND HHI CALCULATIONS FOR L+M ACQUISITION ONLY,  
WITHOUT MILFORD HOSPITAL ACQUISITION, BY AREA**

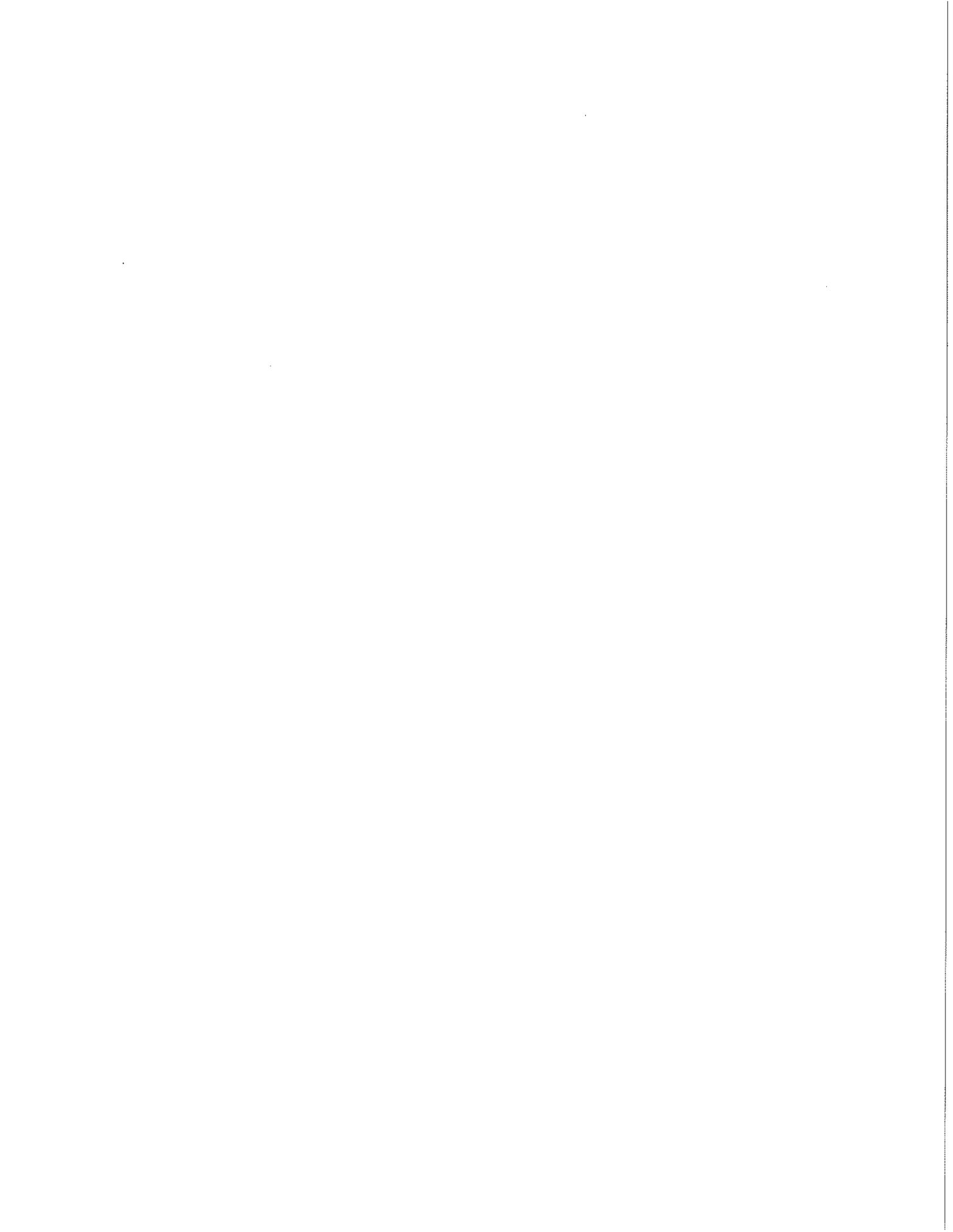
*Data in this table include YNHHS's proposed acquisition of L+M, but not the addition of Milford Hospital. HHI increase is compared to HHI with the Yale-New Haven system as is.*

<b>Market name</b>	<b>YNHHS Discharges</b>	<b>HHI</b>	<b>HHI Increase</b>
State	31%	1667	+254
Lawrence + Memorial Primary Service Area	83%	6972	+1884
Lawrence + Memorial Secondary Service Area	59%	4592	+1107
YNHHS Local Service Area	57%	3539	+628
Greater New Haven (SCRCOG)	79%	6309	+643
YNHH Primary Service Area	61%	3933	+14

# NOTES

- 1 US Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, August 19, 2010. <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.
- 2 The Synthesis Project, Update: New Insights from Research Results, the Robert Wood Johnson Foundation, <http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html>
- 3 Kaiser Family Foundation "Out of Pocket Pain: Cumulative Growth in Worker Health Expenses vs. Earnings," April 8, 2015. <http://kff.org/health-costs/slide/out-of-pocket-pain-cumulative-growth-in-worker-health-expenses-vs-earnings/>
- 4 Rebecca Riffkin, "Cost Still a Barrier Between Americans and Medical Care," The Gallup Organization, November 28, 2014. <http://www.gallup.com/poll/179774/cost-barrier-americans-medical-care.aspx>
- 5 Ana Radelat, "Congress scrutinizes Aetna-Humana and Anthem-Cigna deals, Connecticut Mirror, September 10, 2015. <http://ctmirror.org/2015/09/10/congress-scrutinizes-aetna-humana-and-anthem-cigna-deals/>
- 6 Dani Gordon, "100 Largest Hospitals in America, Becker's Hospital Review August 7, 2014. <http://www.beckershospitalreview.com/lists/8-7-14-100-largest-hospitals-in-america.html>
- 7 Greater New Haven defined as the fifteen towns represented in the Southern Connecticut Regional Council of Governments. <http://www.scrkog.org/municipalities.html>
- 8 See Connecticut Office of Health Care Access Certificate of Need Docket #s 13-31838-CON (Waterbury), 14-31926-486 (ECHN), 14-31928-486 (Bristol), and 14-31927-486 (St. Mary's). Note that Tenet and Yale-New Haven would split St Mary's equity 64%/16%, with a community foundation controlling 20%, see p. 52.
- 9 Connecticut Office of Health Care Access Certificate of Need, "Affiliation of Lawrence + Memorial Corporation with Yale-New Haven Health Services Corporation," Docket #15-32033, October 7, 2015., Page 23. [http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15\\_32033\\_con.pdf](http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15_32033_con.pdf)
- 10 Connecticut Office of Health Care Access Certificate of Need "Application to Terminate Inpatient Obstetrical Labor and Delivery Services at Milford Hospital, Docket #15-31998, page 9. [http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15\\_31998\\_con.pdf](http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15_31998_con.pdf).
- 11 OHCA Docket #15-31988, [http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15\\_31998\\_con.pdf](http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15_31998_con.pdf)
- 12 State of Connecticut, Department of Public Health, Office of Health Care Access, Annual Report on the Financial Status of Connecticut's Acute Care Hospitals for Fiscal Year 2014. [http://www.ct.gov/dph/lib/dph/ohca/hospitalfillings/2014/fsreport\\_2014.pdf](http://www.ct.gov/dph/lib/dph/ohca/hospitalfillings/2014/fsreport_2014.pdf)
- 13 OHCA Docket #15-32033, [http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15\\_32033\\_con.pdf](http://www.ct.gov/dph/lib/dph/ohca/conapplications/2015/15_32033_con.pdf)
- 14 Universal Health Care Foundation of Connecticut, Hospital Consolidations and Conversions: A Review of the Literature, December, 2014 [http://universalhealthct.org/images/publications/Hospital\\_Consolidations\\_and\\_Conversions.pdf](http://universalhealthct.org/images/publications/Hospital_Consolidations_and_Conversions.pdf) citing <http://c-hit.org/2014/03/23/hospital-mergers-raise-concerns-over-patient-costs>
- 15 For 1994-2009, Martin Gaynor, Samuel A. Kleiner, and William B. Vogt, "A Structural Approach to Market Definition with an Application to the Hospital Industry" The Journal of Industrial Economics, June 2013, 61(2); 243-289; for 2010-2013, Seth Freedman, Effects of Provider Consolidation in Healthcare: The Latest Research, November 21, 2014; for 2014, Lisa Phillips, 2015 Health Care Services Acquisition Report, Irving Levin Associates, March 31, 2015. <http://www.businesswire.com/news/home/20150331006369/en/Newly-Published-Report-2014-Health-Care-Services>
- 16 Cf Martin Gaynor, Samuel A. Kleiner, William B. Vogt, "A Structural Approach to Market Definition with an Application to the Hospital Industry" Carnegie Mellon University, March 4, 2012.; Dranove and Sefkas, "The Revolution in Health Care Antitrust: New Methods and Provocative Implications," The Milbank Quarterly, 2009 Sep; 87(3); 607-632.; Kenneth Elzinga, Anthony Swisher, "Limits of the Elzinga-Hogarty Test in Hospital Mergers: The Evanston Case," International Journal of the Economics of Business, (18)2011; 1 133-146.
- 17 Seth Freedman, Effects of Provider Consolidation in Healthcare: The Latest Research, November 21, 2014; for 2014, Lisa Phillips, 2015 Health Care Services Acquisition Report, Irving Levin Associates, March 31, 2015. <http://www.businesswire.com/news/home/20150331006369/en/Newly-Published-Report-2014-Health-Care-Services>
- 18 <http://emma.msrb.org/EA608904-EA476406-EA872921.pdf>
- 19 <http://emma.msrb.org/EA507875-EA395651-EA792545.pdf>
- 20 <http://emma.msrb.org/EA570061-ER555314-ER956343.pdf>
- 21 US Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, August 19, 2010. <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.
- 22 Horizontal Merger Guidelines

- 23 The Synthesis Project, Update: New Insights from Research Results, the Robert Wood Johnson Foundation, [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf73261](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261) accessed 5/18/2015
- 24 Universal Health Care Foundation of Connecticut, Hospital Consolidations and Conversions: A Review of the Literature, December, 2014. [http://universalhealthct.org/images/publications/Hospital\\_Consolidations\\_and\\_Conversions.pdf](http://universalhealthct.org/images/publications/Hospital_Consolidations_and_Conversions.pdf) p. 8
- 25 Examination of Health Care Cost Trends and Cost Drivers, Office of the Attorney General, June 22, 2001. <http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf>
- 26 Commonwealth v. Partners Healthcare System, Inc., & Others, Memorandum of Decision and Order on Motion for Joint Entry of Amended Final Judgement by Consent, SUCV2014-02033-BLS2, <http://www.mass.gov/ago/docs/press/2015/partners-memo-of-decision-and-order.pdf>
- 27 In the Matter of Evanston Northwestern Healthcare Corporation, Opinion of the Commission. Federal Trade Commission Docket No. 9315, August 6, 2007. <https://www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf> p.38.
- 28 Authors' transcription of Comptroller Lembo's oral remarks to the Bipartisan Roundtable on Hospitals and Healthcare, 12/18/2014
- 29 Clark Havighorst and Barak Richman, "The Provider Monopoly Problem in Health Care," *Oregon Law Review* 89:858, 3/31/2011. [http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2905&context=faculty\\_scholarship](http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2905&context=faculty_scholarship)
- 30 <http://www.nytimes.com/2013/12/17/us/benefits-questioned-in-tax-breaks-for-nonprofit-hospitals.html>
- 31 ", Kaiser Family Foundation, "Health Care Expenditures Per Capita by State of Residence". <http://kff.org/other/state-indicator/health-spending-per-capita/>
- 32 Centers for Medicare and Medicaid Services, "Total All-Payer State Estimates by State of Residence - Personal Health Care" <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/res-tables.pdf>
- 33 Medicare Readmission Penalties by Hospital, Year 4, Kaiser Health News, August 3, 2015. <http://khn.org/news/half-of-nations-hospitals-fail-again-to-escape-medicare-readmission-penalties/#state>
- 34 Medicare Readmission Penalties by Hospital, Year 4, Kaiser Health News, August 3, 2015. <http://cdn.kaiserhealthnews.org/attachments/MedicareReadmissionPenaltiesByHospital,Year4.pdf>
- 35 <https://data.medicare.gov/data/hospital-compare>
- 36 Matthew J. Austin, et al, "Safety in Numbers: The Development of the Leapfrog's Composite Patient Safety Score for U.S. Hospitals," *Journal of Patient Safety*, 2013; 9 (1-9). [http://www.hospitalsafetyscore.org/media/file/JournalofPatientSafety\\_HospitalSafetyScore.pdf](http://www.hospitalsafetyscore.org/media/file/JournalofPatientSafety_HospitalSafetyScore.pdf)
- 37 The Leapfrog Group "How Safe is Your Hospital?," state rankings, Fall 2015. <http://www.hospitalsafetyscore.org/your-hospitals-safety-score/state-rankings>, December 3, 2015
- 38 The Leapfrog Group "How Safe is Your Hospital?," rankings for Connecticut, <http://www.hospitalsafetyscore.org/December3>, 2015
- 39 Martin Gaynor and Robert Town, "The Impact of Hospital Consolidation - Update," Robert Wood Johnson Foundation, The Synthesis Project, June 2012, [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf73261](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261)
- 40 CGA 19a-639; Public Act 16-148 section 28(a)(11) and 28(a)(12).
- 41 US Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, August 19, 2010. <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>
- 42 Cf O'Brien and Wicklegren, "A Critical Analysis of Critical Loss," FTC, May 23, 2003; Frech, Langenfeld and McCluer, "Elzinga-Hogarty Tests and Alternative Approaches for Market Share Calculations in Hospital Markets," *Antitrust Law Journal* 2004; 3
- 43 See especially David Dranove and Andrew Sefkas, "The Revolution in Health Care Antitrust: New Methods and Provocative Implications," *The Milbank Quarterly*, 2009 Sep; 87(3): 607-632. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881459/#fn10>
- 44 Martin Gaynor, Samuel A. Kleiner, and William B. Vogt, "A Structural Approach to Market Definition with an Application to the Hospital Industry" *The Journal of Industrial Economics*, June 2013, 61(2); 243-289
- 45 Kenneth Elzinga, Anthony Swisher, "Limits of the Elzinga-Hogarty Test in Hospital Mergers: The Evanston Case," *International Journal of the Economics of Business*, (18)2011; 1133-146. <https://ideas.repec.org/a/taf/ijecbs/v18y2011i1p133-146.html>
- 46 Dranove and Sefkas, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881459/#fn10>
- 47 Gaynor, et al.
- 48 Kenneth Elzinga, Anthony Swisher, "Limits of the Elzinga-Hogarty Test in Hospital Mergers: The Evanston Case," *International Journal of the Economics of Business*, (18)2011; 1133-146. <https://ideas.repec.org/a/taf/ijecbs/v18y2011i1p133-146.html>



## **EXHIBIT 5**

## **Exhibit Two**

### **Higher Cost but No Higher Quality: Hospital-Owned Physician Groups, Academic Medical Centers**

Baker, L., et al, "Physician Practice Competition and Prices Paid by Private Insurers for Office Visits," *JAMA*, October 22/29, 2014, 312(16):1653-1662

Berenson, R., et al, "Unchecked Provider Clout in California Foreshadows Challenges To Health Reform," *Health Affairs*, 29, No. 4 (2010): 699-705

Burns, L., et al, Horizontal and Vertical Integration of Physicians: A Tale of Two Tails, Annual Review of Health Care Management: Revisiting the Evolution of Health Systems Organization, *Advances in Health Care Management*, Volume 15, 39-117, 2013

Carlin, C., et al, "Changes in Quality of Health Care Delivery after Vertical Integration," *Health Services Research*, 50:4, August 2015

Casalino, L., "The Federal Trade Commission, Clinical Integration, and the Organization of Physician Practice," *Journal of Health Politics, Policy and Law*, Vol. 31, No. 3, June 2006

Casalino, L., et al, "Small Primary Care Physician Practices Have Low Rates of Preventable Hospital Admissions," *Health Affairs*, 33, No. 9 (2014)

Frakt, A., "The Downside of Merging Doctors and Hospitals," *The New York Times*, June 13, 2016

Girod, C., et al, "2016 Milliman Medical Index: Healthcare costs for the typical American family will exceed \$25,000 in 2016. Who cooked up this expensive recipe?" Milliman, May 24, 2016

Goldsmith, J., et al, "Integrated Delivery Networks: In Search of Benefits and Market Effects," National Academy of Social Insurance, February 2015

Harris, G., "More Doctors Giving Up Private Practices," *The New York Times*, March 25, 2010

HIS Talk, "Epic: The Cold Hard Facts," Healthcare IT News & Opinion, February 29, 2016

Kirchhoff, S., "Physician Practices: Background, Organization, and Market Consolidation," Congressional Research Service, R42880, January 2, 2013

Kocher, R. and N. Sahni, "Hospitals' Race to Employ Physicians – The Logic behind a Money-Losing Proposition," *The New England Journal of Medicine*, 364:19, May 12, 2011

Laugesen, M., and S. Glied, "Higher Fees Paid to US Physicians Drive Higher Spending For Physician Services Compared To Other Countries," *Health Affairs*, 30, No. 9 (2011); 1647-1656

Massachusetts Health Policy Commission, Community Hospitals at a Crossroads, February 24, 2016

McWilliams, J., et al, "Early Performance of Accountable Care Organizations in Medicare," *The New England Journal of Medicine*, April 13, 2016

Neprash, H., et al, "Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices," *JAMA Internal Medicine*, 2015:175(12):1932-1939

Pineault, R., et al, "Why Is Bigger Not Always Better in Primary Health Care Practices? The Role of Mediating Organizational Factors," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 2016, 1-9

Robinson, J. and K. Miller, "Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California," *JAMA*, October 22/29, 2014;312(16):1663-1669

Rosin, T., "Moody's: High rate of physician employment linked to lower profitability," *Becker's Hospital Review*, December 9, 2015

Sun, E. and L. Baker, "Concentration In Orthopedic Markets Was Associated With A 7 Percent Increase In Physician Fees For Total Knee Replacements," *Health Affairs*, 34, No. 6 (2015): 916-921

Watson, S., et al, "Owned vertical integration and health care: Promise and performance," *Health Care Management Review*, 1996, 21(1), 83-92

## **EXHIBIT 6**

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# Community Hospitals at a Crossroads

## Findings from an Examination of the Massachusetts Health Care System

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## Background of the report: building a path to a thriving, community-based health care system

### The need for the report

- Hospitals and health systems across the country are facing **unprecedented impetus to adapt** to new care delivery approaches and value-based payments
- Community hospitals are under particular pressure to change and are uniquely challenged **by current market and utilization trends**, as evidenced by a number of recent consolidations, closures, and conversions in Massachusetts
- The state is pursuing sweeping delivery system transformation to achieve shared cost containment goals, and effective, **action-oriented planning is necessary**

### Objectives of the report

- To understand and describe the **current state of and challenges facing community hospitals**
- To examine the implications of **market dynamics** that can lead to elimination or reduction of community hospital services
- **To identify challenges to and opportunities for transformation** in community hospitals
- To **encourage proactive planning** to ensure sustainable access to high-quality and efficient care and catalyze a **multi-stakeholder dialogue** about the future of community health systems

“ I don’t see any future for community hospitals...I think there’s a **fantastic future for community health systems**. If small stand-alone hospitals are only doing what hospitals have done historically, I don’t see much of a future for that. But I see a **phenomenal future** for health systems with a strong community hospital that breaks the mold [of patient care].”

COMMUNITY HOSPITAL CEO

## Key themes of the report

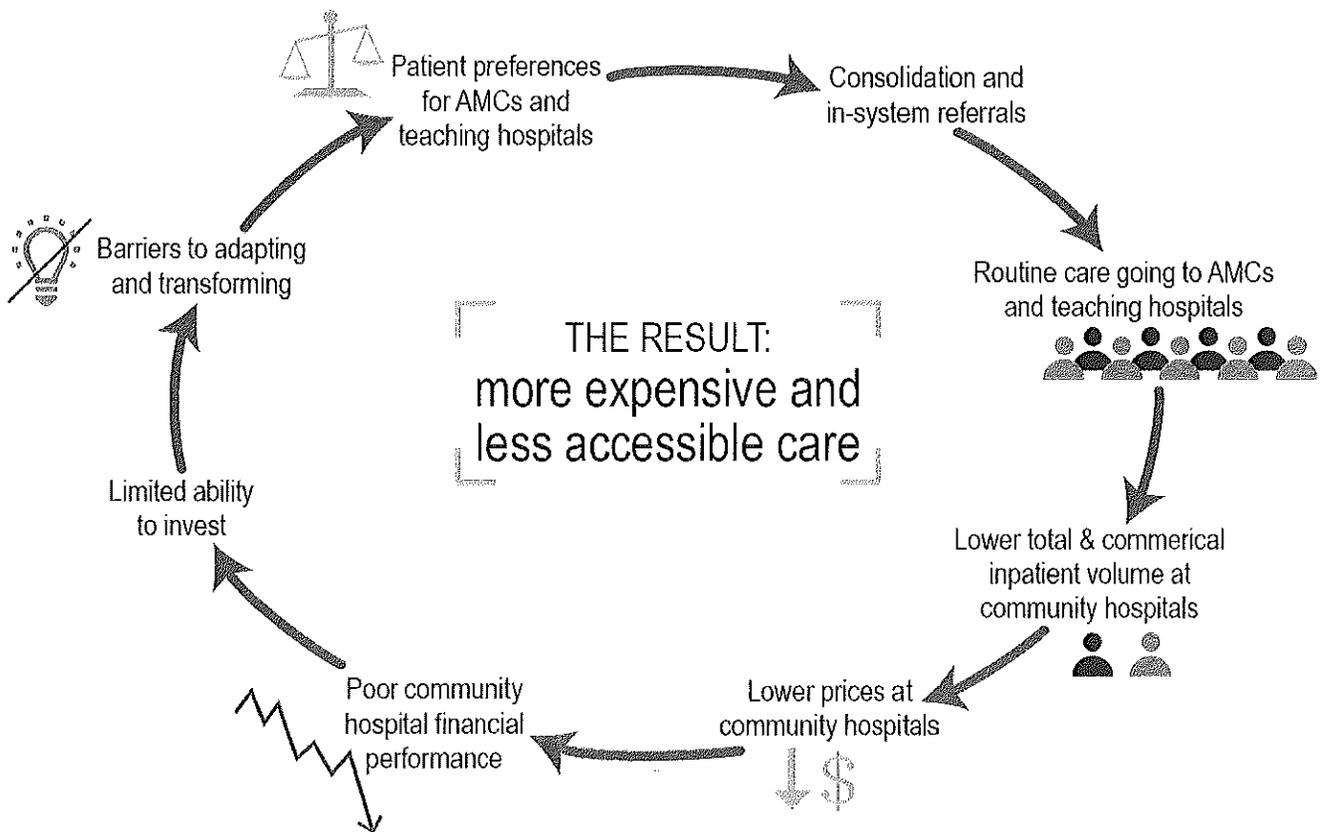
Community hospitals provide a unique value to the Massachusetts health care system

- While individual characteristics vary, as a cohort community hospitals play a critical role in care for publicly insured patients; providing local, community-based access; and, in particular, meeting behavioral health needs
- Community hospitals provide more than half of all inpatient discharges and more than 2/3 of all ED visits statewide
- Community hospitals generally provide high-quality health care at a low-cost, providing a direct benefit to the consumers and employers who ultimately bear the costs of the health care system

The traditional role and operational model for many community hospitals faces tremendous challenges

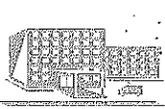
- Community hospitals generally have worse financial status, older facilities, and lower average occupancy rates than AMCs and teaching hospitals
- Many hospitals face barriers to transformation:
  - Consolidation of acute and physicians services into major health systems
  - Routine care going to AMCs and teaching hospitals
  - Lower commercial volume and prices leading to lack of resources for reinvestment
  - Difficulty participating in current alternative payment models

## Community hospitals face self-reinforcing challenges that lead to more expensive and less accessible care



# Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System

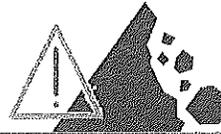
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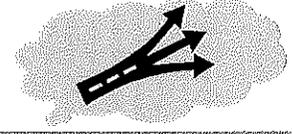
Overview



Value



Challenges

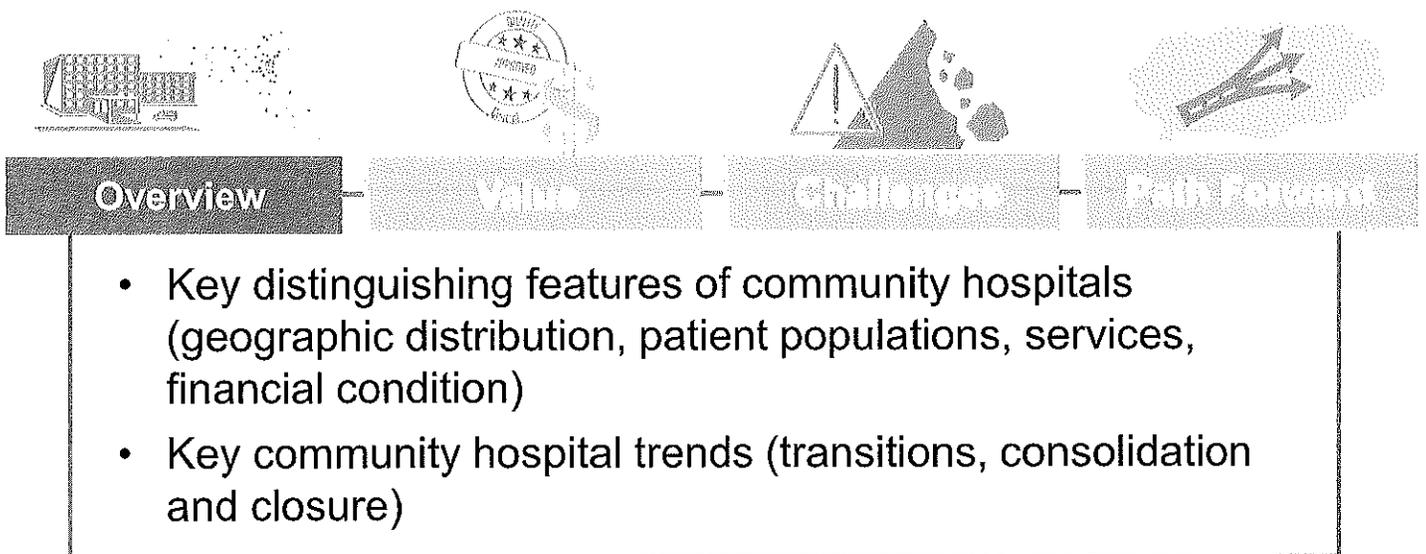


Path Forward

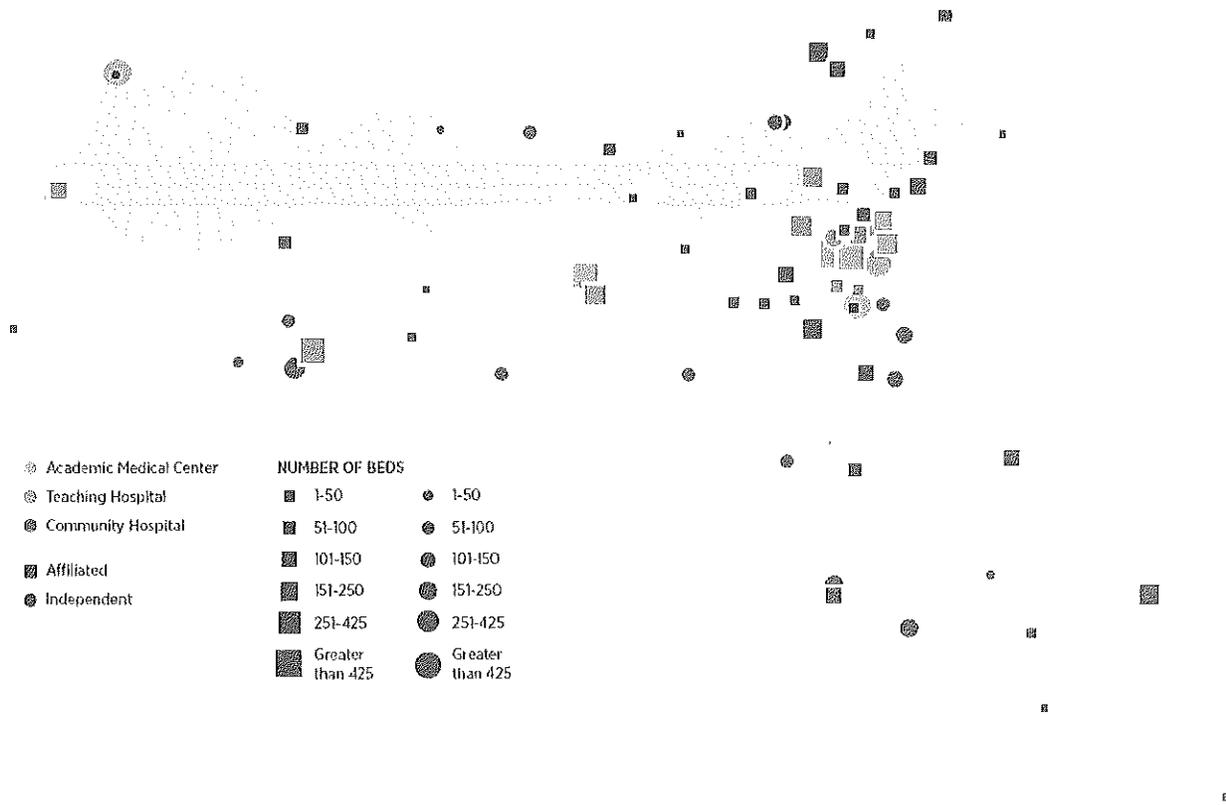
- An **overview** of community hospitals in Massachusetts
- The **value** of community hospitals to the health care system
- **Challenges** facing community hospitals
- The **path** to a thriving community-based health care system

## An overview of community hospitals in Massachusetts

---



# Community hospitals serve all parts of the Commonwealth



Source: HPC analysis of CHIA Hosp. Profiles, 2013

## Community hospitals at a glance



**7,518 | 52%**  
more than half of beds statewide  
(19 – 556)

**417,275 | 51.3%**  
more than half of discharges statewide  
(556 – 40,303)

**5.8 | 42**  
million | %  
outpatient visits

**1.9 | 65**  
million | %  
2/3 of ED visits  
(10,329 – 155,236)

**64% | 84%**  
community hospitals | AMCs  
low occupancy rate  
(29% – 74%)

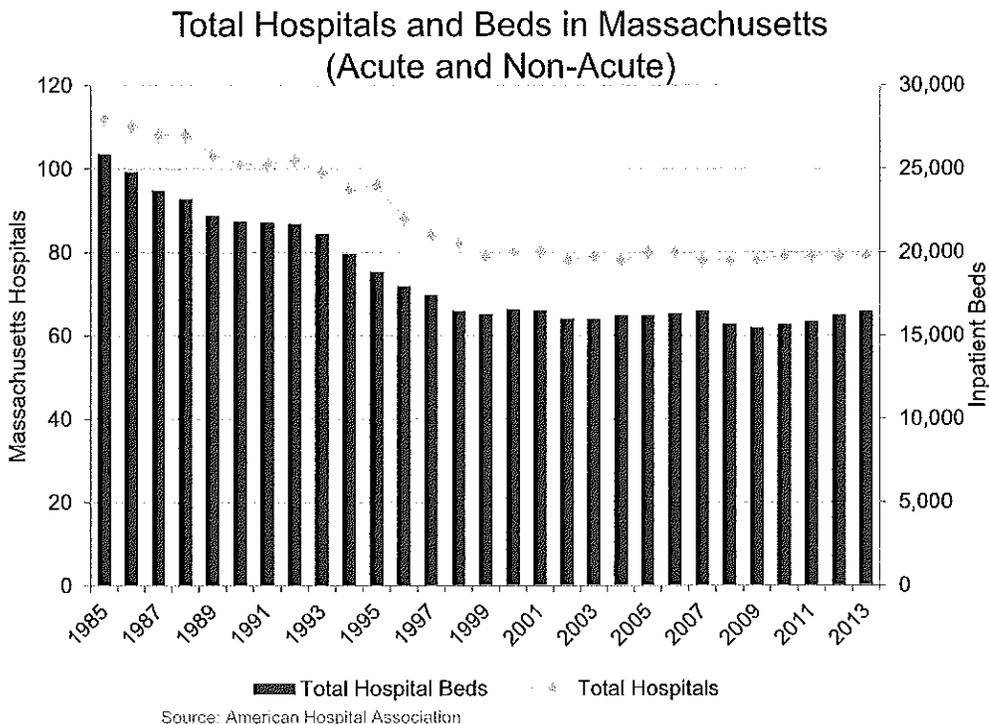
**0.8 | 1.33**  
community hospitals | AMCs  
low case mix index  
(0.60 – 0.93)

**9.3 | +11**  
minutes | minutes  
local patients drive 9.3  
minutes on average to  
community hospitals;  
they would drive 11  
minutes more on  
average to get to the  
next closest hospital

**Older age of plant**  
Community hospitals generally  
have older physical plants than  
AMCs or teaching hospitals

**Higher public payer mix**  
Community hospitals generally  
have disproportionately high  
shares of Medicaid and Medicare  
patients

## Consolidations and closures over the last 30 years have contributed to a dynamic hospital market in Massachusetts



**Recent Conversions in Massachusetts Have Had Varied Impact**

*North Adams Regional Hospital*

*Steward Quincy Medical Center*

**Two Conversions Are Being Currently Contemplated**

*Baystate Mary Lane Hospital*

*Partners North Shore Medical Center – Union Hospital*

Hospital-related Material Change Notices since 2013

**11**

mergers or acquisitions of one hospital by another

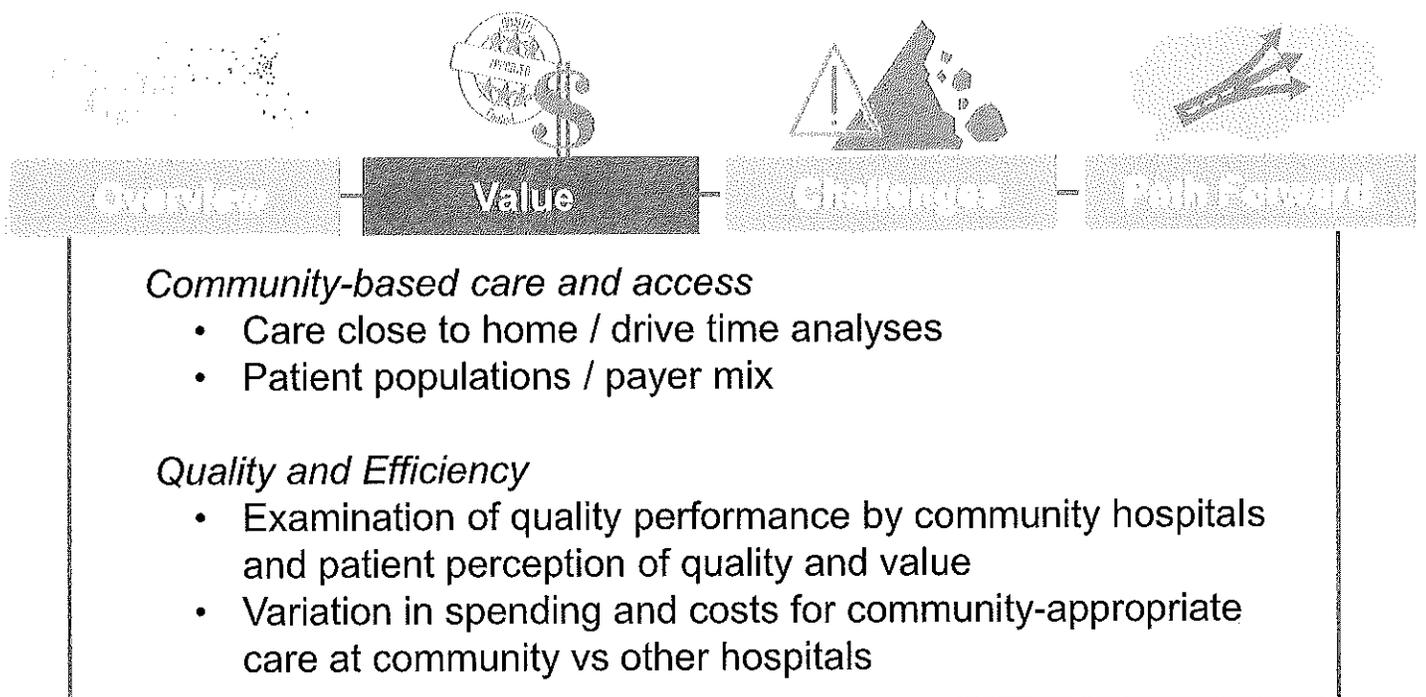
**16**

new contracting or clinical relationships between hospitals

**5**

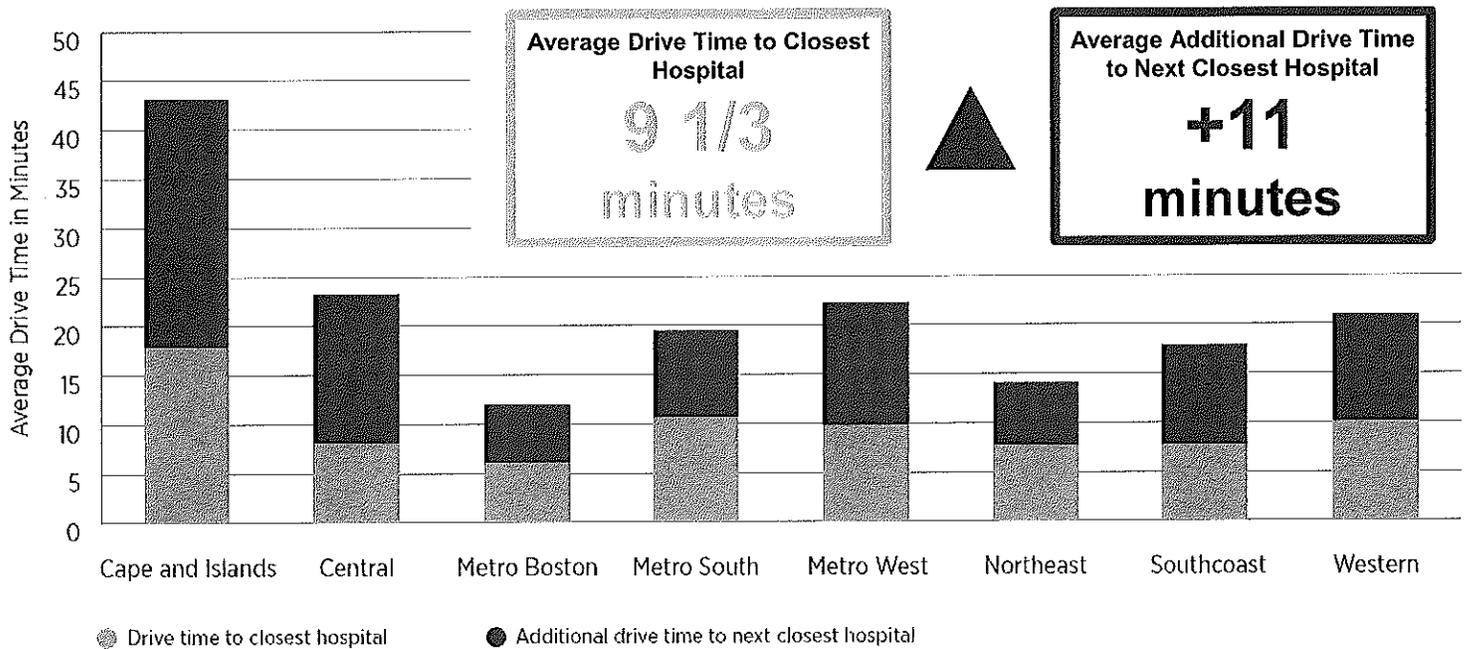
hospitals acquiring physician groups

## The value of community hospitals to the health care system



## Community hospitals provide local access for local patients

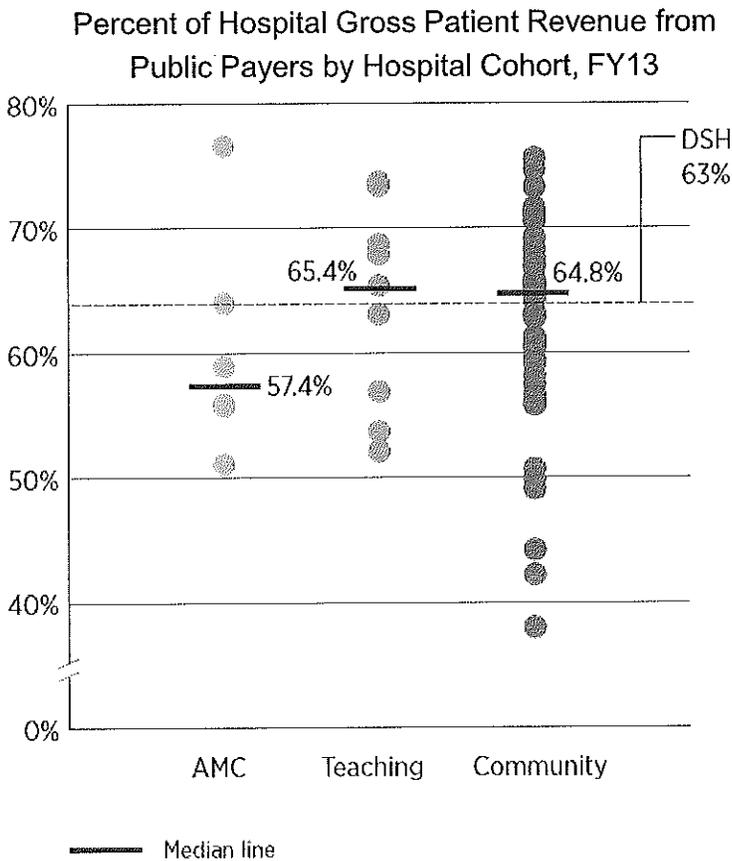
**Average Drive Times for Patients Using Their Local Community Hospital**  
*Analysis of patients who use their closest community hospital as a usual site of care*



Source: HPC analysis of MHDC 2013 discharge data.

Notes: Drive times may underrepresent travel time and travel time differentials for populations relying on public modes of transportation. The Cape and Islands region includes only Falmouth and Cape Cod Hospital for the purposes of this analysis, since measuring drive times for Hospitals on Nantucket and Martha's Vineyard islands would not be meaningful.

**Community hospitals serve a high proportion of vulnerable populations for whom access to care is often difficult, such as elders, individuals with disabilities, and individuals with low incomes**

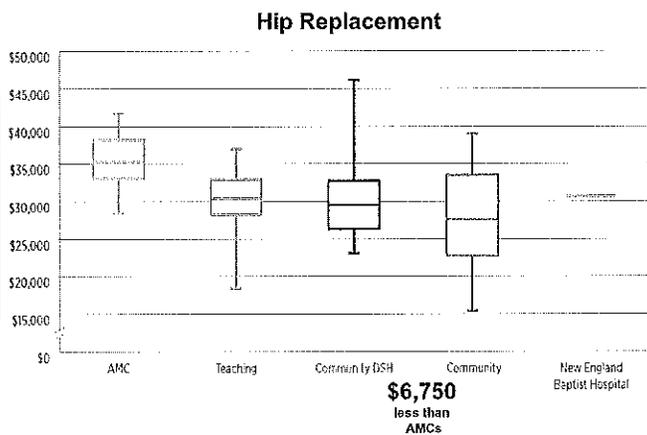


“  
*The community hospital plays a role as a cultural and social staple for the community that it serves. It’s the place you’re born at, that you grow up with, and get most of your basic care at...The state should ensure access to community-based, cost-effective care*  
 ”  
 MASSACHUSETTS STATE LEGISLATOR

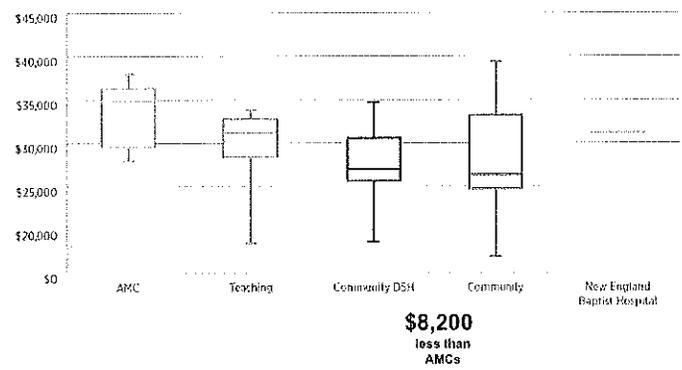
Source: HPC analysis of CHHA Acute Hosp. Databook, supra footnote 11, at Appendix D.  
 Note: Public payers include Medicaid and Medicaid/Massal health fee for service and managed care plans, Health Safety Net payments, and charges designated by hospitals as “other government.”

## Spending at community hospitals is generally lower for low-acuity orthopedic and maternity care and is not associated with any difference in quality

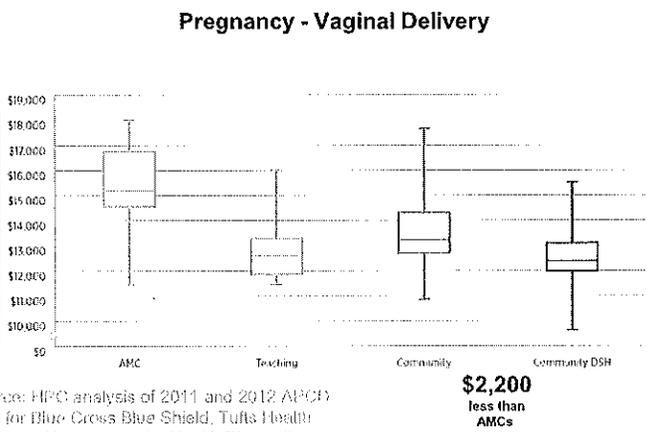
Orthopedics



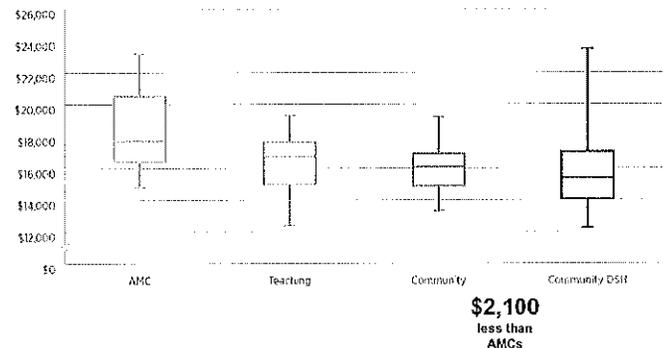
### Knee Replacement



Deliveries



### Pregnancy - Caesarian Delivery

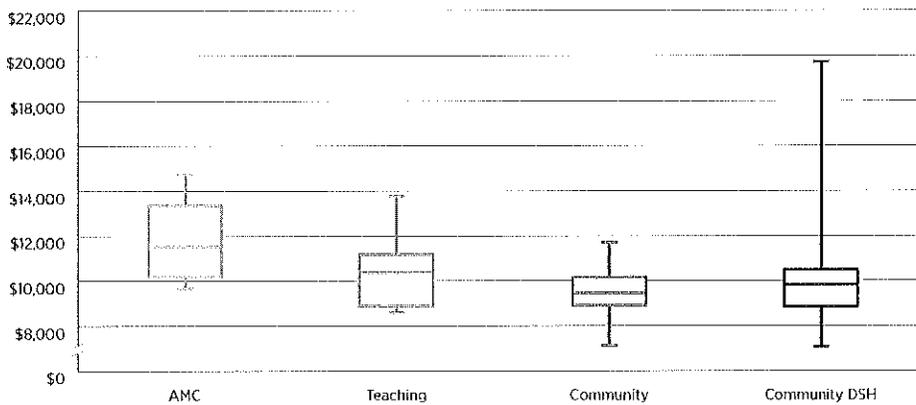


Source: HPC analysis of 2011 and 2012 APCD data for Blue Cross Blue Shield, Tufts Health Plan, and Harvard Pilgrim Health Plan patients

We found no correlation between hospital cost and quality. Each group of hospitals has higher and lower quality performers but no cohort outperforms any other overall.

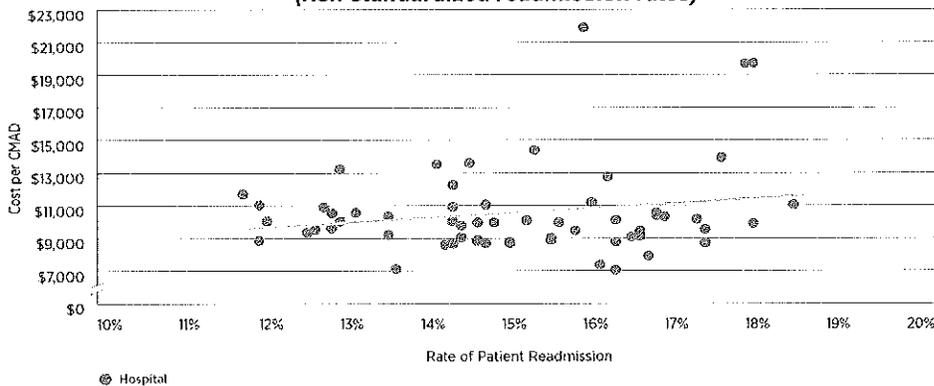
## Most community hospitals provide care at a lower cost per discharge, without significant differences in quality

Hospital costs per case mix adjusted discharge, by cohort



Source: HPC analysis of CHA Hosp. Profiles, 2013

Costs per CMAD are not correlated with lower quality (risk-standardized readmission rates)



Source: HPC analysis of CHA Hosp. Profiles, 2013; CHA Focus on Provider Quality Databook, Jan 2015

On average, **community hospital costs are nearly \$1,500 less per inpatient stay** as compared to AMCs, although there is some variation among the hospitals in each group

Although costs per discharge for community hospitals have grown at a slightly higher rate than those for AMCs, the gap between AMC and community hospital costs has not substantially changed

Reasons for differences in efficiency likely vary, and may include service offerings, support for teaching programs, and, particularly for community hospitals, the pressure of tight operating margins

## **Increases in health care spending on inpatient care would result from the closure of most community hospitals, due to commercial price variation**

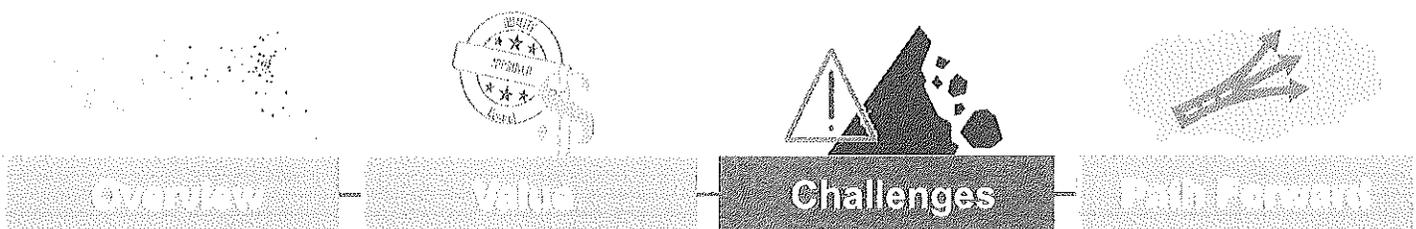
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The HPC modeled where patients would likely seek care if community hospitals were to close and to estimate commercial spending impact.

- In most cases, a community hospital closure would **increase annual spending on inpatient care**
- **The majority of these increases would be less than \$4 million**, due to the disproportionately low volume of commercially insured patients at many community hospitals
- Spending would increase by **more than \$5 million for seven community hospitals**
  - The closure of **Lowell General Hospital** would cause the greatest increase: **over \$16 million**
- Spending would actually **decrease** in the event of the closure of any of eight community hospitals, primarily those with higher relative prices
  - The greatest decreases in spending would result from **South Shore Hospital (\$4.2 million annually)** or **Cooley-Dickinson Hospital (\$2.8 million annually)** becoming unavailable

## Challenges facing community hospitals

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- Referral patterns and consumer perceptions
- Consolidation of hospitals and primary care providers with large systems
- Decreasing inpatient volume and misalignment of supply and demand for hospital services (current and future)
- Payer mix, service mix, and variation in prices
- Competition from non-traditional market entrants
- Implications if current trends continue

## Driven by referrals and perceived quality, many patients are choosing AMCs and teaching hospitals over community hospitals for routine care

HPC commissioned qualitative analyses (8 focus groups in four regions of the state) by Tufts University to better understand what drives consumer choices of hospitals

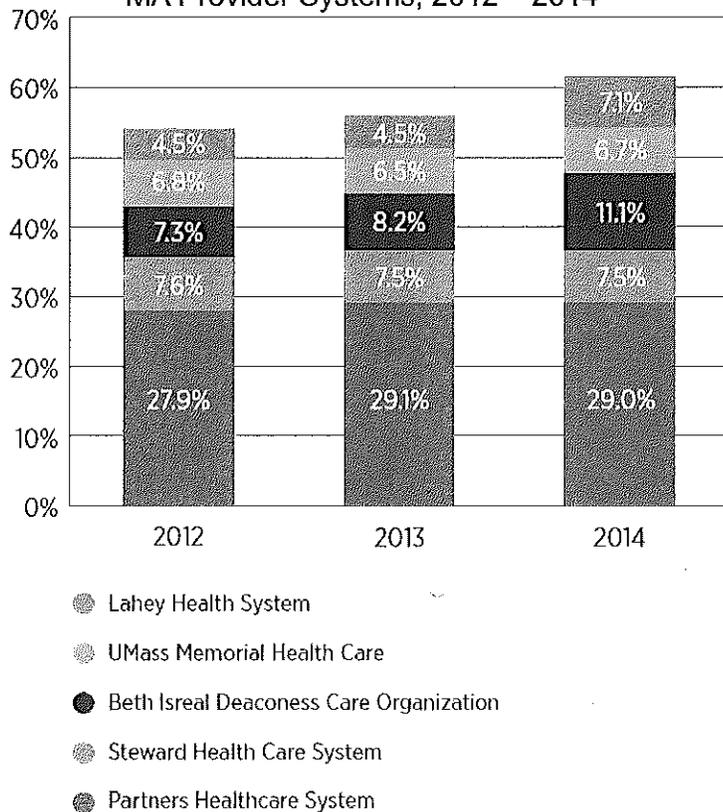
*“ I guess it might be something in your psyche because I like brand-name products. So maybe that’s what drives me to Boston. ”*

FOCUS GROUP PARTICIPANT

- Patients often mentioned that **they did not feel that they had a choice** of hospitals because their primary care provider or insurance plan determined where they could go for care
- **Two in three Massachusetts adults** have **never sought information** about the safety or quality of medical care, instead valuing the experiences of peers and recommendations of their primary care physicians.
- Many patients stated that they felt that **AMCs and teaching hospitals were better** because they had the best physicians, including doctors who had graduated from medical schools they considered prestigious. Many patients indicated that they **believed AMCs and teaching hospitals had developed reputable brands**
- Some patients stated that the **higher costs of AMCs and teaching hospitals must mean that they provided better quality**, regardless of what quality data showed. Many also said they wanted to “get their money’s worth” from the health care system after investing heavily in health insurance coverage. Others reported that **cost is not a factor when it comes to health**

## Increased consolidation of providers has driven referrals to large provider systems, including their anchor AMCs and teaching hospitals

Percent of Statewide Inpatient Discharges at the Five Largest MA Provider Systems, 2012 – 2014



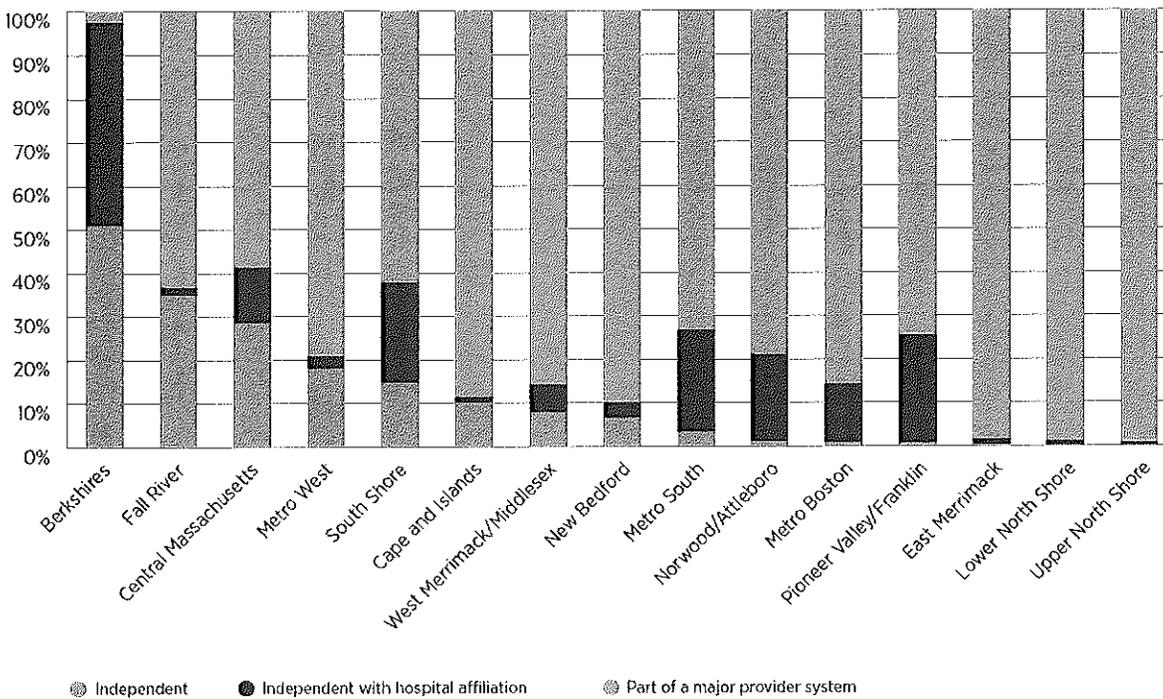
“Retaining primary care staff and specialists, ‘the gatekeepers to volume’ is challenging. Providers continue to leave for big-name systems and AMCs – and patients follow”

Synthesis of  
MASSACHUSETTS PROVIDER INTERVIEWS

Source: HPC analysis of MADC discharge data.  
Note: Systems shown have the highest total net patient service revenue among providers in the Commonwealth.

## Most primary care services are now delivered by physicians affiliated with major provider systems

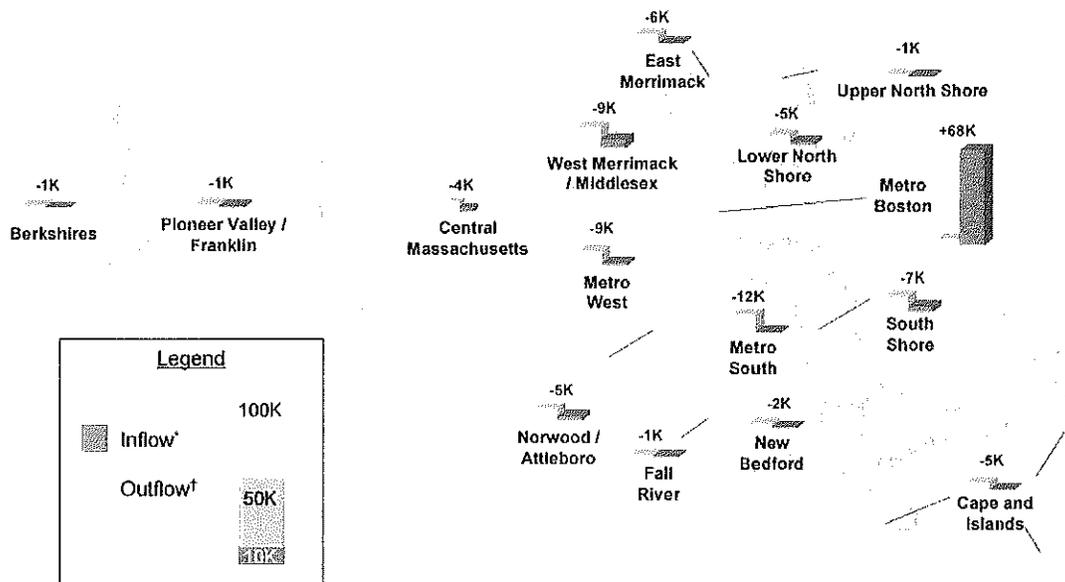
Percentage of Primary Care Services Delivered by Independent versus Affiliated Physicians by Region, 2012



Percentage of PCPs Affiliated with Eight Largest Systems Grew from **62%** in 2008 to **76%** in 2014

Source: HPC analysis of 2012 APCD claims for BCBS and HPHIC; 2012 MHOP Master Provider Database.  
 Note: For the purposes of this analysis, major provider systems include Atrius Health, Baycare Health Partners, Beth Israel Deaconess Care Organization, Lincy Health System, New England Quality Alliance, Partners Community Health Care, Steward Health Care Network, and UMass Memorial Health Care. PCPs affiliated with multiple systems are counted as being part of a major provider system.

## Most Massachusetts residents who leave their home region for inpatient care seek care in Metro Boston at higher-priced hospitals



Commercially insured patients are most likely to outmigrate to Boston

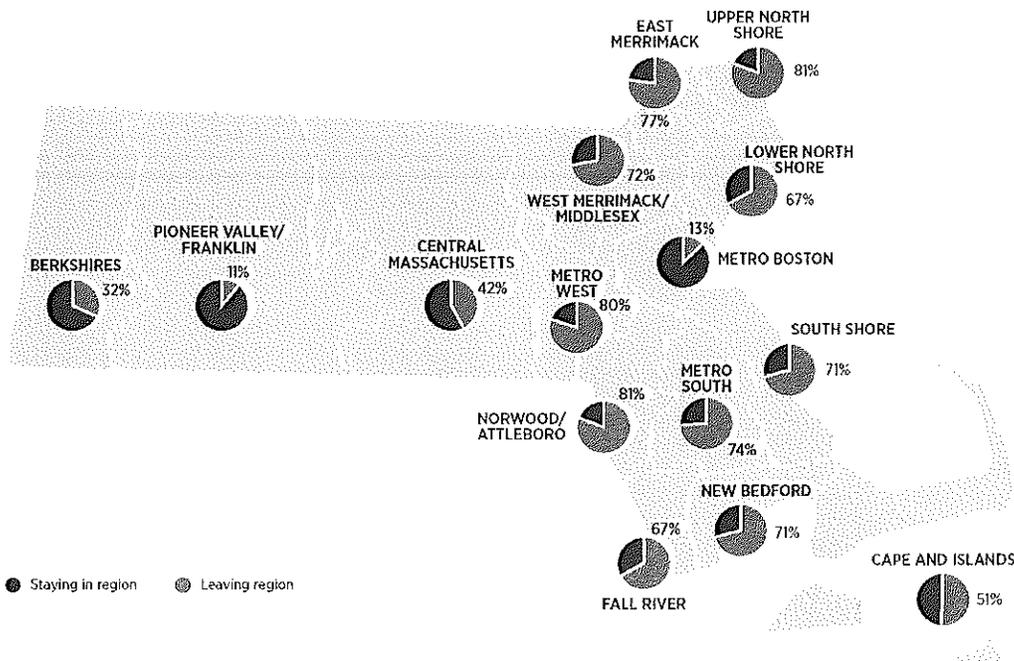
Patients from higher income regions are more likely to outmigrate to Boston

Trends hold across a variety of service lines, including deliveries

\* Inpatient care at hospitals in region for patients who reside outside of region  
 † Inpatient care at hospitals outside of region for patients who reside in region  
 Source: HPC Cost Trends Report, July 2014 Supplement

## Large proportions of patients leave their home regions for deliveries

Percentage of Patients Leaving their Home Regions for Community-Appropriate Deliveries, 2013



**74% → 50%**

change in proportion of all births in community hospitals from 1992 – 2012<sup>1</sup>

<sup>1</sup> Institute for Health Care Equality and Affordability League, *Healthcare Equity in Massachusetts: Breaking the Victim Cycle*

**6** hospitals saw **53%**

of low risk births in 2011-2012. 5 of these hospitals had above average delivery costs.

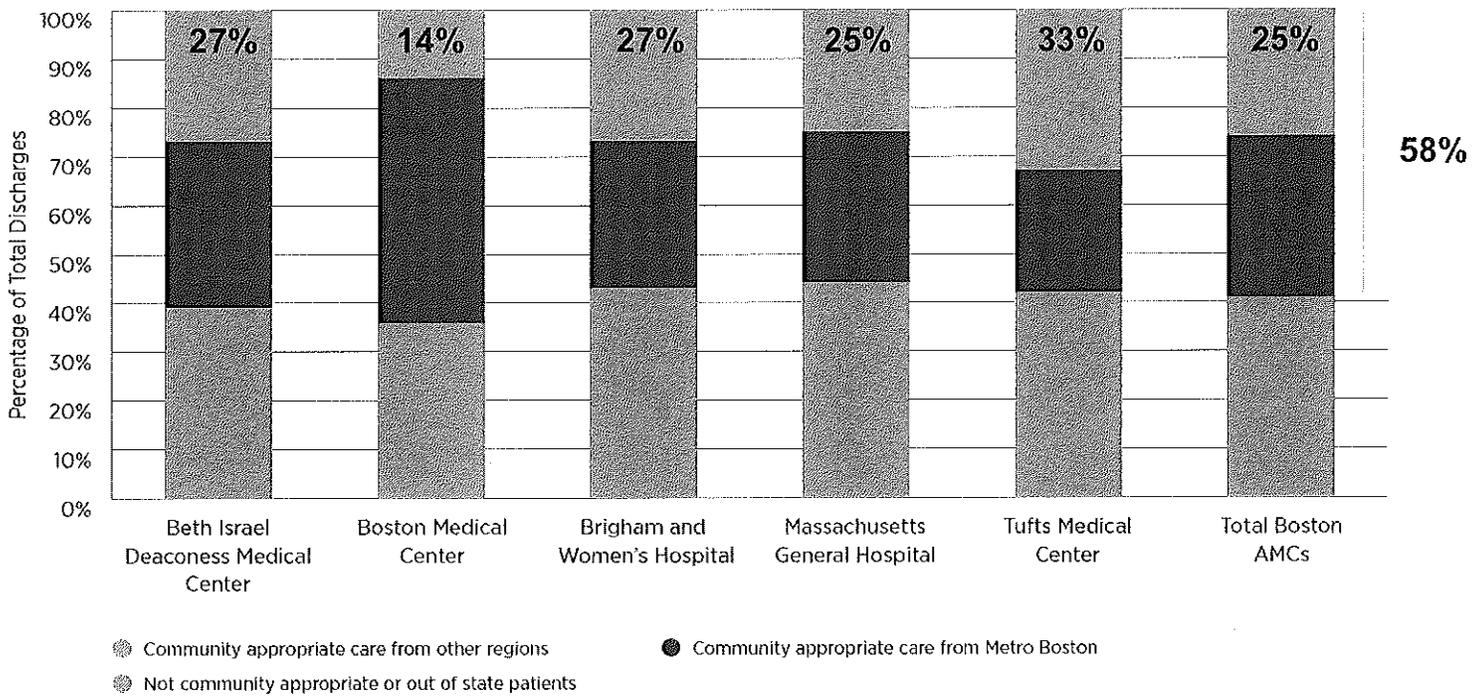
Massachusetts General Hospital and Brigham and Women's Hospital have highest costs statewide for maternity care and saw

**20%**

of all low-risk births in the state

## A significant portion of the care provided at Boston AMCs could be appropriately provided in a community hospital setting

Inpatient Discharges at Boston AMCs, 2013  
Community-Appropriate Volume as a Proportion of Total Volume

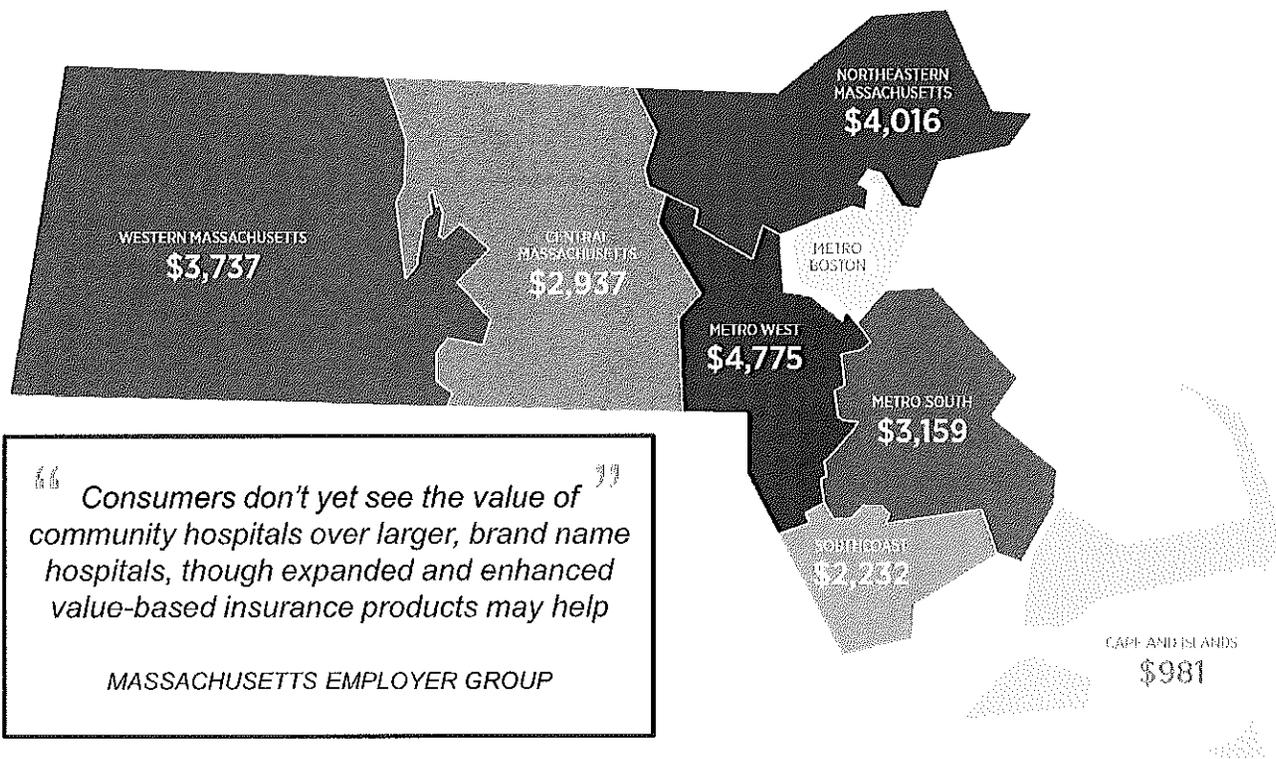


Source: HMC analysis of MEDC 2013 discharge data.

Note: Figure shows proportion of volume at each hospital, and does not reflect differences in total volume amongst the hospitals shown. Estimates of the volume of community appropriate care provided at AMCs are conservative as community appropriate care is defined to exclude cases which some community hospitals could effectively handle but that many community hospitals could not.

## Patient migration to Boston increases health care spending

Average Additional Case-Mix Adjusted Cost for Each Commercial Discharge at a Boston Hospital Rather Than a Local Hospital, by Region of Patient Origin

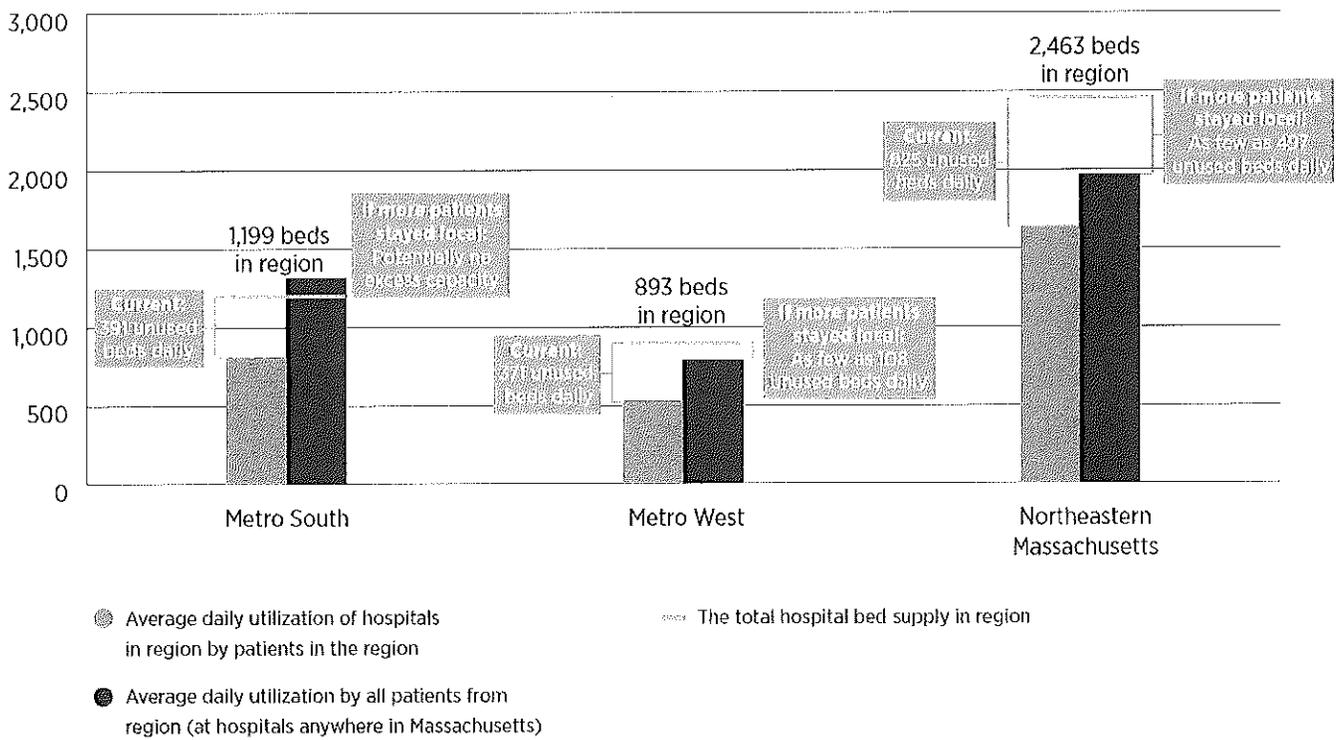


Source: HPC analysis of MHDC 2013 discharge data and raw CHIA relative price data.

Note: Figures shown are differences in average commercial revenue per CMAD for hospitals in each region compared to those in Metro Boston, adjusted for payer mix.

# In most regions, hospitals have the capacity to treat more patients locally

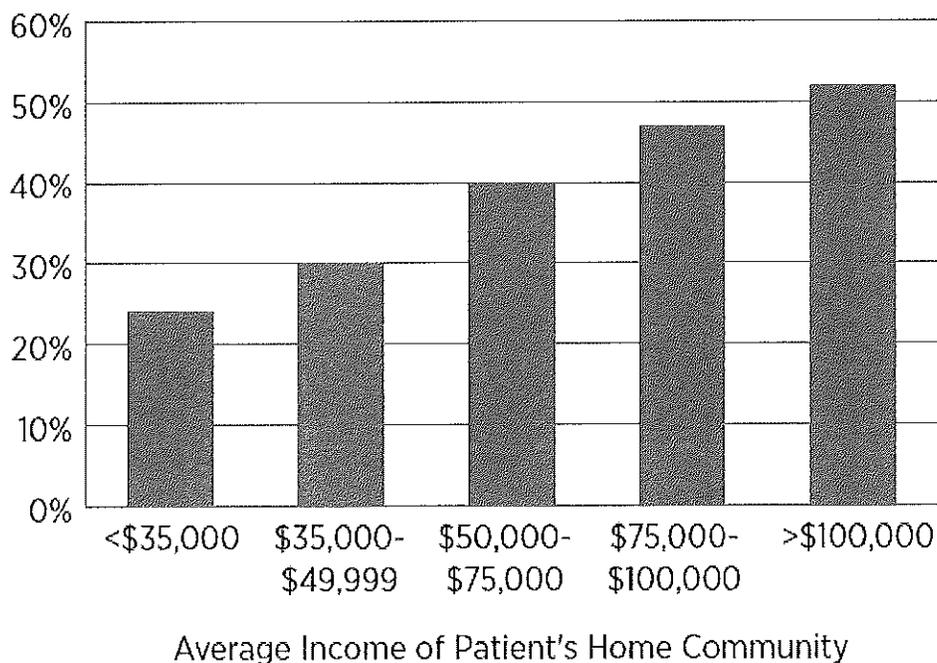
Average Use of Hospitals in Regions Neighboring Metro Boston versus Average Use of All Hospitals by Region Residents, 2013



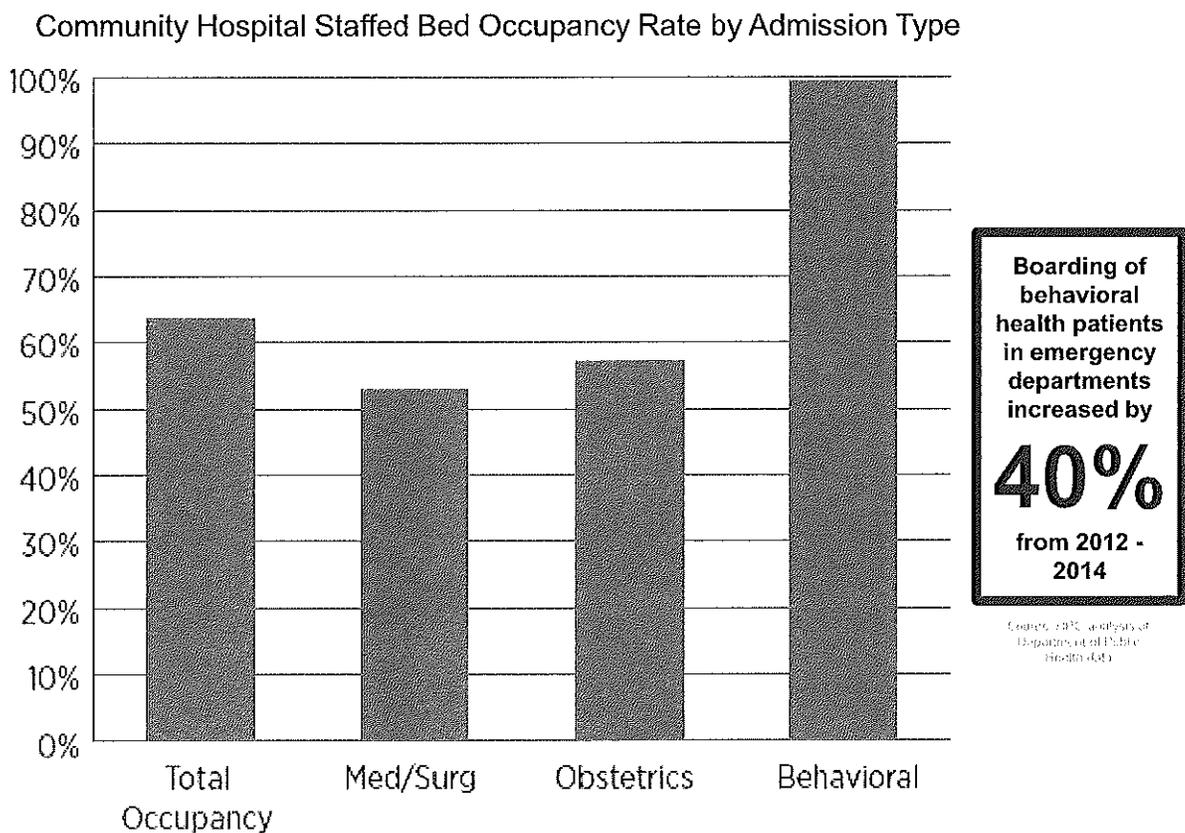
Source: HPC analysis of MHDG 2013 discharge data and CHA hospital 403 reports.

## Commercially insured patients and patients from wealthier communities are more likely to migrate to Boston for care

Probability that Patient will Travel Outside of His/Her Home Region for Inpatient Care, Based on Home Community Income



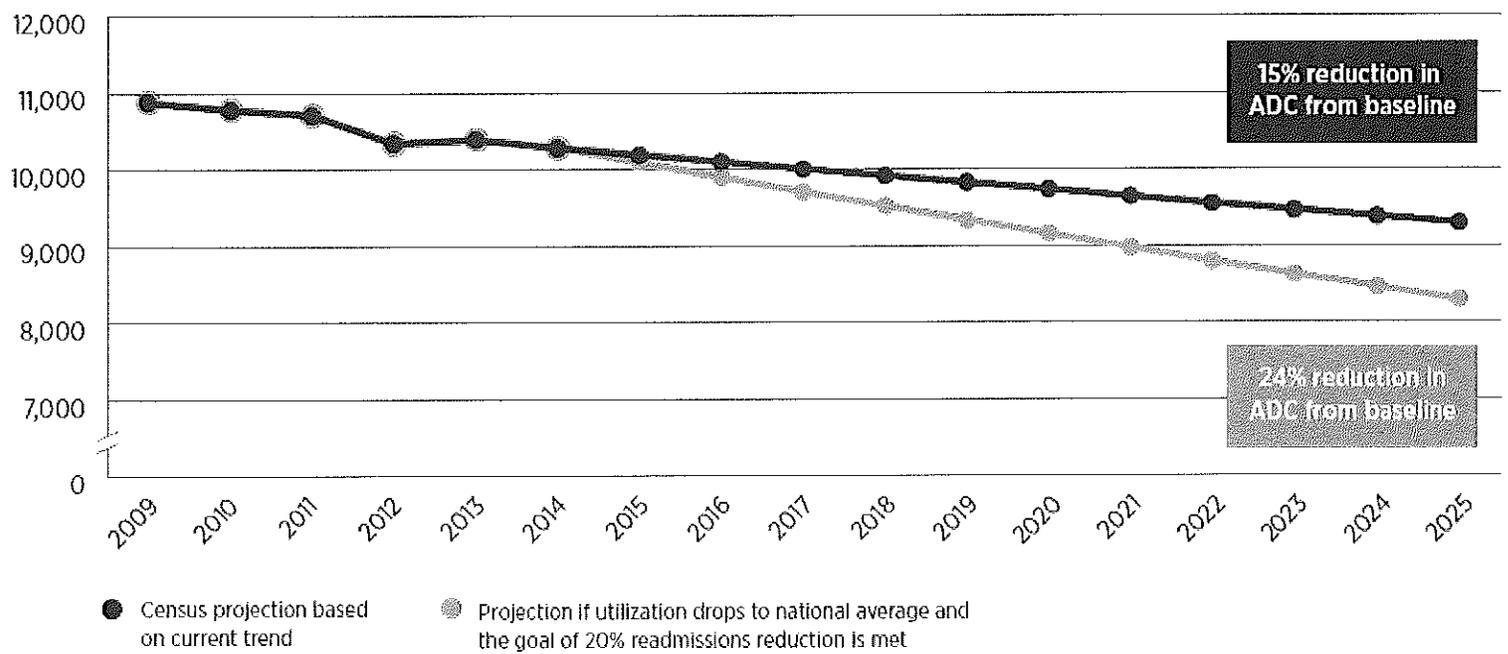
**In addition to lowering volume, migration results in community hospitals seeing larger proportions of government payer patients and those seeking low-margin services**



Source: CDC Analysis of Department of Public Health Data

## Declining inpatient utilization poses a structural challenge to the traditional community hospital model

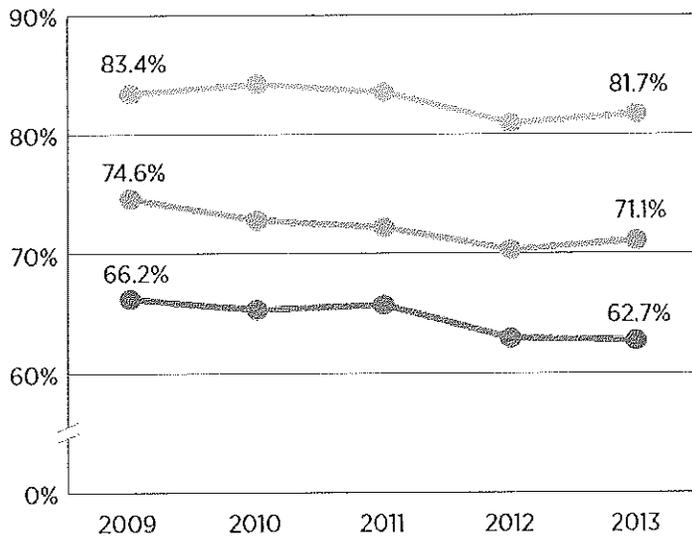
Total Average Daily Census Projections for all Massachusetts Hospitals, 2009 - 2025



Source: Health Policy Commission, based on data from the Massachusetts Department of Health, "Massachusetts Hospital Industry Statistics, 2009-2011." The chart shows a steady decline in the total average daily census (ADC) from 2009 to 2025. The current trend projection shows a 15% reduction in ADC from the 2009 baseline by 2025. The projection assuming a 20% readmissions reduction goal is met shows a 24% reduction in ADC from the 2009 baseline by 2025.

## Community hospitals have lower average occupancy, and declining hospital utilization has further impacted occupancy rates

Total Inpatient Occupancy by Hospital Cohort,  
2009 – 2013



- AMCs
- Teaching Hospitals
- Community Hospitals

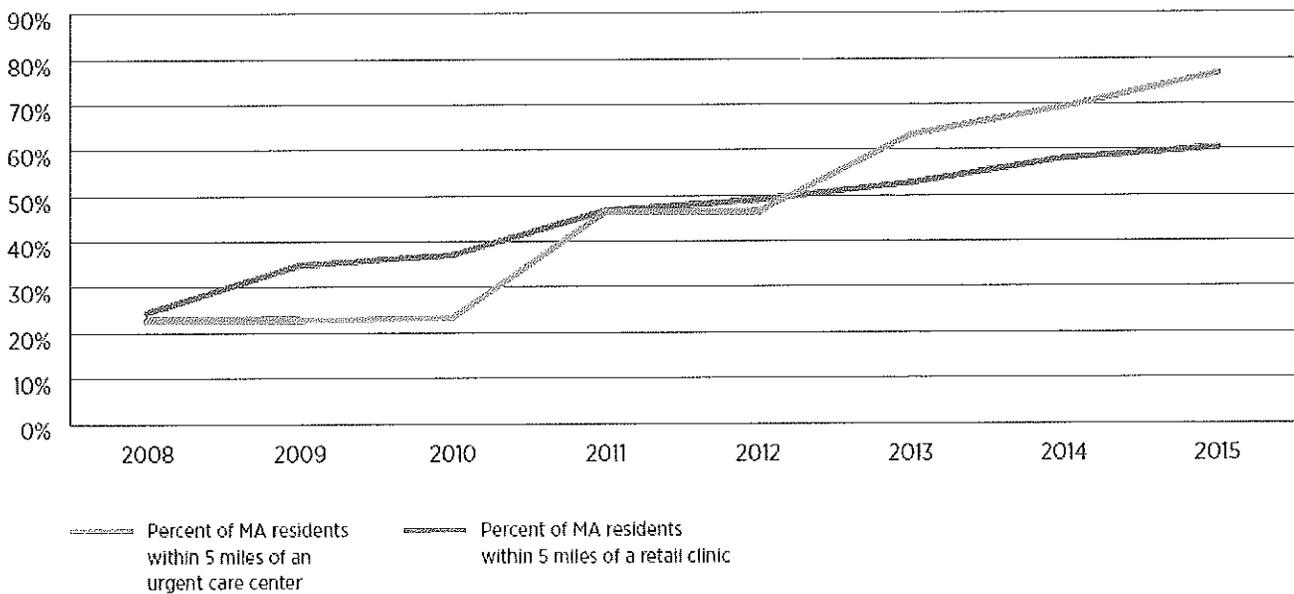
Source: HPC analysis of HCUP data and other data from the American Hospital Association. Note: The data on occupancy rates are based on the average annual occupancy rate. As a result of hospital consolidation, the number of hospitals in each cohort has decreased over the period of the study. The data on occupancy rates are based on the average annual occupancy rate.

If current trend continues, community hospitals could face average occupancy rates of less than

**50%** within  
**10 years**

## Declining inpatient utilization is driven in part by growing accessibility of non-hospital health care providers

Percent of MA Residents Living Within 5 Miles of Retail Clinics and Urgent Care Centers



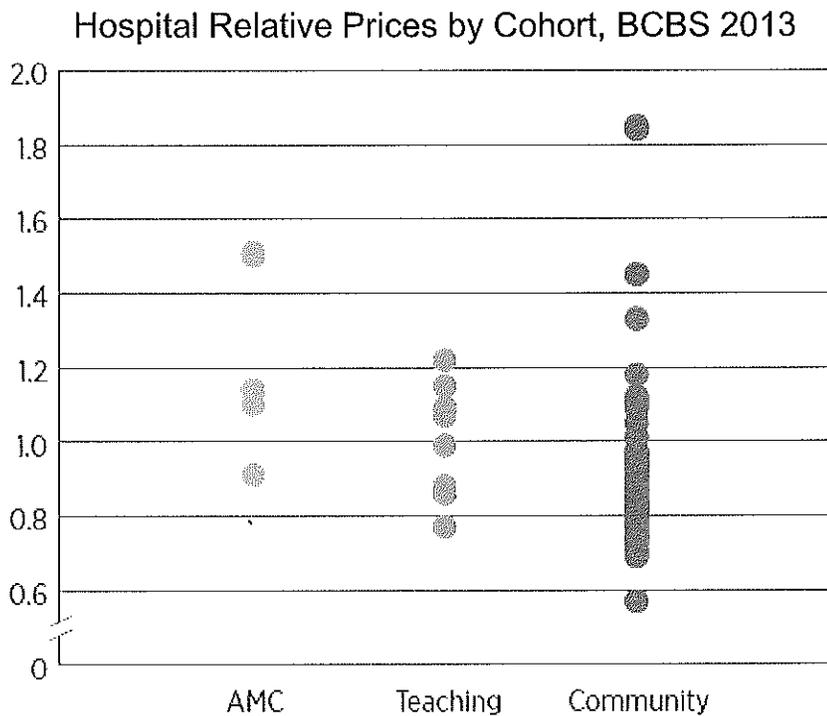
Source: Massachusetts Department of Health, "Retail Clinics and Urgent Care Centers: A Review of the Current Landscape," 2015

*“When [they] opened an urgent care center down the block we saw an immediate and precipitous decline in ED volume, especially the commercially insured, non-acute patients. It might be good for costs in the short term, but if we cannot keep our ED open, then what’s next?”*

COMMUNITY HOSPITAL CHIEF STRATEGY OFFICER



## Community hospitals tend to receive lower commercial relative prices than AMCs or teaching hospitals



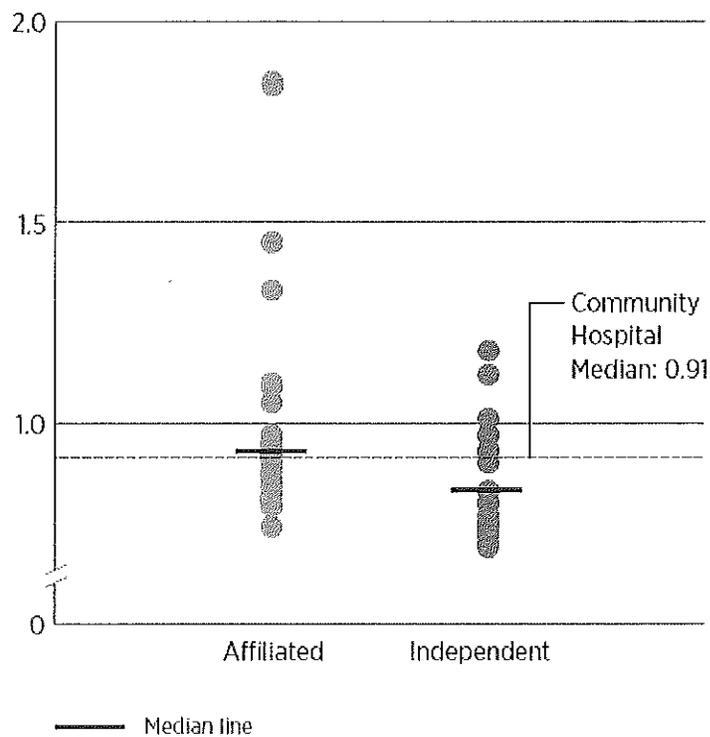
“The gap in prices, [which is] a reflection of the market power dynamics in the state, is probably the biggest threat to a lot of the community hospitals

MASSACHUSETTS HEALTH  
INSURANCE LEADER

Sources: HPC analysis of Ctr. For Health Info & Analysis, Provider Price Variation in the Massachusetts Health Care Market (calendar year 2013 data), Databook (Feb. 2015), [hereinafter CHIA 2013 RP Databook] available at <http://chiamass.gov/assets/Uploads/relative-price-databook-2013.xlsx>

## Community hospitals affiliated with systems tend to have higher relative prices

Community Hospital Relative Prices and Affiliation Status, BCBS FY13

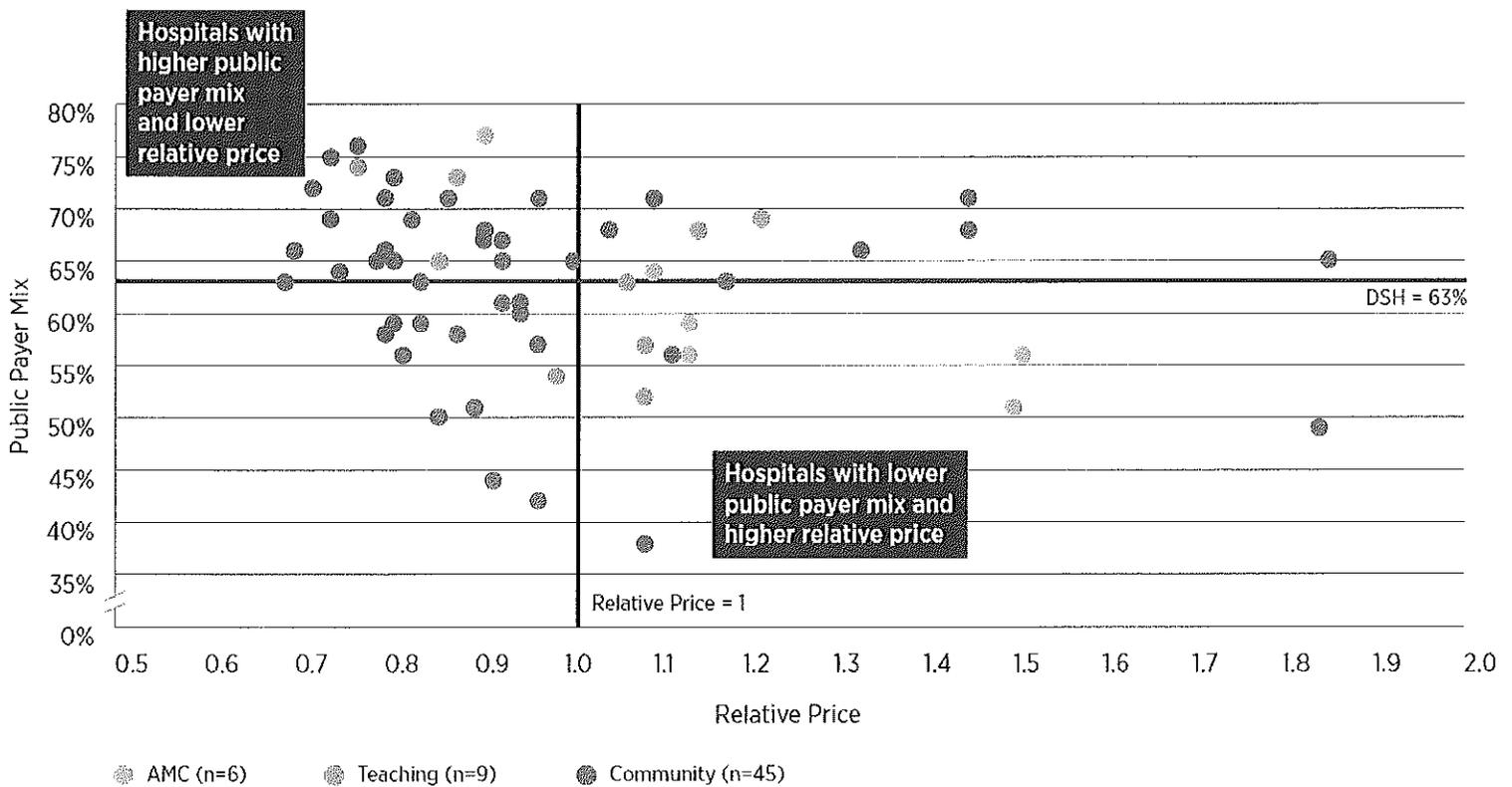


Source: HPC analysis of CHIA 2013 RP Database

Note: While this graph shows relative prices for only one major commercial payer, price and affiliation status are similarly correlated for the other two major commercial payers.

**Hospitals with higher public payer mix tend to have lower relative prices, compounding financial stresses; cross-subsidization of higher public payer mix with higher commercial prices is not observed**

Hospital Commercial RP and Percent of Revenue from Public Payers by Cohort, BCBS FY13



Source: HPC analysis of CHA 2013 RP Databook and CHA Hosp. Profiles, 2013

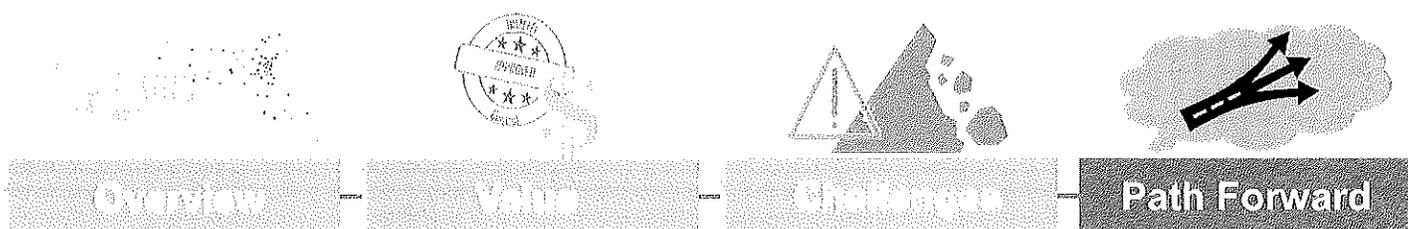
## Market participants report facing additional barriers to transformation

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To successfully meet challenges and adapt to a changing delivery and payment system, community hospitals must overcome barriers and utilize resources and capabilities that may not be readily available. Barriers reported to the HPC during stakeholder interviews include:

- Lack of **resources**, including financial resources and the ability to attract and retain new staff.
- Lack of needed **data and analytic support** to enable transformation efforts, including a lack of information about health needs and coordinated health planning.
- **Concern about change** by hospital governing bodies and community representatives.
- Challenges **aligning the interests of hospital labor and management** to more effectively pursue transformation efforts.
- Difficulty participating in **alternative payment models**, including challenges under current risk adjustment methodologies for hospitals serving patient populations with socioeconomic disadvantages.
- **Insufficient alignment** among programs designed to fund or assist transformation efforts.
- **Policy or regulatory frameworks** that limit deployment of new structures of care.

## The path to a thriving community-based health care system



- Most patients should get most care in an efficient and high-quality setting close to home
- Providers must adapt to make this possible, and incentives and policies should align to support them
- Call to develop an Action Plan in concert with market participants

## Building a path to a thriving community-based health care system

### Vision of Community-based Health

A health care system in which patients in Massachusetts are able to get most of their health care in a local, convenient, cost-effective, high-quality setting.

- **The traditional role and operational model for many community hospitals faces tremendous challenges:**
  - evolution in the health care delivery and payment system
  - persistent market dysfunction → resource inequities and overreliance on higher cost care settings
- **A re-envisioning of the role of community hospitals will require:**
  - development of a roadmap for care delivery transformation focused around the community
  - planning and investment for better alignment of providers with community needs
- **Multi-sector dialogue** is necessary to build consensus and identify a series of targeted actions to be taken by providers, payers, consumers, and government

## Fostering dialogue and developing an Action Plan

# Community Hospitals at a Crossroads: A Conversation to Foster a Sustainable Community Health System

Developing a successful path to a thriving community-based health care system requires multi-stakeholder engagement and incorporation of many diverse viewpoints.

The report findings are designed to spur market-wide dialogue and support identification of priority actions to be taken by providers, payers, purchasers and government.

### **March 29, 2016 at 9:00AM at Suffolk University School of Law**

The HPC Commissioners and staff will convene industry leaders and stakeholders to discuss findings from the report and its implications for transformation of the Commonwealth's community hospitals. Interested members of the public are invited to attend: register online at [www.mass.gov/hpc](http://www.mass.gov/hpc)

In collaboration with stakeholders, HPC will develop an Action Plan to address findings of the report. Action Plan recommendations will be oriented towards providers, payers, purchasers and policymakers

Key themes for further discussion, consensus-building, and action planning

## **Community Hospitals at a Crossroads: A Conversation to Foster a Sustainable Community Health System**

*Planning and support for community  
hospital transformation*

*Encouraging consumers to use high-value  
providers for their care*

*Creating a sustainable, accessible, and  
value-based payment system*

“ We need to **stop playing defense and start playing offense**. This [challenge of supporting community hospitals] is one of the most complex health policy issues we have, but we cannot keep just relying on short term fixes. These hospitals are the backbones of our communities — we owe it to our communities to come together to develop a plan for their future ”

MASSACHUSETTS STATE LEGISLATOR

## **EXHIBIT 7**

Applicant: LHM Health System  
Financial Worksheet (A)

NON-PROFIT  
Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following spreadsheet format:

LINE	Total Entity Description	(1)			(2)			(3)			(4)			(5)			(6)			(7)			(8)			(9)			(10)			(11)			(12)			(13)		
		FY 2014 Actual Results	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON	FY 2020 Projected W/out CON	FY 2020 Projected Incremental	FY 2020 Projected With CON	FY 2021 Projected W/out CON	FY 2021 Projected Incremental	FY 2021 Projected With CON	FY 2022 Projected W/out CON	FY 2022 Projected Incremental	FY 2022 Projected With CON	FY 2023 Projected W/out CON	FY 2023 Projected Incremental	FY 2023 Projected With CON	FY 2024 Projected W/out CON	FY 2024 Projected Incremental	FY 2024 Projected With CON	FY 2025 Projected W/out CON	FY 2025 Projected Incremental	FY 2025 Projected With CON								
<b>A. OPERATING REVENUE</b>																																								
1	Total Gross Patient Revenue	\$1,078,837,000	\$1,168,843,000	(\$18,227,000)	\$1,181,116,000	\$1,213,309,000	(\$24,104,000)	\$1,189,145,000	\$1,281,041,000	(\$9,784,000)	\$1,292,067,000	\$1,312,315,000	\$3,789,000	\$1,318,054,000	\$11,076,000	\$1,329,130,000	\$11,076,000	\$1,340,206,000	\$11,076,000	\$1,351,282,000	\$11,076,000	\$1,362,358,000	\$11,076,000	\$1,373,434,000	\$11,076,000	\$1,384,510,000	\$11,076,000	\$1,395,586,000	\$11,076,000	\$1,406,662,000	\$11,076,000	\$1,417,738,000	\$11,076,000	\$1,428,814,000	\$11,076,000					
2	Less: Allowances	\$619,861,000	\$673,832,000	(\$53,971,000)	\$687,346,000	\$717,136,000	(\$38,505,000)	\$708,831,000	\$782,009,000	(\$73,178,000)	\$782,194,000	\$811,076,000	\$28,877,000	\$820,472,000	\$48,396,000	\$820,668,000	\$48,396,000	\$820,864,000	\$48,396,000	\$821,060,000	\$48,396,000	\$821,256,000	\$48,396,000	\$821,452,000	\$48,396,000	\$821,648,000	\$48,396,000	\$821,844,000	\$48,396,000	\$822,040,000	\$48,396,000	\$822,236,000	\$48,396,000	\$822,432,000	\$48,396,000					
3	Less: Charity Care	\$7,833,000	\$7,336,000	\$497,000	\$7,374,000	\$7,830,000	(\$457,000)	\$7,760,000	\$7,835,000	(\$73,000)	\$7,810,000	\$7,885,000	(\$75,000)	\$7,960,000	(\$75,000)	\$7,960,000	(\$75,000)	\$7,960,000	(\$75,000)	\$7,960,000	(\$75,000)	\$7,960,000	(\$75,000)	\$7,960,000	(\$75,000)	\$7,960,000	(\$75,000)	\$7,960,000	(\$75,000)	\$7,960,000	(\$75,000)	\$7,960,000	(\$75,000)	\$7,960,000	(\$75,000)					
4	Less: Other Deductions	\$1,469,000	\$1,202,000	\$267,000	\$1,202,000	\$1,202,000	\$0	\$1,202,000	\$1,202,000	\$0	\$1,202,000	\$1,202,000	\$0	\$1,202,000	\$0	\$1,202,000	\$0	\$1,202,000	\$0	\$1,202,000	\$0	\$1,202,000	\$0	\$1,202,000	\$0	\$1,202,000	\$0	\$1,202,000	\$0	\$1,202,000	\$0	\$1,202,000	\$0	\$1,202,000	\$0					
5	Net Patient Service Revenue	\$463,633,000	\$467,275,000	(\$3,642,000)	\$468,194,000	\$470,341,000	(\$2,146,000)	\$468,314,000	\$473,817,000	(\$5,503,000)	\$473,871,000	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)			
6	Medicare	\$161,244,000	\$169,559,000	(\$8,315,000)	\$169,705,000	\$170,182,000	(\$477,000)	\$169,705,000	\$171,320,000	(\$1,615,000)	\$171,320,000	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)	\$171,415,000	(\$89,000)			
7	Medicaid	\$40,110,000	\$39,691,000	\$419,000	\$39,691,000	\$39,691,000	\$0	\$39,691,000	\$39,691,000	\$0	\$39,691,000	\$39,691,000	\$0	\$39,691,000	\$0	\$39,691,000	\$0	\$39,691,000	\$0	\$39,691,000	\$0	\$39,691,000	\$0	\$39,691,000	\$0	\$39,691,000	\$0	\$39,691,000	\$0	\$39,691,000	\$0	\$39,691,000	\$0	\$39,691,000	\$0					
8	CHAMPUS & Tricare	\$12,447,000	\$13,089,000	(\$642,000)	\$12,819,000	\$13,136,000	(\$317,000)	\$12,819,000	\$13,225,000	(\$406,000)	\$12,819,000	\$13,232,000	(\$413,000)	\$12,819,000	(\$413,000)	\$12,819,000	(\$413,000)	\$12,819,000	(\$413,000)	\$12,819,000	(\$413,000)	\$12,819,000	(\$413,000)	\$12,819,000	(\$413,000)	\$12,819,000	(\$413,000)	\$12,819,000	(\$413,000)	\$12,819,000	(\$413,000)	\$12,819,000	(\$413,000)	\$12,819,000	(\$413,000)					
9	Other	(\$2,458,000)	(\$18,202,000)	\$15,744,000	(\$18,202,000)	(\$18,202,000)	\$0	(\$18,202,000)	(\$18,202,000)	\$0	(\$18,202,000)	(\$18,202,000)	\$0	(\$18,202,000)	\$0	(\$18,202,000)	\$0	(\$18,202,000)	\$0	(\$18,202,000)	\$0	(\$18,202,000)	\$0	(\$18,202,000)	\$0	(\$18,202,000)	\$0	(\$18,202,000)	\$0	(\$18,202,000)	\$0	(\$18,202,000)	\$0	(\$18,202,000)	\$0					
10	Total Government	\$219,343,000	\$216,017,000	\$3,326,000	\$216,832,000	\$216,887,000	(\$55,000)	\$216,887,000	\$217,459,000	(\$572,000)	\$217,459,000	\$217,499,000	(\$440,000)	\$217,499,000	(\$440,000)	\$217,499,000	(\$440,000)	\$217,499,000	(\$440,000)	\$217,499,000	(\$440,000)	\$217,499,000	(\$440,000)	\$217,499,000	(\$440,000)	\$217,499,000	(\$440,000)	\$217,499,000	(\$440,000)	\$217,499,000	(\$440,000)	\$217,499,000	(\$440,000)	\$217,499,000	(\$440,000)					
11	Commercial Insurers	\$216,858,000	\$223,780,000	(\$6,922,000)	\$223,886,000	\$227,857,000	(\$3,971,000)	\$227,857,000	\$227,315,000	\$5,542,000	\$227,315,000	\$227,315,000	\$0	\$227,315,000	\$0	\$227,315,000	\$0	\$227,315,000	\$0	\$227,315,000	\$0	\$227,315,000	\$0	\$227,315,000	\$0	\$227,315,000	\$0	\$227,315,000	\$0	\$227,315,000	\$0	\$227,315,000	\$0	\$227,315,000	\$0					
12	Uninsured	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0							
13	Self Pay	\$9,055,000	\$10,499,000	(\$1,444,000)	\$10,499,000	\$10,606,000	(\$107,000)	\$10,606,000	\$10,677,000	(\$71,000)	\$10,677,000	\$10,748,000	(\$71,000)	\$10,748,000	(\$71,000)	\$10,748,000	(\$71,000)	\$10,748,000	(\$71,000)	\$10,748,000	(\$71,000)	\$10,748,000	(\$71,000)	\$10,748,000	(\$71,000)	\$10,748,000	(\$71,000)	\$10,748,000	(\$71,000)	\$10,748,000	(\$71,000)	\$10,748,000	(\$71,000)	\$10,748,000	(\$71,000)					
14	Workers Compensation	\$9,502,000	\$9,036,000	\$466,000	\$9,036,000	\$9,067,000	(\$31,000)	\$9,067,000	\$9,126,000	(\$59,000)	\$9,126,000	\$9,185,000	(\$59,000)	\$9,185,000	(\$59,000)	\$9,185,000	(\$59,000)	\$9,185,000	(\$59,000)	\$9,185,000	(\$59,000)	\$9,185,000	(\$59,000)	\$9,185,000	(\$59,000)	\$9,185,000	(\$59,000)	\$9,185,000	(\$59,000)	\$9,185,000	(\$59,000)	\$9,185,000	(\$59,000)	\$9,185,000	(\$59,000)					
15	Other	\$972,000	\$972,000	\$0	\$972,000	\$972,000	\$0	\$972,000	\$972,000	\$0	\$972,000	\$972,000	\$0	\$972,000	\$0	\$972,000	\$0	\$972,000	\$0	\$972,000	\$0	\$972,000	\$0	\$972,000	\$0	\$972,000	\$0	\$972,000	\$0	\$972,000	\$0	\$972,000	\$0	\$972,000	\$0					
16	Total Non-Government	\$234,166,000	\$234,230,000	(\$64,000)	\$234,230,000	\$234,457,000	(\$227,000)	\$234,457,000	\$234,417,000	\$438,000	\$234,417,000	\$234,315,000	(\$90,000)	\$234,315,000	(\$90,000)	\$234,315,000	(\$90,000)	\$234,315,000	(\$90,000)	\$234,315,000	(\$90,000)	\$234,315,000	(\$90,000)	\$234,315,000	(\$90,000)	\$234,315,000	(\$90,000)	\$234,315,000	(\$90,000)	\$234,315,000	(\$90,000)	\$234,315,000	(\$90,000)	\$234,315,000	(\$90,000)					
17	Net Patient Service Revenue* (Government/Non-Government)	\$463,633,000	\$467,275,000	(\$3,642,000)	\$468,194,000	\$470,341,000	(\$2,146,000)	\$468,314,000	\$473,817,000	(\$5,503,000)	\$473,871,000	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)	\$475,814,000	(\$1,943,000)					
18	Less: Provision for Bad Debts	\$20,298,000	\$17,177,000	\$3,121,000	\$17,177,000	\$17,240,000	(\$63,000)	\$17,177,000	\$17,355,000	(\$178,000)	\$17,355,000	\$17,355,000	\$0	\$17,355,000	\$0	\$17,355,000	\$0	\$17,355,000	\$0	\$17,355,000	\$0	\$17,355,000	\$0	\$17,355,000	\$0	\$17,355,000	\$0	\$17,355,000	\$0	\$17,355,000	\$0	\$17,355,000	\$0	\$17,355,000	\$0					
19	Net Patient Service Revenue less provision for bad debts	\$443,335,000	\$450,098,000	(\$6,763,000)	\$451,017,000	\$453,101,000	(\$2,084,000)	\$451,137,000	\$456,462,000	(\$5,345,000)	\$456,516,000	\$458,459,000	(\$1,942,000)	\$458,459,000	(\$1,942,000)	\$458,459,000	(\$1,942,000)	\$458,459,000	(\$1,942,000)	\$458,459,000	(\$1,942,000)	\$458,459,000	(\$1,942,000)	\$458,459,000	(\$1,942,000)	\$458,459,000	(\$1,942,000)	\$458,459,000	(\$1,942,000)	\$458,459,000	(\$1,942,000)	\$458,459,000	(\$1,942,000)	\$458,459,000	(\$1,942,000)					
20	Other Operating Revenue	\$20,795,000	\$19,825,000	\$970,000	\$19,825,000	\$19,825,000	\$0	\$19,825,000	\$19,825,000	\$0	\$19,825,000	\$19,825,000	\$0	\$19,825,000	\$0	\$19,825,000	\$0	\$19,825,000	\$0	\$19,825,000	\$0	\$19,825,000	\$0	\$19,825,000	\$0	\$19,825,000	\$0	\$19,825,000	\$0	\$19,825,000	\$0	\$19,825,000	\$0							
21	Net Assets Released from Restrictions	\$976,000	\$0	\$976,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0							
22	TOTAL OPERATING REVENUE	\$464,302,000	\$469,723,000	(\$5,421,000)	\$463,842,000	\$473,126,000	(\$9,284,000)	\$463,842,000	\$474,881,000	(\$11,076,000)	\$474,881,000	\$475,715,000	(\$833,000)	\$475,715,000	(\$833,000)	\$475,715,000	(\$833,000)	\$475,715,000	(\$833,000)	\$475,715,000	(\$833,000)	\$475,715,000	(\$833,000)	\$475,715,000	(\$833,000)	\$475,715,000	(\$833,000)	\$475,715,000	(\$833,000)	\$475,715,000	(\$833,000)	\$475,715,000	(\$833,000)							
<b>B. OPERATING EXPENSES</b>																																								
1	Salaries and Wages	\$218,488,000	\$221,743,000	(\$3,255,000)	\$205,239,000	\$210,732,000	(\$5,493,000)	\$210,732,000	\$220,784,000	(\$10,052,000)	\$220,784,000	\$223,224,000	(\$2,440,000)	\$223,224,000	(\$2,440,000)	\$223,224,000	(\$2,440,000)	\$223,224,000	(\$2,440,000)	\$223,224,000	(\$2,440,000)	\$223,224,000	(\$2,440,000)	\$223,224,000	(\$2,440,000)	\$223,224,000	(\$2,440,000)	\$223,224,000	(\$2,440,000)	\$223,224,000	(\$2,440,000)	\$223,224,000	(\$2,440,000)	\$223,224,000	(\$2,440,000)					
2	Fringe Benefits	\$50,186,000																																						

Applicant: LNH Hospital  
Financial Worksheet (A)

NON-PROFIT  
Please provide one year of actual results and three years of projections of Total Entail revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entail Description	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
		FY 2014 Actual Results	FY 2016 Projected Without CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected Without CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected Without CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected Without CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
<b>A. OPERATING REVENUE</b>														
1	Total Gross Patient Revenue	\$795,267,000	\$860,163,000	\$14,094,000	\$874,277,000	\$884,560,000	\$37,460,000	\$922,020,000	\$930,374,000	\$63,320,000	\$993,694,000	\$907,589,000	\$83,908,000	\$1,036,497,000
2	Less: Allowances	\$450,251,000	\$487,244,000	\$9,292,000	\$495,926,000	\$521,292,000	\$22,690,000	\$543,882,000	\$563,773,000	\$42,780,000	\$598,653,000	\$590,539,000	\$43,352,000	\$633,891,000
3	Less: Charity Care	\$5,449,000	\$5,894,000	\$397,000	\$6,291,000	\$6,376,000	\$287,000	\$6,642,000	\$6,895,000	\$395,000	\$7,290,000	\$7,457,000	\$531,000	\$7,988,000
4	Less: Other Deductions	\$2,450,000	\$10,202,000	\$0	\$10,202,000	\$18,202,000	\$0	\$18,202,000	\$18,202,000	\$0	\$18,202,000	\$18,202,000	\$0	\$18,202,000
5	Net Patient Service Revenue	\$337,129,000	\$348,843,000	\$5,715,000	\$354,658,000	\$348,712,000	\$14,693,000	\$363,405,000	\$351,594,000	\$20,145,000	\$371,739,000	\$351,391,000	\$25,026,000	\$376,415,000
6	Medicare	\$119,154,000	\$123,501,000	\$1,924,000	\$125,425,000	\$123,539,000	\$4,916,000	\$128,455,000	\$124,491,000	\$9,783,000	\$134,274,000	\$124,492,000	\$9,426,000	\$133,878,000
7	Medicaid	\$36,749,000	\$39,097,000	\$600,000	\$39,708,000	\$39,084,000	\$1,555,000	\$40,639,000	\$39,355,000	\$2,146,000	\$41,501,000	\$39,373,000	\$2,866,000	\$42,039,000
8	CHAMPUS & Tricare	\$10,961,000	\$11,583,000	\$162,000	\$11,885,000	\$11,079,000	\$495,000	\$11,544,000	\$11,769,000	\$341,000	\$12,110,000	\$11,786,000	\$397,000	\$12,663,000
9	Other	\$(2,450,000)	\$(18,202,000)	\$0	\$(18,202,000)	\$(18,202,000)	\$0	\$(18,202,000)	\$(18,202,000)	\$0	\$(18,202,000)	\$(18,202,000)	\$0	\$(18,202,000)
10	Total Government	\$161,425,000	\$158,169,000	\$2,716,000	\$160,874,000	\$166,100,000	\$5,916,000	\$172,016,000	\$167,443,000	\$5,870,000	\$173,313,000	\$167,389,000	\$11,883,000	\$179,278,000
11	Commercial Insurers	\$163,214,000	\$173,849,000	\$2,704,000	\$176,553,000	\$173,691,000	\$6,909,000	\$180,499,000	\$174,820,000	\$9,531,000	\$184,459,000	\$174,873,000	\$11,828,000	\$186,712,000
12	Uninsured	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
13	Net Pay	\$5,132,000	\$5,460,000	\$883,000	\$5,645,000	\$5,468,000	\$217,000	\$5,675,000	\$5,500,000	\$300,000	\$5,800,000	\$5,498,000	\$372,000	\$5,870,000
14	Workers Compensation	\$7,358,000	\$7,629,000	\$122,000	\$7,751,000	\$7,826,000	\$311,000	\$8,137,000	\$7,886,000	\$430,000	\$8,316,000	\$7,884,000	\$534,000	\$8,418,000
15	Other	\$0	\$5,748,000	\$69,000	\$5,817,000	\$5,748,000	\$220,000	\$5,975,000	\$5,748,000	\$316,000	\$6,064,000	\$5,748,000	\$392,000	\$6,140,000
16	Total Non-Government	\$175,704,000	\$192,674,000	\$3,909,000	\$196,583,000	\$192,621,000	\$7,665,000	\$200,286,000	\$195,852,000	\$10,978,000	\$206,832,000	\$194,901,000	\$13,137,000	\$207,135,000
17	Net Patient Service Revenue* (Government+Non-Government)	\$337,129,000	\$348,843,000	\$5,715,000	\$354,658,000	\$348,712,000	\$14,693,000	\$363,405,000	\$351,594,000	\$20,145,000	\$371,739,000	\$351,391,000	\$25,026,000	\$376,415,000
18	Less: Provision for Bad Debts	\$163,900,000	\$163,900,000	\$210,000	\$164,110,000	\$173,790,000	\$337,000	\$174,130,000	\$173,909,000	\$741,000	\$174,650,000	\$173,894,000	\$921,000	\$174,815,000
19	Net Patient Service Revenue less provision for bad debts	\$173,229,000	\$184,943,000	\$5,505,000	\$190,548,000	\$174,922,000	\$14,056,000	\$189,275,000	\$177,685,000	\$19,404,000	\$197,089,000	\$177,497,000	\$24,104,000	\$191,600,000
20	Other Operating Revenue	\$29,151,000	\$31,188,000	\$0	\$31,188,000	\$31,188,000	\$0	\$31,188,000	\$31,188,000	\$0	\$31,188,000	\$31,188,000	\$0	\$31,188,000
21	Net Assets Released from Restrictions	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
22	TOTAL OPERATING REVENUE	\$337,129,000	\$366,226,000	\$5,605,000	\$371,731,000	\$355,109,000	\$14,066,000	\$380,176,000	\$368,751,000	\$19,404,000	\$388,185,000	\$368,673,000	\$24,104,000	\$392,771,000
<b>B. OPERATING EXPENSES</b>														
1	Salaries and Wages	\$145,839,000	\$143,677,000	\$604,000	\$144,181,000	\$140,019,000	\$761,000	\$140,780,000	\$141,973,000	\$765,000	\$142,738,000	\$143,883,000	\$1,270,000	\$145,053,000
2	fringe Benefits	\$61,045,000	\$59,029,000	\$194,000	\$59,674,000	\$59,457,000	\$1,222,000	\$60,679,000	\$62,771,000	\$1,285,000	\$64,056,000	\$65,088,000	\$1,498,000	\$66,586,000
3	Physicians Fees	\$38,049,000	\$39,764,000	\$2,845,000	\$39,059,000	\$22,860,000	\$4,618,000	\$27,678,000	\$22,663,000	\$4,789,000	\$27,452,000	\$22,849,000	\$4,922,000	\$27,771,000
4	Supplies and Drugs*	\$59,539,000	\$64,289,000	\$55,000	\$64,344,000	\$64,810,000	\$348,000	\$65,158,000	\$65,541,000	\$652,000	\$66,193,000	\$66,471,000	\$191,000	\$67,382,000
5	Depreciation and Amortization	\$22,720,000	\$26,054,000	\$777,000	\$26,131,000	\$27,672,000	\$154,000	\$27,826,000	\$27,826,000	\$164,000	\$27,990,000	\$28,040,000	\$154,000	\$28,194,000
6	Provision for Bad Debts-Other*	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7	Interest Expense	\$3,643,000	\$3,398,000	\$0	\$3,398,000	\$3,188,000	\$0	\$3,188,000	\$3,274,000	\$0	\$3,274,000	\$3,240,000	\$0	\$3,240,000
8	Malpractice Insurance Cost	\$4,539,000	\$4,815,000	\$0	\$4,815,000	\$4,815,000	\$0	\$4,815,000	\$4,815,000	\$0	\$4,815,000	\$4,815,000	\$0	\$4,815,000
9	Lease Expense	\$4,518,000	\$4,952,000	\$0	\$4,952,000	\$4,852,000	\$0	\$4,852,000	\$4,852,000	\$0	\$4,852,000	\$4,852,000	\$0	\$4,852,000
10	Other Operating Expenses	\$25,333,000	\$30,491,000	\$0	\$30,491,000	\$30,491,000	\$0	\$30,491,000	\$30,785,000	\$0	\$30,785,000	\$29,266,000	\$0	\$29,266,000
11	TOTAL OPERATING EXPENSES	\$355,832,000	\$361,724,000	\$4,420,000	\$366,144,000	\$350,976,000	\$7,168,000	\$358,144,000	\$354,076,000	\$7,595,000	\$361,671,000	\$356,901,000	\$8,672,000	\$365,573,000
12	INCOME/(LOSS) FROM OPERATIONS	\$(2,810,000)	\$4,502,000	\$1,076,000	\$5,978,000	\$15,134,000	\$6,893,000	\$22,032,000	\$14,763,000	\$11,799,000	\$26,514,000	\$11,772,000	\$15,432,000	\$27,204,000
<b>C. PROFITABILITY SUMMARY</b>														
1	Hospital Operating Margin	-0.8%	1.2%	19.5%	1.6%	4.1%	49.0%	6.8%	4.0%	60.8%	6.8%	3.2%	84.0%	9.9%
2	Hospital Non Operating Margin	2.5%	2.1%	0.0%	2.2%	2.3%	0.0%	2.2%	2.2%	0.0%	2.1%	2.2%	0.0%	2.1%
3	Hospital Total Margin	1.7%	3.3%	19.5%	3.7%	6.4%	49.0%	9.0%	6.2%	60.8%	9.0%	6.4%	84.0%	12.0%
4	FTEs	1,849	1,827	2	1,829	1,765	3	1,758	1,745	7	1,782	1,735	18	1,763
<b>D. VOLUME STATISTICS*</b>														
1	Inpatient Discharges	14,151	14,212	179	14,391	14,083	329	14,412	13,940	478	14,418	13,823	627	14,460
2	Outpatient Visits	458,110	455,977	3,482	459,459	455,077	10,930	466,007	455,977	14,489	469,466	455,077	17,407	472,484
3	TOTAL VOLUME	472,261	469,289	3,641	473,930	469,160	11,259	480,419	469,917	14,967	483,884	469,154	18,834	484,944

\*Total amount should equal the total amount on cost the "Net Patient Revenue" row 14.

\*Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

\*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

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## Lawrence + Memorial Health System Affiliation with Yale New Haven Health System Assumptions

<u>Net Revenue Rate Increases</u>	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
1) Government	0 - 1.4%	0 - 1.4%	0 - 1.2%	0 - 1.2%
2) Non-Government	0 - 2.5%	0 - 2.0%	0 - 2.0%	0 - 2.0%
3) Inpatient Volume	1.1%	0.1%	0.0%	0.2%
4) Outpatient Volumes	1.0%	1.5%	0.8%	0.5%
	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
<u>EXPENSES</u>				
A. Salaries and Fringe Benefits	1.5%	1.5%	1.5%	1.5%
B. Non-Salary				
1) Supplies and Drugs	2.0%	1.5%	1.5%	1.5%
2) Professional and Contracted Services	2.0%	1.5%	1.5%	1.5%
3) Malpractice Insurance and Lease Expense	0.0%	0.0%	0.0%	0.0%
4) All Other Expenses	1.0%	1.0%	1.0%	1.0%
5) All Other Expenses				
	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
<u>FTEs</u>				
1) Total estimated FTEs	<u>2,641</u>	<u>2,386</u>	<u>2,378</u>	<u>2,378</u>

Note - The above increase projections reflect all changes relating to Medicare and Medicaid reimbursement regulations.

**YALE-NEW HAVEN System  
Lawrence + Memorial Affiliation  
Assumptions**

<u>Net Revenue Rate Increases</u>	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
1) Government	1.0%	1.0%	1.0%	1.0%
2) Non-Government	1.0%	1.0%	1.0%	1.0%
3) Inpatient Volume	1.0%	1.0%	1.0%	1.0%
4) Outpatient Volume	1.0%	1.0%	1.0%	1.0%
	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
<b><u>EXPENSES</u></b>				
<b>A. Salaries and Fringe Benefits</b>	3.0%	3.0%	3.0%	3.0%
<b>B. Non-Salary</b>				
1) Supplies and Drugs	3.0%	3.0%	3.0%	3.0%
2) Professional and Contracted Services	3.0%	3.0%	3.0%	3.0%
3) Malpractice Insurance and Lease Expense	3.0%	3.0%	3.0%	3.0%
4) All Other Expenses	3.0%	3.0%	3.0%	3.0%
	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
<b><u>FTEs</u></b>				
1) Total estimated FTEs	14,391	14,412	14,418	14,450

# **EXHIBIT 8**

## **EXHIBIT 9**

**William W. Backus Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Former President & CEO			\$3,357,690	\$738,636	\$666,118	\$925,503	\$645,419		
Regional President		\$858,680							
President & CEO			\$975,550	\$664,781	\$573,317	\$410,672		\$627,001	\$596,473
Regional VP, Finance		\$598,856							
Medical Affairs Regional VP	\$410,993	\$577,237							
Medical Director, Medicare Care Admin	\$552,137								
BPS Physician	\$622,339	\$558,100		\$523,896	\$497,357				
Hospitalist Physician	\$489,374								
Sr. Vice President & CFO			\$659,230	\$488,297	\$438,868	\$494,684	\$407,839	\$404,988	\$382,897
Chief of Emergency Medicine		\$495,605							\$357,592
Clinical Services Sr. VP & CMO			\$587,917						
ER Physician	\$424,203	\$414,709				\$437,095	\$415,402	\$406,279	\$345,324
Medical Director				\$479,197	\$458,448	\$407,519	\$380,678	\$366,158	
ER Physician	\$418,265	\$414,453		\$469,984	\$471,117	\$404,362	\$379,087	\$347,302	\$330,183
Vice President & COO						\$391,942	\$360,153	\$345,700	\$317,502
BPS Physician		\$551,117	\$548,961	\$400,639	\$397,513				
BPS Physician			\$504,965	\$384,636	\$377,448				
ER Physician	\$416,812								
ER Physician	\$409,255	\$405,635	\$481,414	\$380,816	\$382,452	\$369,115	\$346,575	\$339,930	\$328,021
ER Physician	\$391,415	\$396,123	\$421,693	\$372,326	\$380,316	\$362,716	\$344,000	\$336,916	\$326,419
ER Physician			\$411,993			\$358,594	\$343,575	\$332,063	\$322,176
ER Physician			\$403,912				\$342,098	\$326,881	\$320,727
Rheumatology Physician	\$407,038								
<b>Total</b>	<b>\$4,541,831</b>	<b>\$5,270,515</b>	<b>\$8,353,325</b>	<b>\$4,903,208</b>	<b>\$4,642,954</b>	<b>\$4,562,202</b>	<b>\$3,964,826</b>	<b>\$3,833,218</b>	<b>\$3,627,314</b>

**Bridgeport Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	\$1,447,989	\$1,222,022	\$1,101,139	\$764,779	\$1,352,509	\$1,702,615	\$2,543,047	\$1,021,040	\$932,810
Chief Financial Officer									\$510,450
Physician Chief								\$1,222,471	
Sr. VP of Administration	\$955,867	\$929,905	\$885,638						
Senior VP of Finance & CFO	\$941,809	\$796,077	\$741,380	\$668,999	\$687,985	\$646,716	\$572,020	\$572,249	
VP of Finance	\$778,986								
Medical Director			\$632,905	\$570,304	\$571,351	\$748,468			
Physician General Surgery								\$561,283	
Sr. VP Medical Affairs	\$582,014	\$516,861					\$640,909	\$646,930	
Senior VP of Human Resources				\$468,241	\$494,194	\$464,453	\$449,781	\$445,356	\$425,297
Surgeon in Chief & Chairman of Surgery Dept								\$518,721	
Senior VP & COO				\$458,001	\$529,615	\$514,318	\$475,065	\$477,510	\$416,311
Chief, ER Physician									\$353,048
Chief, Section of Cardiology								\$504,253	
Chief, Maternal Fetal Medicine								\$488,249	
VP				\$452,611					
Senior VP, Planning & Marketing	\$522,220	\$487,114	\$460,560		\$465,508				\$328,370
ER Physician	\$481,515	\$457,886	\$455,310		\$409,341	\$414,117	\$386,542		\$327,312
ER Physician	\$466,707	\$433,118		\$402,984	\$404,703	\$375,929	\$353,626		\$315,697
VP of Performance Management	\$436,837								
Sr. VP of Quality Control and Risk Management			\$412,762	\$397,219	\$396,540	\$355,398	\$331,960		
ER Physician	\$393,898	\$403,033	\$397,495	\$391,752	\$366,594	\$354,567	\$337,643		\$308,417
ER Physician		\$399,524	\$393,302	\$365,621		\$351,726	\$334,460		\$307,444
ER Physician		\$381,032	\$392,410						
<b>Total</b>	<b>\$7,007,842</b>	<b>\$6,026,572</b>	<b>\$5,872,901</b>	<b>\$4,940,511</b>	<b>\$5,678,340</b>	<b>\$5,928,307</b>	<b>\$6,425,053</b>	<b>\$6,458,062</b>	<b>\$4,225,156</b>

**Bristol Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	\$756,841	\$659,742	\$605,526	\$495,299	\$441,821	\$368,985	\$358,071	\$301,300	\$145,757
Interim CEO/CFO									\$250,043
Chief Operating Officer									\$236,857
Senior Vice President, Chief Medical Officer	\$395,340	\$375,135	\$368,261	\$392,474	\$353,187	\$307,376			
Vice President of Admin Services								\$202,603	
Oncology Physician						\$327,712	\$280,817		
Senior Vice President, Patient Care Services & CNO	\$318,668	\$308,975	\$304,551	\$237,201		\$212,105			
Senior Vice President/CFO		\$328,273	\$268,516		\$331,856	\$287,078		\$134,945	
Vice President/CFO	\$348,020					\$200,460	\$186,930		
Vice President, Human Resources and Support Services	\$221,100	\$207,363	\$204,326						
Clinic Physician						\$197,383	\$202,405	\$199,016	
Vice President of Operations					\$227,176	\$195,850			
Occupational Health Physician	\$179,366	\$177,125	\$176,987			\$157,692	\$213,798	\$216,973	\$186,222
Assistant Vice President, Information Services	\$215,018	\$210,272	\$198,613	\$197,149	\$180,780				
Assistant Vice President/In House Counsel								\$166,354	\$146,325
Vice President of Patient Care Services				\$195,892			\$196,267		\$143,244
Assistant Vice President, Human Resources & Support				\$181,069	\$146,022	\$142,091			
Director of Physician Recruitment									\$140,180
Controller			\$168,117	\$174,159					
Director of Revenue Cycle		\$157,556							
Staff Psychiatrist				\$168,640	\$206,727		\$189,381	\$200,513	
Psych Physician								\$143,448	\$194,500
Psych Physician									\$140,095
Assistant Vice President, Chief Development Officer	\$193,117	\$186,781	\$169,549	\$168,198	\$149,114				
Director, Clinical Operations	\$168,848		\$165,578	\$168,106					
Director, Diagnostic Imaging	\$167,114								
Biomedical Technician							\$149,554		
Director of Perioperative Services							\$148,407		
Manager of Applications & Programming		\$156,752			\$145,775		\$147,965	\$139,438	
Psychologist								\$138,061	\$135,572
Clinical Staff Pharmacist					\$143,422				
<b>Total</b>	<b>\$2,963,432</b>	<b>\$2,767,974</b>	<b>\$2,630,024</b>	<b>\$2,378,187</b>	<b>\$2,325,880</b>	<b>\$2,396,732</b>	<b>\$2,073,595</b>	<b>\$1,842,651</b>	<b>\$1,718,795</b>

**Hospital of Central Connecticut**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>
President & CEO	\$2,325,846	\$999,354	\$1,499,546	\$2,764,505	\$609,893	\$2,851,220	\$1,110,502	\$852,338
Physician, Private Practice								\$625,058
Executive Vice President and CMO		\$849,179	\$776,392	\$736,855	\$603,486			
Senior VP of Medical Affairs						\$652,298	\$498,636	
Chief of Pediatrics						\$563,571	\$401,551	\$360,656
Hospitalist	\$763,388			\$568,564				\$395,449
Chief Emergency Room Physician	\$728,973	\$663,474	\$550,999	\$497,610	\$499,051	\$475,774	\$400,568	\$379,873
Chief Operating Officer						\$454,785	\$473,762	\$445,037
Chief of Medicine	\$664,689	\$555,465	\$500,547	\$480,323	\$474,233	\$411,214		\$374,604
Neurosurgeon		\$542,218						
Director of Cardiology	\$476,866	\$463,175			\$459,292	\$382,490	\$377,094	\$360,863
Director Hospitalist Medicine	\$438,866							
Hospitalist		\$598,728	\$491,528		\$450,815	\$415,460	\$439,224	
Director Surgical Oncology	\$712,251	\$645,121	\$487,581					
Chief of Psychiatry		\$498,562	\$484,686		\$440,082		\$360,201	
Medical Director of Quality					\$420,419			
Vice President Human Resources		\$644,445		\$461,731				
Vice President Patient Services				\$455,425				
Vice President Finance			\$598,466	\$458,671				
VP Analytics & Decision Report	\$604,754							
Oncologic Surgeon				\$439,374	\$376,249			
Chief Financial Officer					\$309,038	\$547,595	\$604,747	\$479,362
Medical Director BMH ED	\$461,593		\$447,047			\$364,789	\$356,421	\$337,862
Medical Director NBG ED	\$474,401		\$438,419	\$418,618				
<b>Total</b>	<b>\$7,651,627</b>	<b>\$6,459,721</b>	<b>\$6,275,211</b>	<b>\$7,281,676</b>	<b>\$4,642,558</b>	<b>\$7,119,196</b>	<b>\$5,022,706</b>	<b>\$4,611,102</b>

**Charlotte Hungerford Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Physician Surgeon	\$784,306	\$748,423	\$661,640	\$619,607	\$378,765				
Pathologist Medical Director	\$498,959	\$511,240	\$520,852	\$530,760	\$536,040	\$499,855	\$473,687	\$455,147	\$249,074
CEO President	\$625,107	\$522,445	\$503,491	\$504,603	\$540,443	\$476,023	\$456,011	\$413,138	\$358,641
Physician Surgeon	\$745,495	\$659,650	\$581,148	\$473,947					
Cardiologist	\$459,094	\$443,487	\$515,457						
VP Medical Affairs	\$409,022		\$400,445	\$368,032	\$427,464	\$447,908	\$363,622	\$340,417	\$309,144
Physician Surgeon	\$592,094	\$640,888	\$498,646	\$365,008					
Cardiologist	\$450,788	\$430,722	\$483,052						
Cardiologist	\$433,352	\$430,225	\$441,292						
Cardiologist		\$422,353	\$435,124						
Psychiatrist Medical Director				\$349,331	\$372,589	\$356,994	\$312,884	\$293,876	\$278,137
CFO					\$330,796	\$375,568	\$288,650	\$300,901	\$251,468
Orthopedic Surgeon	\$724,504			\$343,470	\$285,223				
Physician Hospitalist				\$289,357	\$312,841	\$303,332	\$213,128		
VP Administration						\$292,016	\$220,139	\$240,948	\$195,225
Physician Surgeon				\$279,548	\$308,569				
Pathologist						\$254,361	\$243,633	\$233,915	
VP Human Resources						\$252,639			
Physician Hospitalist						\$249,054			
Walk in Physician									\$211,324
Physician Walk In Med Director							\$217,483	\$218,017	
Psychiatrist							\$212,833	\$215,421	\$208,815
Psychiatrist									\$204,676
VP Patient Care									\$201,576
Medical Physicist								\$181,556	
Hospitalist Med Director		\$546,781			\$288,930				
<b>Total</b>	<b>\$5,722,721</b>	<b>\$5,356,214</b>	<b>\$5,041,147</b>	<b>\$4,123,663</b>	<b>\$3,781,660</b>	<b>\$3,507,750</b>	<b>\$3,002,070</b>	<b>\$2,893,336</b>	<b>\$2,468,080</b>

CT Children's Medical Center

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Physician in Chief		\$460,190	\$512,905	\$468,345	\$468,999	\$388,964	\$513,586	\$366,915	\$380,057
Former President & CEO									\$735,259
Executive VP & CFO		\$426,289	\$478,476	\$429,575	\$443,284	\$352,157			
Senior VP & CFO							\$485,969	\$354,737	\$388,977
EVP & COO	\$444,836	\$420,424	\$468,676						
Chief Operating Officer				\$336,211	\$375,179	\$339,764	\$399,608	\$282,887	
President & CEO	\$618,181	\$516,728	\$748,347	\$315,696	\$480,870	\$336,532	\$490,926	\$368,969	
Senior VP and General Counsel	\$413,375	\$367,734	\$391,769	\$299,663					
General Council					\$338,238	\$250,232	\$308,223	\$251,259	\$264,825
VP Clinical Services & Chief RN Officer		\$286,793	\$250,382		\$285,981	\$237,795	\$292,464	\$239,987	\$251,280
Senior VP Quality Improvement & Patient Safety	\$548,936	\$469,599	\$253,456	\$277,035	\$391,164	\$264,622			
Executive VP Community & Child Health	\$506,930								
VP Quality Improvement & Patient Safety							\$248,438	\$231,484	\$189,791
Interim CFO	\$315,779								
CIO	\$299,080	\$292,330	\$300,302	\$266,623					
President, Specialty Group			\$267,602						
Chief Medical Information Officer	\$335,252	\$293,608							
VP Human Resources	\$292,022			\$229,430	\$262,535	\$211,180	\$266,708	\$233,645	
Director, Human Resources									\$175,107
Director of IT					\$210,421	\$185,045			
VP Marketing & Business Development	\$334,482	\$323,482							
VP Strategy & Regional Development					\$191,027		\$402,005	\$326,282	\$323,556
Staff Nurse - Operating Room						\$167,452			\$213,405
Staff Nurse - Emergency Department								\$197,469	\$169,796
Mid-Level Practitioner NICU							\$204,601		
Professional Practice RN IV				\$221,543					
Director, Perioperative Services			\$235,505	\$173,491					
<b>Total</b>	<b>\$4,108,873</b>	<b>\$3,857,177</b>	<b>\$3,907,420</b>	<b>\$3,017,612</b>	<b>\$3,447,698</b>	<b>\$2,733,743</b>	<b>\$3,612,528</b>	<b>\$2,853,634</b>	<b>\$3,092,053</b>

**Danbury Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
Chief Executive Officer	\$1,173,053	\$1,056,889	\$955,838	\$1,075,078	\$1,867,610	\$6,445,204	\$1,010,458	\$957,098	\$734,223
Executive VP/CEO					\$862,137	\$475,935			
VP Human Resources	\$820,052	\$948,869	\$836,281	\$872,756	\$838,535	\$726,912	\$2,050,637	\$470,470	\$400,817
Chief Information Officer	\$412,631	\$377,700		\$570,359	\$362,411	\$312,899	\$318,742		\$355,439
Chief Financial Officer	\$672,565	\$616,267	\$614,912	\$562,520	\$555,894	\$309,028	\$4,650,958	\$839,689	\$496,428
Chief Operating Officer	\$475,605	\$428,450	\$456,821	\$399,887			\$550,628	\$513,664	\$452,822
Executive VP, Medical Education									\$413,029
Medical Director Southbury Geriatric								\$331,878	
VP IT								\$323,281	
VP Planning	\$338,621	\$307,327							\$387,954
Chief Nursing Officer	\$389,086	\$363,505	\$366,115	\$368,420	\$439,491	\$373,122	\$347,111		
VP Marketing				\$327,799	\$384,914	\$343,416		\$300,910	
Medical Director Community Health Center					\$362,936	\$362,935	\$333,882	\$278,085	
Senior VP Operations					\$349,398	\$309,492			\$333,766
Cardiac Perfusionist								\$272,516	\$256,225
VP Operations							\$279,730		
General Counsel	\$410,471	\$385,527	\$318,627						
VP Compliance							\$273,892		
Executive Medical Director			\$324,499	\$319,748					
Director Education and Research	\$380,708	\$368,511	\$317,847	\$316,265					
VP Facilities	\$322,491	\$311,890	\$288,360	\$314,273	\$326,248	\$318,800	\$308,571	\$311,928	\$316,438
Chief Compliance Officer			\$269,435						
<b>Total</b>	<b>\$5,395,283</b>	<b>\$5,164,935</b>	<b>\$4,748,735</b>	<b>\$5,127,105</b>	<b>\$6,349,574</b>	<b>\$9,977,743</b>	<b>\$10,124,609</b>	<b>\$4,599,519</b>	<b>\$4,147,141</b>

Day Kimball Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	\$516,452	\$513,986	\$514,375	\$474,666	\$560,836	\$411,409	\$507,590	\$345,096	
Interim President & CEO									\$216,080
Director, OBS/GYN									\$354,236
Director, ICU									\$323,919
OB/GYN Physician			\$411,489	\$407,455	\$336,629	\$313,335	\$338,181	\$331,018	\$299,684
ICU Physician	\$300,114	\$296,501							
Chief Nursing Officer/COO	\$258,269								
VP Philanthropy/Corp. Communications								\$274,810	
VP Information Technology							\$414,745	\$227,892	
Director Informatics		\$224,605							
Pulmonary Physician		\$376,468	\$349,728	\$346,213	\$296,573	\$256,479			
VP Medical Affairs	\$344,214	\$336,971	\$364,114	\$339,071	\$306,047	\$294,738	\$305,808		
Senior VP Human Resources							\$273,219		\$230,147
Primary Care Physician		\$345,634	\$310,908	\$303,899					
Sr. VP of Finance/CFD	\$223,937	\$224,475					\$269,690	\$248,725	\$264,433
Corporate Controller	\$188,798								
Director, Pulmonary Services									\$242,043
Clinical Coordinator	\$165,232								
Psychiatric Physician	\$257,275	\$368,447	\$285,299	\$282,325	\$315,466	\$334,821			
Senior VP, M.I.S.									\$240,796
Director, Pediatric Center									\$238,397
Pulmonary Physician		\$261,912					\$263,369	\$233,040	
OB/GYN Physician			\$233,012	\$230,477	\$300,832				
Psychiatric Physician	\$250,064	\$260,024							
Psychiatric Physician	\$232,919								
Cardiologist			\$309,121		\$266,480	\$253,808	\$263,028	\$240,878	
OB/GYN Physician					\$230,630	\$237,022		\$301,577	
Pediatrician			\$228,861	\$226,361	\$230,070	\$210,606		\$236,100	
Pediatrician			\$225,507	\$223,035	\$226,780	\$209,303			
Pediatrician				\$221,314					
Director of Diagnostic Imaging							\$262,389		
Sr. VP of Patient Services						\$204,924	\$241,376	\$220,463	\$232,287
<b>Total</b>	<b>\$2,737,274</b>	<b>\$3,209,023</b>	<b>\$3,232,414</b>	<b>\$3,054,816</b>	<b>\$3,070,343</b>	<b>\$2,726,445</b>	<b>\$3,139,395</b>	<b>\$2,659,599</b>	<b>\$2,642,022</b>

**Essent-Sharon**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	\$277,021	\$314,605	\$736,907	\$259,785	\$270,070	\$317,324	\$474,064	\$283,984	\$262,966
General Surgeon								\$306,608	\$325,221
Hospitalist								\$259,673	\$239,511
Chief Financial Officer	\$244,320	\$268,966	\$149,605	\$243,219	\$223,506	\$218,844	\$210,290	\$154,111	\$157,443
Chief Nursing Officer	\$169,868		\$189,966	\$166,424	\$173,838	\$170,212	\$216,423	\$195,159	\$136,670
Hospitalist								\$183,785	\$191,623
Registered Nurse	\$145,966			\$168,971	\$164,087				\$147,995
Registered Nurse, Operating Room		\$141,012						\$129,873	
Director of Clinical Services, RN		\$134,126							
Director, Rehab Services	\$148,054	\$140,011	\$134,254						
Radiology Technician							\$150,220	\$120,207	\$141,799
Registered Nurse, ICU							\$150,198	\$119,137	
Associate Administrator/Director HR	\$178,790	\$176,514	\$168,637	\$165,449	\$156,926	\$151,963			
Director, Human Resources							\$139,260	\$118,928	
Registered Nurse, Surgical Services							\$136,772		
Chief Quality Officer				\$154,903	\$149,086	\$145,354			
Assistant Chief Financial Officer					\$141,916	\$136,640			
Director Information Management		\$151,335					\$133,325		
Director					\$141,526				
Director Cardiology							\$131,238		
Director, OB/OR									\$133,378
Ultrasound Technician					\$131,927	\$126,922			
Corp. Compliance/Director HIM	\$154,697			\$140,648		\$139,163			
Director ICU/Medical Floor						\$137,798			
Registered Nurse			\$130,821	\$138,152					\$124,818
Director				\$132,448	\$136,750				
Director, Facilities	\$137,605	\$134,220							
Director Surgical Services			\$132,286	\$130,566		\$123,914	\$121,299		
Director, Emergency Services	\$140,971	\$137,453	\$132,012						
Registered Nurse			\$130,196						
Director, Quality	\$137,992	\$136,886	\$130,009						
<b>Total</b>	<b>\$1,735,284</b>	<b>\$1,735,128</b>	<b>\$2,034,693</b>	<b>\$1,700,565</b>	<b>\$1,689,632</b>	<b>\$1,668,134</b>	<b>\$1,863,089</b>	<b>\$1,871,465</b>	<b>\$1,861,424</b>

**Greenwich Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	\$1,357,317	\$1,523,283	\$1,530,629	\$1,712,494	\$5,220,127	\$1,370,221	\$1,197,091	\$1,043,126	\$967,072
Executive VP & COO	\$854,537	\$687,992	\$791,085	\$773,054	\$2,249,823	\$697,391	\$606,122	\$561,225	
Senior VP & CFO	\$794,818	\$772,022	\$716,899	\$717,888	\$749,638	\$701,024	\$613,265	\$580,578	
CFO									\$555,583
COO									\$538,885
Physician - Emergency Medicine				\$600,733					
Director, Pathology	\$630,556	\$594,309	\$602,825	\$588,104	\$637,971	\$633,638	\$530,313	\$653,882	\$568,169
Pathologist	\$586,829	\$568,771	\$592,050	\$566,033	\$591,098	\$599,523	\$571,407	\$543,299	\$505,003
Breast Cancer Surgeon							\$487,387	\$493,628	
Pathologist		\$543,930	\$567,963	\$562,933	\$568,572	\$570,470	\$518,699	\$538,592	\$485,429
Pathologist		\$484,800	\$538,472	\$555,083	\$550,747	\$568,928	\$452,651	\$521,624	\$474,045
Pathologist	\$483,016	\$433,270		\$548,782	\$501,860	\$464,975	\$431,605		\$449,961
Sr VP of Medical Services	\$545,816							\$476,104	
Perinatologist								\$469,742	\$444,738
VP YNHH/COO Greenwich			\$546,303						
SVP - Health System Development	\$564,526	\$524,668	\$504,529	\$510,007	\$520,234	\$501,699	\$429,141		
Pathologist	\$564,333					\$451,166			\$419,929
Chief Quality Officer		\$513,401	\$506,060		\$500,206				
Chief Safety Officer/Director OPC	\$392,587								
<b>Total</b>	<b>\$6,774,335</b>	<b>\$6,646,446</b>	<b>\$6,896,815</b>	<b>\$7,135,111</b>	<b>\$12,090,276</b>	<b>\$6,559,035</b>	<b>\$5,837,681</b>	<b>\$5,881,800</b>	<b>\$5,408,814</b>

Griffin Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	\$557,181	\$499,284	\$558,543	\$489,758	\$547,978	\$411,802	\$454,181	\$443,586	\$395,345
Chief, Psychiatric Physician	\$291,115	\$320,377	\$314,419	\$291,232	\$296,341	\$299,790	\$308,476	\$303,398	
Chief Financial Officer	\$296,929	\$256,683		\$289,096	\$346,302	\$244,324	\$268,883	\$262,323	\$219,846
Chair, Preventative Medicine		\$337,159							
Director, Preventative Medicine		\$282,169	\$308,557	\$277,693	\$301,503	\$273,033	\$240,111	\$217,064	
Chief, Pulmonary Physician	\$287,582	\$280,819	\$279,175	\$272,275	\$307,978	\$246,624	\$241,934	\$234,407	\$187,340
Psychiatric Physician	\$280,396	\$310,078	\$303,559	\$269,168	\$332,866	\$257,518	\$249,306		\$229,293
Chief Medical Director		\$244,481	\$271,028	\$255,557	\$344,552				
Vice President Ancillary Services	\$255,685	\$227,218	\$255,880	\$233,095					
Vice President Communication			\$244,003	\$224,973	\$301,463	\$237,288	\$240,378		
Vice President Support Services		\$219,892							
Emergency Room Physician					\$261,883	\$309,873		\$232,257	\$293,228
Chief, Emergency Room Physician					\$265,122	\$320,932	\$316,904	\$308,016	
Emergency Room Physician						\$239,993	\$299,902	\$273,151	\$246,891
Emergency Room Physician							\$237,606	\$208,609	\$230,109
Emergency Room Physician									\$215,742
Emergency Room Physician									\$215,163
Vice President, Facilities	\$218,056							\$215,178	
Vice President, Nursing	\$255,126		\$231,317	\$211,004					
Psychiatric Physician	\$231,109		\$225,621						\$206,328
Psychiatric Physician	\$215,966								
<b>Total</b>	<b>\$2,889,145</b>	<b>\$2,978,160</b>	<b>\$2,992,102</b>	<b>\$2,813,851</b>	<b>\$3,305,988</b>	<b>\$2,841,177</b>	<b>\$2,857,681</b>	<b>\$2,697,999</b>	<b>\$2,439,285</b>

**Hartford Hartford**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Director of Arrhythmia Center	\$493,748				\$1,900,259				\$481,940
VP, Medical Affairs								\$1,820,511	
VP Academic Affairs & Chief Academic Officer	\$659,689		\$3,351,507						
VP Physician Relations	\$775,366		\$2,975,037						
President and CEO			\$917,623	\$1,738,078	\$1,730,709	\$1,200,432	\$1,037,800	\$1,225,925	\$1,129,631
Director of Maternal & Fetal Medicine			\$1,198,676						
President and CEO (former)					\$1,176,466	\$7,222,700	\$1,271,472		
VP Finance and CFO (former)						\$2,183,659	\$732,281		
Executive VP and COO (former)							\$686,910		
VP, Support Services (former)							\$691,664		
VP, Human Resources						\$1,946,399	\$672,239		
Executive VP and COO		\$1,023,714		\$770,537	\$718,644	\$916,347		\$820,361	\$632,172
SVP & Chief Strategy Officer		\$662,244							
SVP & Treasurer		\$647,196							
Director of Nuclear Cardiology						\$863,309			
VP, Finance and Admin Services								\$731,102	\$663,234
Director of Surgery	\$807,330	\$735,506	\$687,588	\$708,508	\$637,627	\$623,888	\$587,306	\$582,937	\$552,460
Chair, Cancer Institute	\$673,632								
VP, Psychiatry		\$3,235,078	\$736,656	\$705,069	\$726,491				
VP Behavioral Health		\$747,573							
Director of Cardiology	\$599,205	\$694,590	\$1,694,841	\$694,379	\$671,144	\$635,051	\$602,750	\$571,217	\$522,269
Director of Electrophysiology	\$532,089								
Director of Critical Care	\$511,264								
Director of Medicine	\$466,270								
Executive VP and CFO		\$879,820	\$783,046	\$673,245	\$642,618				
VP, Academic Affairs		\$724,793	\$705,560	\$660,035	\$840,004	\$1,838,533	\$601,862	\$592,607	\$563,150
VP, HR and Support Services								\$575,835	\$539,645
SVP & Chief Medical Officer		\$821,632	\$663,431						
Chief Medical Officer				\$615,860					
Director of Emergency Med. & Trauma Svcs.				\$604,599	\$601,875	\$638,169	\$704,026	\$680,234	\$627,615
Director of OB/GYN	\$693,448							\$522,364	\$495,873
Director of Women's Health Services				\$594,607					
<b>Total</b>	<b>\$6,212,041</b>	<b>\$10,172,146</b>	<b>\$13,713,965</b>	<b>\$7,764,917</b>	<b>\$9,645,837</b>	<b>\$18,068,487</b>	<b>\$7,588,310</b>	<b>\$8,123,093</b>	<b>\$6,207,989</b>

**John Dempsey Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
CFO					\$423,912	\$467,571	\$433,800		
Professor/Clinical Operation/CEO								\$366,377	\$226,139
Assistant Professor/Clinical/ ER	\$302,012	\$305,075	\$270,370	\$336,160	\$298,171	\$282,759	\$323,057	\$339,593	\$340,415
Assistant Professor/Clinical/ ER	\$300,619	\$297,040	\$264,648	\$280,994	\$280,062	\$282,087	\$287,737	\$284,186	\$272,033
Assistant Professor/Clinical/ ER	\$297,959	\$291,942	\$258,459	\$279,646	\$279,395	\$281,404	\$281,933		\$247,466
Assistant Professor/Clinical/ ER	\$263,242	\$289,832	\$226,433	\$256,709	\$278,719		\$255,721		
Assistant Professor/Clinical/ ER		\$268,015		\$256,097	\$273,502				
Associate VP/Quality Assurance				\$255,248					
Associate Vice President/Nursing		\$264,858	\$261,801						
Associate VP/Clinical Operation					\$239,014	\$280,309	\$245,858	\$358,640	\$229,110
Associate VP/Clinical Operation								\$239,070	
Professor/Clinical Operation						\$227,704	\$266,034		
Assistant Professor/Clinical/ ER				\$246,747		\$260,249		\$235,231	
Assistant Professor/Clinical/ ER				\$224,026					
Instructor/Clinical					\$235,563			\$273,965	\$219,033
Director of Nursing/Clinical/COO								\$268,125	\$257,788
Director/Nursing	\$320,187								
Director/Nursing	\$294,743								
Assistant VP/Application Development									\$219,585
Professor, Clinical Care Improvement									\$256,050
Professor/Clinical Operation								\$263,030	
CEO	\$332,520	\$613,215	\$477,518		\$228,363	\$122,728	\$427,968		
Chief Operating Officer/Finance/CFO								\$171,946	\$274,404
COO		\$322,932	\$309,737		\$143,634	\$288,884	\$278,220		
Staff Nurse		\$258,118							
Pharmacist	\$264,600		\$249,078						
Chief Perfusionist			\$235,662						
Director/Care Coordination	\$258,829								
Medical Physicist/Clinical Radiology				\$243,983		\$237,831	\$230,310		
Associate VP/Quality Assurance				\$231,828					
Associate Professor/Clinical/ ER	\$363,522	\$357,331	\$322,819						
<b>Total</b>	<b>\$2,998,233</b>	<b>\$3,268,358</b>	<b>\$2,876,525</b>	<b>\$2,611,438</b>	<b>\$2,680,335</b>	<b>\$2,731,526</b>	<b>\$3,030,638</b>	<b>\$2,800,163</b>	<b>\$2,542,023</b>

**Johnson Memorial Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President	\$198,324	\$477,819	\$483,070	\$439,647			\$605,558	\$682,469	\$236,771
Vice President Medical Affairs			\$176,895	\$365,673	\$409,004	\$405,455	\$392,694	\$314,833	\$230,598
VP Human Resources	\$169,393				\$159,122	\$193,937			
Chief Financial Officer	\$311,922	\$309,070	\$313,450	\$277,196					
Medical Director of Emergency Medicine					\$142,788	\$416,901			
Emergency Room Physician					\$132,475	\$362,056		\$322,870	\$541,108
Chief of Pathology					\$121,619	\$297,052	\$279,230	\$238,786	
Emergency Room Physician					\$119,808	\$338,007	\$381,418	\$285,669	\$310,265
Emergency Room Physician					\$119,592	\$308,800	\$342,751	\$274,052	\$305,792
Emergency Room Physician					\$118,828	\$305,737	\$331,902	\$244,867	\$274,657
Emergency Room Physician					\$91,680		\$291,416	\$222,387	\$267,637
Pathologist					\$19,825	\$265,952			
Vice President Operations	\$144,662							\$231,870	
Emergency Room Physician						\$213,194	\$288,524		\$257,326
Vice President, Patient Care Services	\$184,847	\$205,683	\$208,759	\$189,280					
Vice President Finance							\$268,980	\$297,447	\$215,515
Emergency Room Physician							\$267,113		\$245,908
Director, Perioperative Services		\$129,118	\$130,075	\$155,610					
RN	\$170,448	\$178,553	\$154,463	\$153,493					
Corporate Director, Information Technology				\$153,090					
Corporate Director, Physical Therapy			\$155,226	\$150,314					
Corporate Controller	\$152,428	\$147,108	\$145,680						
RN	\$148,565	\$147,631	\$145,058	\$147,917					
Corporate Director, Pharmacy				\$143,925					
RN		\$142,565	\$143,158						
RN, Nursing Administration	\$150,823	\$125,578							
RN, Med Surg Unit	\$148,549	\$143,973							
<b>Total</b>	<b>\$1,779,961</b>	<b>\$2,007,098</b>	<b>\$2,055,834</b>	<b>\$2,176,145</b>	<b>\$1,434,741</b>	<b>\$3,107,091</b>	<b>\$3,449,586</b>	<b>\$3,115,250</b>	<b>\$2,885,577</b>

**Lawrence and Memorial Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President, CEO	\$761,873	\$694,776	\$761,734	\$743,210	\$723,845	\$682,508	\$607,001	\$506,695	\$521,633
President, CEO								\$413,795	\$488,744
VP, Medical Staff								\$351,265	\$323,290
Chair, Amb. Services									\$411,637
VP, COO		\$456,567			\$434,976		\$382,094	\$342,528	
Executive Vice President/COO									\$323,371
Neonatologist								\$313,122	
Chair, Dept. of Medicine								\$304,762	\$303,344
Chief Operating Officer	\$455,107		\$484,902	\$448,642		\$426,450			
Chair, Department of Surgery			\$428,327	\$392,627	\$329,508				
Vice President, CFO		\$375,843	\$431,702	\$409,269	\$390,983	\$384,955	\$363,470	\$292,612	
Vice President of Strategic Planning	\$305,928	\$301,458	\$347,841	\$328,400	\$317,427				
Vice President, Chief Transformation Officer	\$370,291								
Chief Legal Officer	\$314,655	\$291,513	\$324,214	\$307,829	\$298,788				
Vice President, Human Resources				\$303,273					
Chief Information Officer	\$279,344	\$263,482	\$300,811	\$291,003					
Vice President, Patient Care	\$289,965	\$268,052	\$307,103	\$287,396					
Vice President, Physician Practice Mgmt	\$571,419	\$259,091	\$287,114						
Vice President, Development	\$259,338	\$227,889							
ER Physician					\$293,348	\$292,898	\$318,715	\$459,149	\$339,944
ER Physician					\$292,410	\$292,249	\$280,475	\$282,018	\$334,402
ER Physician					\$281,359	\$288,100	\$269,065		\$308,049
ER Physician						\$283,183	\$268,588		\$296,538
ER Physician						\$267,590	\$267,500		
ER Physician						\$266,996	\$266,945		
ER Physician							\$265,510		
Neonatologist								\$280,617	
Medical Director Physician	\$237,574	\$260,900	\$269,719	\$280,326	\$305,139	\$351,937			
<b>Total</b>	<b>\$3,845,494</b>	<b>\$3,399,571</b>	<b>\$3,943,467</b>	<b>\$3,791,975</b>	<b>\$3,667,783</b>	<b>\$3,536,866</b>	<b>\$3,289,363</b>	<b>\$3,546,563</b>	<b>\$3,650,952</b>

**Manchester Memorial Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
CEO	\$683,398	\$558,098	\$560,793	\$730,743	\$475,878	\$509,190	\$433,628	\$430,334	\$386,610
CFO				\$416,311	\$306,482	\$335,082	\$323,493	\$301,441	\$285,916
Behavioral Health Director, MD									\$314,757
Senior VP of Medical Affairs	\$375,056	\$333,973		\$376,267	\$304,418				
Medical Director ED	\$486,729	\$347,998	\$377,339	\$304,562	\$286,005	\$315,238	\$331,415		
Emergency Room MD	\$411,993	\$407,087	\$410,390	\$280,429	\$262,183	\$361,900	\$359,032	\$339,513	\$296,890
Emergency Room MD	\$384,580	\$401,584	\$378,568	\$302,168	\$260,466	\$331,476	\$309,185	\$321,084	\$296,661
Emergency Room MD	\$374,550	\$372,004	\$374,663	\$274,218	\$255,360	\$330,931	\$311,748	\$334,337	\$293,784
Psychiatrist							\$317,634		
Treasurer/Exec VP		\$338,414	\$342,391						
Emergency Room MD	\$371,405	\$363,455	\$359,568	\$272,895	\$259,570	\$321,268	\$305,500	\$304,625	\$286,261
Emergency Room MD	\$362,526	\$355,113	\$340,878	\$267,058	\$247,008	\$316,460	\$305,252	\$290,023	\$285,301
Medical Director ED	\$396,992		\$336,920						
Emergency Room MD		\$370,834	\$334,601	\$258,061	\$235,264	\$327,577	\$288,101	\$287,442	\$264,082
Emergency Room MD						\$316,051		\$284,711	
Medical Director MD	\$383,624							\$281,648	\$275,259
<b>Total</b>	<b>\$4,230,853</b>	<b>\$3,848,560</b>	<b>\$3,816,111</b>	<b>\$3,482,712</b>	<b>\$2,892,634</b>	<b>\$3,465,173</b>	<b>\$3,284,988</b>	<b>\$3,175,158</b>	<b>\$2,985,521</b>

**Middlesex Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President/CEO	\$1,059,523	\$1,047,527	\$1,022,460	\$855,550		\$1,377,566	\$1,894,107	\$1,933,120	\$1,884,150
President/CEO (11 mos), Retired 8/31/10					\$1,698,891				
Sr. VP, Finance & Operations (11 mos), Pres/CEO (1mo)					\$713,168				
VP, Quality and Patient Safety	\$552,948	\$514,956	\$495,392						
Sr. VP/COO						\$583,273	\$568,734		
VP, Clinical Affairs	\$639,942	\$712,317	\$692,616	\$527,592	\$522,169	\$425,075			
VP, Nursing					\$515,525	\$455,108	\$589,921	\$422,093	
Chairman, Emergency Medicine	\$465,412	\$457,572	\$437,030	\$458,361	\$437,785	\$414,514	\$407,600	\$530,229	\$359,355
VP, Finance/COO/Treasurer	\$507,273	\$491,453	\$472,027	\$443,841	\$420,113	\$366,834			\$476,898
VP, Human Resources	\$407,633	\$485,999	\$458,638					\$771,255	\$571,732
Sr. VP, Finance & Operations								\$688,373	
Sr. VP, Strategic Planning & Operations	\$410,991	\$398,871							
Associate Director, Family Practice									\$326,086
VP, Operations				\$437,276			\$345,141	\$398,682	
Chairman, Dept. of Medicine					\$402,393	\$383,550	\$355,939		
Physician, Emergency Department	\$404,116	\$438,794	\$410,969	\$412,833	\$383,357	\$359,933	\$380,476		\$313,468
Physician, Emergency Department			\$382,622				\$342,129		\$302,881
Physician, Emergency Department							\$333,436		
Chief, Dept. of Psychiatry								\$480,747	\$319,133
Medical Director/MMC Shoreline									\$306,084
Clinical Director of Infectious Disease		\$393,196	\$384,870	\$397,220	\$399,022	\$373,789		\$471,634	
Clinical Director, Family Practice								\$385,914	
Chief, Department of Medicine & Secretary	\$410,301	\$395,704	\$387,577	\$391,924	\$398,797				
ED Physician, Shoreline								\$383,310	
Former President/CEO				\$390,210					
Medical Director/Emergency Department	\$396,768			\$385,161		\$354,820	\$363,313		\$305,760
<b>Total</b>	<b>\$5,254,907</b>	<b>\$5,336,389</b>	<b>\$5,144,201</b>	<b>\$4,699,968</b>	<b>\$5,891,220</b>	<b>\$5,094,462</b>	<b>\$5,580,796</b>	<b>\$6,465,357</b>	<b>\$5,165,547</b>

**Midstate Medical Center**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President/CEO		\$943,218	\$958,020	\$903,186	\$852,851	\$856,294	\$818,081	\$724,372	\$583,640
CFO				\$500,859	\$472,514	\$417,879	\$370,141	\$325,521	\$318,218
Hospitalist Physician Director				\$402,481	\$384,467	\$362,957	\$334,211		
Hospitalist	\$389,707	\$450,232							
Hospitalist	\$347,566	\$383,916							
Hospitalist	\$336,773	\$372,952							
Hospitalist	\$324,813	\$365,712							
Hospitalist	\$320,553	\$359,039							
Hospitalist	\$316,325	\$348,383							
Hospitalist	\$257,561	\$347,761							
Per Diem Hospitalist	\$314,391								
Medical Director Mediquick	\$365,164								
Vice President			\$390,197	\$361,186					
Physician/ED Physician			\$409,553	\$357,013	\$523,033	\$515,538	\$452,689	\$454,104	\$416,177
Physician/ED Physician			\$409,432	\$338,014	\$392,805	\$426,115	\$410,223	\$395,225	\$368,814
Physician/ED Physician			\$351,649	\$327,442	\$373,523	\$366,218	\$354,336	\$345,308	\$336,495
CMO		\$538,417	\$419,637	\$324,801					
Senior VP Operations	\$362,653								
Vice President				\$317,948					
COO		\$418,703						\$418,216	\$372,092
Physician/ED Physician			\$348,160	\$310,134	\$359,090	\$352,368	\$319,583	\$341,842	\$316,487
Physician/ED Physician			\$340,888		\$352,973	\$343,935	\$319,411	\$329,998	\$311,835
Physician/ED Physician			\$340,517		\$345,949	\$336,351	\$310,987	\$323,821	\$311,615
Physician/ED Physician			\$339,775		\$343,328	\$331,467	\$310,000	\$322,437	\$305,567
<b>Total</b>	<b>\$3,335,506</b>	<b>\$4,528,333</b>	<b>\$4,307,828</b>	<b>\$4,143,064</b>	<b>\$4,400,533</b>	<b>\$4,309,122</b>	<b>\$3,999,662</b>	<b>\$3,980,844</b>	<b>\$3,640,940</b>

**Millford Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President	\$875,081	\$596,448	\$579,475	\$409,804	\$369,792	\$368,100	\$584,198	\$564,048	\$542,425
Physician, Dir. ICU						\$435,314	\$436,656	\$366,809	\$311,211
Vice President Finance							\$367,778	\$359,990	\$335,416
Physician, Chief Operating Officer	\$824,032	\$556,742	\$538,527	\$390,015	\$451,013				
Hospitalist		\$363,430	\$351,489	\$358,094	\$370,807		\$308,051		
Pathologist	\$369,566	\$344,700	\$345,094	\$350,286					
ER Physician	\$274,722	\$373,044	\$341,173	\$333,021	\$337,610	\$341,036	\$332,309	\$324,830	\$313,159
ER Physician	\$246,745	\$359,350	\$341,090	\$332,969	\$337,610	\$350,539	\$331,769	\$324,668	\$311,318
ER Physician		\$339,255	\$340,882	\$331,803	\$327,796	\$335,078	\$330,092	\$321,487	\$306,348
Physician, Dir., ER				\$329,567	\$334,377			\$319,726	\$318,225
Hospitalist			\$346,959	\$329,539	\$318,975	\$332,513			
House Physician	\$373,895							\$294,558	\$269,738
House Physician	\$357,857								
House Physician	\$346,822								
House Physician	\$286,221								
House Physician	\$267,192								
ER Physician		\$339,099	\$339,691	\$322,711	\$327,783	\$325,638	\$326,820	\$320,258	
ER Physician		\$335,714	\$332,195		\$323,799	\$326,493	\$307,639	\$291,567	\$241,487
ER Physician		\$335,209				\$322,325			\$234,035
ER Physician						\$315,317			
Vice President Finance							\$301,943		
<b>Total</b>	<b>\$4,222,133</b>	<b>\$3,942,991</b>	<b>\$3,856,575</b>	<b>\$3,487,809</b>	<b>\$3,499,562</b>	<b>\$3,452,353</b>	<b>\$3,627,255</b>	<b>\$3,487,941</b>	<b>\$3,183,362</b>

**New Milford Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
VP Human Resources				\$598,225					
President/CEO	\$240,264	\$216,471	\$195,774			\$579,769	\$551,928	\$378,612	\$510,994
SVP Operations	\$305,899	\$390,795	\$399,446						
Controller	\$175,328	\$169,748	\$187,679						
Director, Finance	\$202,764	\$197,173	\$187,168						
Ex-President						\$504,699	\$520,642	\$556,305	
Director, Patient Experience	\$185,544	\$181,583							
PVT-Physician				\$524,365	\$415,363	\$388,286		\$314,473	\$294,239
PVT-Physician					\$402,659				
PVT-Physician					\$372,602				
Lab-Physician			\$480,036	\$433,162	\$458,129	\$444,620	\$431,352	\$393,499	\$395,072
Dir., Emergency Services				\$425,241	\$455,760	\$442,595	\$493,692	\$391,352	\$397,819
Ear, Nose & Throat Physician						\$393,109	\$419,422		
Chief Medical Physicist	\$241,166	\$236,050	\$236,050						
Manager, Cancer Center	\$172,631								
Radiology-Physician			\$237,151	\$388,596	\$463,809	\$453,172	\$452,354	\$409,046	\$390,278
ER-Physician				\$324,724	\$356,520		\$357,558	\$333,064	\$303,683
VP, Finance				\$304,635	\$320,582	\$1,574,460	\$332,954	\$286,657	\$291,461
ER-Physician				\$296,090	\$325,727	\$341,992	\$324,888	\$301,257	\$301,090
ER Physician								\$296,044	\$297,204
ER Physician									\$290,550
VP, Nursing, COO			\$206,897	\$279,629	\$335,896	\$379,013	\$377,312		
PVT-Physician				\$268,123					
Director, Nursing	\$169,779	\$213,871							
Director, Medical Affairs & Quality	\$199,888	\$197,694							
Director, Planetree			\$180,756						
Director, Employee Health	\$171,529	\$173,850	\$180,359						
Mgr, Pharmacy Operations		\$157,679							
MIS Officer			\$178,965						
<b>Total</b>	<b>\$2,064,792</b>	<b>\$2,134,914</b>	<b>\$2,670,281</b>	<b>\$3,842,790</b>	<b>\$3,907,047</b>	<b>\$5,501,715</b>	<b>\$4,262,102</b>	<b>\$3,660,309</b>	<b>\$3,472,390</b>

Norwalk Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
VP & Chief Medical Officer				\$810,916	\$911,520				
President & CEO	\$1,268,795	\$1,050,930	\$901,148	\$797,727		\$941,545	\$947,473	\$753,038	\$712,447
COO									\$624,360
President & CEO (through April 2010)					\$2,769,742				
VP & Chief Operating Officer/President & CEO					\$631,222				
VP & Chief Operating Officer						\$580,806			
VP Quality				\$651,642					
Physician, Emergency Department	\$590,305	\$626,548	\$685,615	\$644,978	\$598,761	\$546,877	\$571,541	\$581,690	
Chairman, Dept. of Emergency Medicine		\$568,977	\$585,218	\$582,032		\$520,710	\$499,071	\$471,022	\$530,410
VP Planning/VP and Chief Operating Officer					\$495,864				
Chairman, Dept. of OB/GYN				\$576,298		\$787,458	\$510,698	\$469,596	\$458,545
Sr. VP & COO			\$535,681	\$534,321			\$715,282	\$475,350	
Physician, Emergency Department	\$516,291	\$475,854	\$519,445	\$518,578	\$616,208	\$539,434	\$508,100	\$555,721	\$464,069
Chairman, Dept. of Medicine				\$499,713	\$545,236	\$827,220	\$708,223	\$574,213	\$564,770
VP & Chief Financial Officer	\$664,111	\$610,069	\$489,543				\$461,558		
VP Nursing Patient Care Services						\$436,783			
VP Planning and Business Development						\$407,117			\$358,054
Sr. VP Strategy & System Development	\$601,931								
Sr. VP & COO		\$560,049					\$413,961		
VP, Human Resources	\$926,697	\$472,049							
Chairman, Dept. of Surgery				\$478,153	\$437,306		\$400,520	\$436,043	
Chief Pulmonary/Critical Care					\$495,115				
Director, Real Estate								\$411,611	
Physician, Emergency Department	\$501,242		\$478,304		\$392,756	\$392,120		\$380,719	\$401,936
Chief Financial Officer									\$399,721
VP & Chief Nursing Officer			\$472,525						
Chairman, Psychiatry		\$454,227							\$395,655
Physician, Emergency Department	\$473,446	\$420,766	\$442,639						
Physician, Emergency Department	\$472,663	\$411,006	\$412,040						
Physician, Emergency Department	\$455,025								
<b>Total</b>	<b>\$6,470,506</b>	<b>\$5,650,475</b>	<b>\$5,522,158</b>	<b>\$6,094,358</b>	<b>\$7,893,730</b>	<b>\$5,980,070</b>	<b>\$5,736,427</b>	<b>\$5,109,003</b>	<b>\$4,909,967</b>

Rockville General Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
CEO	\$269,844	\$239,511	\$240,340	\$313,176	\$203,947	\$218,224	\$185,155	\$184,429	\$165,690
Medical Director	\$338,865	\$353,700	\$324,458						
Medical Director		\$279,461	\$267,332						
Emergency Room Staff MD						\$298,633	\$288,830	\$316,140	\$284,842
Urgent Care MD	\$311,021	\$237,773							
Urgent Care MD	\$256,590	\$198,751							
Urgent Care MD	\$237,577								
OB/GYN				\$296,847	\$287,075	\$253,645	\$134,771		
VP Patient Care Services	\$224,341	\$194,226	\$168,500						
Infection Control Director MD	\$264,351			\$267,035	\$213,063	\$231,082	\$231,252	\$251,377	
Emergency Room Staff MD						\$156,625	\$286,392	\$308,333	\$279,951
Emergency Room Staff MD								\$233,212	\$275,186
Infectious Disease MD									\$250,121
Emergency Room Staff MD									\$227,994
Psychiatrist	\$261,240	\$226,768							
CFO				\$178,419	\$131,350	\$143,386	\$140,036	\$129,190	\$122,535
Senior VP of Medical Affairs				\$161,257	\$131,123	\$134,648			
RN - Amb Surg					\$144,581				
VP Quality							\$151,625		\$153,245
Emergency Room Staff MD									\$135,879
Senior Director									\$128,113
RN Supervisor		\$174,125	\$167,806	\$144,695	\$126,755				
RN Supervisor		\$185,757							
Registered Nurse	\$176,954		\$148,917						
Treasurer/Exec VP			\$146,739						
Admin Director				\$147,232	\$140,026	\$139,004	\$131,485		
Medical Director MD		\$149,601	\$144,450					\$120,706	
Staff Nurse Practitioner								\$119,658	
Registered Nurse			\$126,837						
Senior VP/Medical Director			\$124,441						
Clinician	\$155,922								
Admin Director							\$134,895		
RN-ICU				\$146,783	\$135,200	\$132,657			
RN-ICU					\$128,826				
Medical Director ED				\$130,526		\$135,102	\$142,034	\$117,224	
Pharmacist								\$126,810	
Medical Imaging Director				\$149,607					
<b>Total</b>	<b>\$2,496,705</b>	<b>\$2,239,673</b>	<b>\$1,859,820</b>	<b>\$1,935,577</b>	<b>\$1,641,946</b>	<b>\$1,843,006</b>	<b>\$1,826,475</b>	<b>\$1,907,079</b>	<b>\$2,023,556</b>

**Saint Francis Hospital and Medical Center**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President	\$3,135,570	\$1,697,418	\$1,521,090	\$1,422,730	\$1,534,640	\$1,225,460	\$1,295,178	\$1,161,713	\$1,052,791
Retired President									\$842,802
Senior Vice President and CFO			\$715,743		\$820,051	\$764,883	\$782,085	\$592,563	\$525,978
Executive Vice President						\$776,959	\$732,722	\$624,226	\$553,559
Executive Vice President and COO	\$635,702	\$898,975	\$731,103	\$693,126	\$629,960	\$506,142			
Executive Vice President, Chief Admin Officer	\$785,531	\$843,425							
Senior Vice President and General Counsel			\$395,262			\$739,382	\$543,618	\$436,409	
Department Chairman, Surgery	\$731,925	\$667,064	\$627,085			\$433,126			
Executive Vice President and CPO		\$823,171	\$564,996						
President - Saint Francis Foundation				\$568,974	\$475,818	\$480,084			
Senior Vice President, Chief Academic Officer	\$505,762	\$522,703	\$497,259	\$515,074	\$498,851	\$453,270			
Senior Vice President, Chief Dev. Officer	\$483,872	\$487,359							
Section Chief - Pathology					\$489,166	\$434,053	\$487,549	\$473,932	\$455,029
President, JMMC	\$442,406								
Vice President, Financial Planning		\$380,990	\$495,310						
Department Chairman - Pathology					\$467,804		\$471,696	\$460,763	\$442,915
Senior Vice President - Nursing		\$441,176	\$419,088						
Program Director - Pathology					\$442,922		\$440,671	\$428,034	\$409,916
Vice President - Interim CFO				\$436,565		\$494,094			
Department Chairman - Emergency				\$427,080	\$410,602		\$473,425	\$433,598	\$415,766
Senior Vice President - Planning	\$415,876	\$412,053	\$413,512	\$426,075	\$444,464		\$418,495		
SVP, Human Resources	\$376,149								
SVP, Chief Information Officer	\$374,456								
Staff Physician - Emergency				\$417,086			\$398,410		\$422,436
Staff Physician - Emergency				\$419,896					\$348,989
Staff Physician - Emergency				\$394,466				\$397,797	
Psychiatrist								\$388,889	
<b>Total</b>	<b>\$7,887,249</b>	<b>\$7,174,334</b>	<b>\$6,380,448</b>	<b>\$5,721,072</b>	<b>\$6,214,278</b>	<b>\$6,307,453</b>	<b>\$6,043,849</b>	<b>\$5,397,924</b>	<b>\$5,470,181</b>

**St. Mary's Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	\$913,009	\$853,512	\$791,256	\$649,453	\$599,134			\$765,051	\$764,919
Medical Director Cardiology									\$314,576
Vice President & CFO former								\$306,178	\$166,517
Executive Vice President						\$593,749	\$404,367		
Vice President and CFO	\$334,247	\$266,887	\$218,577	\$479,091	\$363,355	\$392,216	\$424,741	\$199,564	\$299,653
Vice President & CNO	\$256,164	\$338,629							
Vice President & CNO, former		\$265,011							
Vice President Patient Services			\$560,617	\$284,285	\$293,715	\$296,546	\$343,210	\$259,189	\$228,563
VP, Marketing & Business Development								\$224,306	\$172,878
Former President & CEO							\$305,243		
Vice President Human Resources	\$303,346	\$280,376	\$290,284	\$255,565	\$240,600	\$246,038	\$247,611		\$163,764
Physician Hospitalist Program Internal Med.									\$190,874
Chairman, Department of Medicine		\$275,582							
Vice President & Chief Medical Officer	\$435,298	\$245,516	\$425,825	\$432,762	\$475,162	\$270,057			
Chief Information Officer		\$228,524	\$244,993	\$240,094	\$200,300	\$178,502	\$181,117	\$152,782	
Chief Marketing Officer	\$257,678	\$240,125	\$226,403	\$221,048	\$201,173	\$178,752	\$159,775		
Vice President Surgical Services			\$353,905	\$318,435	\$201,394				
Vice President Surgical Services, Former	\$372,127								
Vice President Operations	\$349,154	\$325,082	\$333,779	\$296,349	\$241,116		\$284,820	\$222,746	\$167,537
Chief Operating Officer	\$307,756								
Critical Care Nurse						\$162,859			
Div. Dir. Perioperative and Invasive Services							\$168,939	\$161,555	
Divisional Director, Clinical Quality			\$185,905	\$185,753		\$173,009	\$163,605	\$158,061	
Director of Pharmacy								\$151,739	
Director, Operating Room					\$178,178	\$162,039			\$146,949
Executive Director Revenue Cycle	\$219,286								
<b>Total</b>	<b>\$3,748,065</b>	<b>\$3,319,244</b>	<b>\$3,631,544</b>	<b>\$3,362,835</b>	<b>\$2,994,127</b>	<b>\$2,653,767</b>	<b>\$2,683,428</b>	<b>\$2,601,171</b>	<b>\$2,616,230</b>

**St. Raphael**

<b>Position Title</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President	\$1,803,605	\$1,043,560	\$911,333	\$4,282,605	\$1,013,140	\$903,330	\$890,725
Former President			\$2,168,074				
Senior Vice President, COO & CFO		\$734,111	\$987,313	\$635,609			
Senior Vice President, CMO (MD)	\$724,139	\$705,420	\$773,004	\$651,886			
Clinical Chair, Surgery (MD)			\$680,736	\$713,955	\$648,922	\$624,624	\$527,845
Clinical Chair, Emergency Medicine (MD)	\$460,733	\$630,934		\$629,011	\$516,934	\$437,898	
Vice President - Medical Services							\$488,498
Clinical Chair, Medicine (MD)	\$541,652	\$595,195		\$714,365	\$534,595	\$503,169	\$483,632
Former Sr. Vice President, CMO (MD)			\$635,338				
Cardiologist (MD)	\$514,489	\$524,696				\$501,371	\$325,398
Clinical Chair, Women's/Children's Services (MD)	\$472,267			\$580,409	\$621,357	\$613,674	\$545,164
Associate Clinical Chair, Surgery (MD)						\$400,079	\$387,694
Director, Cardiology Fellowship/CDU (MD)	\$503,734	\$510,919	\$515,784				
Director, Surgical Intensive Care Unit (MD)	\$478,876	\$487,030			\$439,540	\$405,821	\$384,802
Section Chief, Thoracic Surgery (MD)	\$564,767	\$484,735	\$486,810	\$468,291	\$493,505		
Section Chief, Cardiology (MD)			\$447,832	\$420,950	\$397,602	\$621,619	\$386,114
Associate Clinical Chair, Medicine (MD)	\$368,478	\$387,201	\$377,221	\$360,560	\$348,214	\$340,498	
Directors, McGivney Cancer Center (MD)							\$308,371
Medical Information Officer (MD)					\$345,612		
<b>Total</b>	<b>\$6,432,740</b>	<b>\$6,103,801</b>	<b>\$7,983,445</b>	<b>\$9,457,641</b>	<b>\$5,359,421</b>	<b>\$5,352,083</b>	<b>\$4,728,243</b>

**St. Vincent's Medical Center**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	\$1,076,770	\$984,669	\$2,394,278	\$1,484,755	\$1,485,490	\$1,275,826	\$922,813	\$954,683	\$813,986
Former Chief Executive Officer		\$1,110,833							
President/Chief Academic Officer			\$978,878						
Chairperson Medicine					\$771,879				
Senior Vice President			\$929,797						
CMO/Clinical VP Cardiology							\$715,872	\$815,402	\$588,172
Chief, Cardiothoracic Surgery						\$714,299	\$688,391	\$470,873	
Clinical Chair Oncology						\$659,205	\$567,940	\$562,094	
Corp. Sr. VP Marketing/Govt Relations						\$624,541	\$575,899	\$497,550	\$640,952
Sr. VP Chief Clinical/Chief Medical Officer	\$921,307	\$910,454			\$717,509				
Clinical Chair Oncology/Chief Medical Officer				\$837,791					
Clinical Vice President Cardiac Services			\$774,448	\$634,145					
Clinical Vice President Surgical Services		\$894,493	\$778,042	\$630,797	\$587,507	\$594,139		\$561,609	\$562,403
Senior Vice President/Chief Financial Officer	\$688,869	\$673,021	\$747,134	\$567,478	\$527,089				
Clinical Vice President Medicine	\$675,890	\$643,993	\$613,539	\$554,058		\$622,403	\$624,660	\$602,937	\$732,012
Vice President/Chief Legal Counsel	\$534,713	\$513,004							
Sr. VP/Chief Nursing Officer/COO	\$497,600	\$482,467							
Senior VP, Corporate Affairs	\$390,699	\$354,899							
Chairperson, Department of Surgery	\$481,159								
Director, Cardiothoracic Surgery						\$536,707	\$582,197		
General Surgeon						\$506,107	\$622,697		
Trauma Surgeon								\$491,733	
Chair Neonatology							\$505,356		
Chairperson Emergency Care	\$443,244		\$592,032	\$525,145	\$626,929		\$454,732	\$457,191	\$476,961
Vice Chairperson Emergency Care				\$491,021	\$527,678				\$354,263
ED Physician						\$443,302		\$378,793	\$331,842
ED Physician						\$435,153			\$313,453
Chief Financial Officer									\$420,933
Senior Vice President				\$456,215	\$653,854				
Sr. VP/Chief Administrative Officer			\$590,696		\$427,992				
Chairperson, Obstetrics & Gynecology	\$376,404				\$390,454				
Sr. VP/Chief Human Resources Officer		\$454,673	\$477,436						
Vice President CHRDO Employee Council				\$455,920					
<b>Total</b>	<b>\$6,086,655</b>	<b>\$7,022,506</b>	<b>\$8,876,280</b>	<b>\$6,637,325</b>	<b>\$6,716,381</b>	<b>\$6,411,682</b>	<b>\$6,260,557</b>	<b>\$5,792,865</b>	<b>\$5,234,977</b>

**Stamford Hospital**

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	\$2,402,748	\$2,222,554	\$1,532,094	\$2,241,639	\$1,695,727	\$2,399,609	\$1,552,751	\$1,424,969	\$1,505,731
Sr. VP Finance CFO									\$1,177,667
Sr. VP of Medical Affairs	\$929,239	\$779,389	\$681,212	\$1,080,817	\$911,568	\$844,466	\$1,084,950	\$916,043	\$827,193
VP of Physician Network Development		\$873,017							
Surgery Physician									\$707,094
Pediatric Physician									\$612,001
Chief of Cardiac Surgery	\$898,824	\$996,839	\$1,180,752	\$992,541					
Chief of Surgery	\$857,348		\$768,216	\$906,571	\$716,968	\$677,257	\$718,271	\$603,072	
Exec. VP and Chief Operating Officer	\$1,316,300		\$784,363	\$756,653	\$586,964	\$556,035	\$669,998	\$555,285	
Sr. VP Operations COO		\$807,104							\$531,798
Sr. VP of Strategy & Marketing	\$721,788	\$649,400	\$663,125	\$740,648	\$584,749	\$555,766	\$702,165	\$560,141	\$516,754
VP of Finance & Chief Financial Officer	\$1,008,955	\$816,687	\$735,596	\$720,187					
Chief Information Officer					\$572,108			\$659,960	
Chief Financial Officer					\$538,917	\$584,026	\$685,468	\$642,151	
VP Ambulatory Services			\$662,001	\$656,204	\$537,897				
Chief of Cardiology		\$619,201	\$608,165	\$580,278					
Chair, Dept. of Pediatrics						\$535,091	\$599,219	\$596,484	
Cardiac Surgeon			\$604,033						\$526,501
Director of Cardiology					\$577,961	\$527,830	\$567,360	\$533,258	
Chief of Bariatric Surgery	\$719,194	\$616,054							
Sr. VP Patient Services					\$523,138				\$608,443
VP and Chief Information Officer	\$688,889								
Chief Financial Officer								\$527,027	
Dept. of Medicine Physician									\$500,240
Sr. VP of Talent & Culture						\$507,757	\$560,848		
Chief, Dept Medicine							\$489,451		
Chair, Dept. of Obstetrics	\$1,063,073	\$673,597		\$579,437		\$579,607			
<b>Total</b>	<b>\$10,606,358</b>	<b>\$9,053,842</b>	<b>\$8,219,557</b>	<b>\$9,254,975</b>	<b>\$7,245,997</b>	<b>\$7,767,444</b>	<b>\$7,630,481</b>	<b>\$7,018,390</b>	<b>\$7,513,422</b>

**Waterbury Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
COO			\$285,001	\$372,533	\$349,800	\$346,933	\$336,115		\$303,422
President	\$700,205	\$663,566	\$520,298		\$559,086	\$557,177	\$543,225	\$497,412	\$495,175
Medical Director ICU							\$429,416	\$404,073	\$368,600
Chief Financial Officer	\$412,354								
Chief Information Officer	\$390,922	\$343,254							
Physician, Director of ED			\$220,141			\$434,224	\$419,545	\$385,225	\$360,832
VP Medical Affairs		\$168,103	\$200,000		\$401,415	\$399,001	\$386,234	\$361,690	\$356,362
VP Patient Care/CNO	\$277,791	\$246,766							
Vice President Operations		\$182,207							
Medical Director Internal Medicine						\$406,881	\$390,191	\$374,049	\$363,491
Psychiatrist	\$241,985		\$206,039						
Medical Director ICU						\$401,214			
ED Physician						\$375,695	\$347,516	\$301,684	\$292,832
Staff Pharmacist		\$183,278							
Physician Assistant Director of Surgery									\$337,710
Associate Director of Surgery							\$350,943	\$342,946	
Attending Faculty Surgeon						\$351,552	\$340,601	\$354,404	
Physician, Director of ED								\$357,059	
CFO			\$174,602	\$366,538	\$342,259	\$340,322			\$304,167
Chief Medical Information Officer: MD				\$279,141	\$241,679				
Chief Medicaid Information Officer		\$235,757							
Medical Director Behavioral Health	\$250,037	\$235,528	\$204,736	\$245,009	\$253,710				
Medical Director Behavioral Health	\$234,438		\$193,939	\$234,970	\$234,482				
Medical Director Adolescent Services	\$230,941								
Psychiatrist		\$189,684	\$200,840	\$240,995	\$242,964				
VP Human Resources	\$272,995	\$249,234	\$177,500	\$224,139	\$213,388				
Psychiatrist	\$238,483			\$237,376	\$237,430				
ED Physician						\$327,404	\$334,097	\$313,796	\$282,454
COO				\$214,294					
VP Finance				\$191,630					
<b>Total</b>	<b>\$3,250,151</b>	<b>\$2,697,377</b>	<b>\$2,383,096</b>	<b>\$2,606,625</b>	<b>\$3,076,213</b>	<b>\$3,940,403</b>	<b>\$3,877,883</b>	<b>\$3,692,338</b>	<b>\$3,465,045</b>

**Windham Community Memorial Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
Chief Executive Officer				\$545,243	\$585,128	\$520,920	\$469,982	\$367,447	\$368,288
Director of ER									\$454,329
Associate Director Emergency Department							\$323,865	\$434,562	
Physician/Hospitalist		\$288,962	\$463,270	\$441,376	\$376,126				
Medical Director			\$347,208	\$359,517	\$290,378				
Chief Financial Officer/VP Finance			\$249,090	\$337,633	\$341,410	\$318,624	\$293,324	\$241,639	
Chief Financial Officer									\$242,778
Emergency Department Physician							\$293,059	\$414,618	\$376,809
Emergency Department Physician							\$246,715	\$366,186	\$345,570
Emergency Department Physician							\$242,264	\$352,725	\$302,407
Emergency Department Physician							\$214,742	\$315,865	\$289,138
Emergency Department Physician							\$206,331	\$312,993	\$273,434
Emergency Department Physician							\$143,862	\$306,390	\$226,486
Emergency Department Physician								\$247,438	\$178,510
Physician/Hospitalist	\$378,887	\$436,964	\$433,682	\$269,810	\$221,757				
Physician/Hospitalist	\$296,315	\$320,462	\$284,341	\$265,443					
Physician/Hospitalist	\$279,557	\$305,674	\$279,696	\$264,125					
Physician/Hospitalist	\$264,022	\$269,719							
Physician/Hospitalist	\$261,230								
Vice-President Operations		\$263,290	\$257,531	\$245,308					
Physician/Hospitalist	\$250,041	\$301,846	\$245,831						
Physician/Hospitalist	\$233,954								
Medical Director			\$223,976	\$229,559	\$222,030				
Vice President Patient Care		\$255,343			\$237,440	\$292,675	\$190,886		
Vice President Human Resources	\$198,295	\$349,509			\$199,093	\$183,859			
IT Director		\$248,557							
Registered Nurse	\$232,524		\$257,641			\$193,937			
Registered Nurse	\$212,515			\$214,202	\$196,156	\$165,936			
Director Inpatient Nursing						\$162,875			
Registered Nurse						\$160,759			
Registered Nurse						\$160,524			
Registered Nurse					\$192,973	\$158,314			
<b>Total</b>	<b>\$2,607,340</b>	<b>\$3,040,326</b>	<b>\$3,042,266</b>	<b>\$3,172,216</b>	<b>\$2,862,491</b>	<b>\$2,318,423</b>	<b>\$2,625,030</b>	<b>\$3,359,863</b>	<b>\$3,057,749</b>

**Yale-New Haven Hospital**

<b>Position Title</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>
President & CEO (YNHH & YNHHS)	\$3,520,872	\$3,263,758	\$2,803,228	\$2,592,381	\$2,547,699	\$2,612,895	\$2,022,544	\$1,798,621	\$1,488,980
Exec. VP, COO (YNHH & YNHHS)	\$2,143,135	\$1,942,688	\$1,680,133	\$1,636,424	\$1,643,996	\$1,625,653	\$1,516,169	\$1,403,271	\$350,233
SR VP, Chief of Staff (YNHH & YNHHS)	\$1,593,847	\$1,482,123	\$1,673,612	\$1,383,291	\$2,713,552	\$1,339,602	\$1,234,724	\$1,115,331	
SR VP Finance, CFO (YNHH & YNHHS)	\$1,806,166	\$1,597,211	\$1,432,214	\$1,359,691	\$1,345,514	\$1,260,656	\$1,114,791	\$1,083,817	\$1,124,783
SVP, Med. Aff/Chief									\$1,102,233
Sr. VP of Quality & Safety	\$909,375								
Senior VP HR (YNHH & YNHHS)	\$1,078,184	\$1,002,344	\$945,388	\$963,800	\$954,346	\$976,093		\$725,218	\$656,327
Senior VP Administration				\$920,989	\$924,331	\$870,911	\$726,378	\$636,947	\$577,249
VP of Legal Services	\$1,100,951	\$998,877	\$903,335	\$802,811	\$780,372				
VP & Exec Dir of Childrens Hospital		\$853,117				\$739,113	\$594,779		
Sr. VP of OPS/Children	\$875,071								
Senior VP Patient Services		\$703,474	\$769,813	\$736,309	\$724,577	\$729,091	\$1,093,847	\$565,102	\$528,715
Senior VP, CIO (YNHH & YNHHS)	\$1,133,727	\$1,003,592	\$895,982	\$687,019	\$902,132	\$985,608	\$739,064	\$686,872	\$676,045
Vice President, Administration									\$508,390
Vice President, Administration									\$486,639
SVP OPS/Smilow	\$898,353	\$800,103	\$647,666						
VP Finance					\$726,759	\$718,587	\$574,932	\$539,790	
VP Ambulatory Services			\$622,898	\$654,217			\$601,502	\$562,377	
<b>Total</b>	<b>\$15,059,681</b>	<b>\$13,647,287</b>	<b>\$12,374,269</b>	<b>\$11,736,932</b>	<b>\$13,263,278</b>	<b>\$11,858,209</b>	<b>\$10,218,730</b>	<b>\$9,117,346</b>	<b>\$7,499,594</b>

## Greer, Leslie

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**From:** Feldman, Joan <JFeldman@goodwin.com>  
**Sent:** Wednesday, July 06, 2016 1:07 PM  
**To:** Hansted, Kevin; Riggott, Kaila; Greer, Leslie  
**Cc:** Carannante, Vincenzo; hfmurray@lapm.org  
**Subject:** FW: Applicants' Supplemental Prefiled Testimony Rebutting Prefile Testimony of Fred Hyde 15-32032-CON and 15-32033-CON  
**Attachments:** 15-32032-CON.PDF; 15-32033-CON.PDF

Please accept our supplemental prefiled testimony in response to the Intervenors' Prefile Testimony.

Thank you.

Joan

**Shipman & Goodwin** LLP  
C O U N S E L O R S   A T   L A W

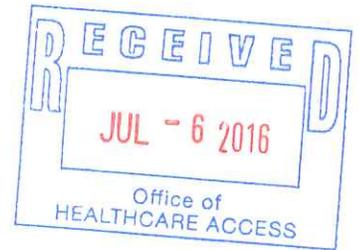
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STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS



MERGER OF L&M PHYSICIAN : DOCKET NO. 15-32032-CON  
ASSOCIATION, INC. AND NORTHEAST :  
MEDICAL GROUP, INC. :  
: July 11, 2016

**APPLICANTS' SUPPLEMENTAL PREFILED TESTIMONY REBUTTING  
PREFILE TESTIMONY OF FRED HYDE ON BEHALF OF INTERVENORS**

The Applicants are filing this supplemental prefiled testimony to address the unsubstantiated, conclusory and false and misleading statements made by Dr. Hyde ("Hyde") in his prefiled testimony on behalf of the Intervenors. More particularly, Hyde's prefiled testimony impugns the intent, the community commitment, and the integrity of the Applicants. The Applicants believe that such statements are irresponsible and self-serving given Hyde's personal history with Windham Community Memorial Hospital ("Windham Hospital") and his role as a member of the Certificate of Need Task Force established pursuant to the Governor's Executive Order No. 51 (the "Task Force"). Certainly, one would expect that the members of the Task Force would refrain from participating in matters in which they have an apparent conflict of interest in or, at a minimum, be less biased and inflammatory in their statements.

Accordingly, for the purpose of ensuring an accurate record, the Applicants respectfully dispute and respond to Hyde's prefiled testimony for the reasons described below and in the order they are presented in his prefiled testimony:

**Hyde's Statement:**

"A portion of this increase in health and hospital expense can be directly attributable to the consolidation of hospitals and health systems. These consolidations result in:

- a) Higher prices through monopoly market position;
- b) Inflated expenses resulting from more complex and more generously compensated management, with hospital administration now accounting for 1.43% of the nation's Gross Domestic Product; and
- c) Compromise to the integrity of physician judgment when such hospital and health system consolidations include physician practices."<sup>1</sup>

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<sup>1</sup> See Page 1 of Hyde's Prefiled Testimony.

### **Applicants' Response:**

The above statements are unsubstantiated, generalized and based upon Hyde's own personal opinion, rather than the facts in the instant Application. Hyde selectively picks and chooses excerpts from publications to support his desired position, objectives and beliefs, and by doing so creates a montage of statements and arguments to support his belief that all affiliations and consolidations of community hospitals with larger systems are bad for consumers. The reality is far more complex and depends on the facts of the particular affiliation in question, as demonstrated by the prefiled testimony of Dr. Noether.

The Applicants would like to provide OHCA with information regarding Hyde's misuse of the word "monopoly." There is no monopoly being created by virtue of the proposal and further, neither Yale New Haven Health nor L+M is currently a monopolist. "Monopoly" is a specific term used by economists and antitrust regulators – the same regulators who declined to further investigate the affiliation between Yale New Haven Health and L+M - to indicate a situation in which a firm faces no competition. Given the geographic distance between the systems and their different clinical focuses, it simply defies common sense that the affiliation of Yale New Haven Health and L+M would eliminate meaningful competition or result in the creation of a monopolist.

The studies referenced by Hyde are neither definitive nor relevant to the instant case. At best, they may show correlation between certain consolidations and price increases, but Dr. Hyde has failed to demonstrate any causal relationship between the two, nor has he demonstrated that the literature applies to the specific market conditions in which this proposed affiliation will occur. In some contexts to assess the competitive effects of an affiliation, regulators may have to consider whether the pass-through of cost-savings (economic theory indicates that a portion of any cost savings is almost always passed on to consumers, even by monopolists) is enough to offset the increase in prices that is associated with the creation of market power. But that is not the calculus that OHCA is faced with here: the affiliation of Yale New Haven Health and L+M results in significant cost savings with no creation or enhancement of market power. So contrary to Hyde's belief, the proposed affiliation can only benefit consumers.

### **Hyde's Statement:**

"In general, not-for-profit hospitals are doing well financially...In fiscal year 2015 Moody's reports that not-for-profit hospitals had median annual growth rate of 7.4% and median three-year revenue compounded annual growth rate of 5.6%."

### **Applicants' Response:**

On May 17, 2016, L+M's bond rating for its CHEFA Series F bonds was downgraded to a BBB+ rating from the A+ rating it was given just three (3) years earlier. According to the Standard & Poor's Global rating agency, this downgrade can be attributed to three (3) factors: "a sharp decrease in operating profitability in the last three fiscal years from historic levels, pressure from the Connecticut state hospital tax, the

impact of which has incrementally increased each year, continued inpatient softness in fiscal 2016 with mix shift to outpatient; and a weakened balance sheet position with less financial flexibility than when the rating was initially assigned.” It is worth noting that in the same report, the rating agency stated that:

There's upward rating potential if the integration with Yale New Haven Health System (which includes Yale New Haven Hospital) comes to fruition and provides immediate lift to financial performance and stability to the balance sheet and our group rating methodology would then apply.<sup>2</sup>

Clearly, the report referenced by Hyde is irrelevant in the instant case.

**Hyde's Statement:**

“This is the background against which OHCA is called upon to evaluate yet another attempt at monopoly acquisition (another hospital by a health system) and consolidation of institutional control over professional judgment through hospital-sponsored medical groups.”<sup>3</sup>

**Applicants' Response:**

Neither Yale New Haven Health nor L+M have any control over the professional judgment of the physicians employed or contracted with their affiliated medical foundations. Hyde has provided no evidence to support these statements in the instant case and the Applicants consider such statements to be harmful to the trust developed by the Applicants with their respective communities. Financial relationships between hospitals and physicians are highly regulated and both Applicants take compliance with these laws very seriously. Had the Connecticut legislature thought that a medical foundation would have interfered with the professional judgment of physicians, it would not have created this statutory exception to the corporate practice of medicine doctrine.

**Hyde's Statement:**

“The FTC has allowed the Hart-Scott-Rodino review period to lapse, and the federal government continues to struggle to win cases under the antitrust laws.”<sup>4</sup>

**Applicant's Response:**

This is a misleading statement at best. First, the use of the word “lapse” suggests that the FTC was negligent in its review of the proposed affiliation, which is not the case.<sup>5</sup> Second, the FTC cleared the proposed affiliation only several months before filing three hospital merger challenges in federal court. At the time they cleared the proposed

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<sup>2</sup> See Page 6 of Bruce Cumming's Prefiled Testimony in Docket No. 15-32033

<sup>3</sup> See Page 1 of Hyde's Prefiled Testimony.

<sup>4</sup> See Page 1 of Hyde's Prefiled Testimony.

<sup>5</sup> Please note that the Connecticut Attorney General participated in the same FTC review.

affiliation, the FTC had not lost a hospital merger challenge since the late 1990s. So, it seems unlikely that the FTC would have hesitated to bring a case in the instant case if they thought there was cause to do so.

**Hyde's Statement:**

"OHCA awards a Certificate of Need 'franchise' to private corporations which are engaged in publicly funded services: the award must be based on the public good, not on private gain."<sup>6</sup>

**Applicants' Response:**

The above statement is false and wrongly characterizes the statutory purpose of OHCA and imbues to OHCA a purpose that only exists in Hyde's own mind.

**Hyde's Statement:**

"Lawrence + Memorial only lacks financial resources as a result of empire building and other imprudent management decisions, including:

- (i) Expensive attempts to outsource services, and to 'lock out' unionized employees performing those services....
- (ii) The acquisition of the bankrupt Westerly Hospital for a reported price of \$35 million; and
- (iii) The extraordinary subsidy of physician practices. The **first attachment** to this document shows the extent to which hospital revenues are generating adequate margins to support operations and maintenance, but are subsidizing practices and other "system" losses...."<sup>7</sup>

**Applicants' Response:**

Hyde fails to understand the efforts and investments made by L+M to bring primary care and specialty services to the Eastern Connecticut region for the purpose of improving access to high quality care for those who live in the region. L+M's financial difficulties are not due to its acquisition of Westerly Hospital. In fact, the continued operation of Westerly Hospital has been very positive for consumers in the Eastern Connecticut region. L+M's financial difficulties are due to declining state and federal government revenues and dramatic increases in state hospital taxes. They are also not caused by executive compensation. It is particularly ironic that Hyde characterizes these actions as mismanagement given the news stories that are highly critical of Hyde's efforts to financially manage the institutions in which he was in charge.

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<sup>6</sup> See Page 1 of Hyde's Prefiled Testimony.

<sup>7</sup> See Page 2 of Hyde's Prefiled Testimony.

More specifically, with respect to Hyde's criticism of mission support associated with the Applicants' two medical foundations, Hyde fails to realize that prior to formation of the legislatively created medical foundations, these expenses would have been incurred by their affiliated hospitals. Both L+M and Yale New Haven Health are tax-exempt entities, and the hospitals that are part of these systems are subject to strict regulatory requirements and limitations with respect to their financial relationships with physicians. Therefore, the extent to which these systems provide mission support to their medical foundations is by no means extraordinary, and complies with all relevant legal standards. Rather, the extent of mission support represents the true cost of maintaining access to physicians in their respective communities. Consistent with a commitment to excellence and innovation in patient care and service to the community, the financial investments made by each Applicant represents an investment in furtherance of the charitable mission of the health system and its hospitals. In order to provide for the key elements of the charitable mission, there are certain programs/service lines that are unable to collect patient revenue in amounts sufficient to cover their associated expenses. For these reasons, hospitals and health systems, including L+M and Yale New Haven Health, typically provide support to physician foundations to cover these losses. Without this mission support, access by Medicaid patients and other underserved populations would be very limited because many physicians in private practice are unwilling to care for individuals whose only source of payment is the government. Moreover, as stated in the Applicants' prefiled testimony and CON application, L+M has historically had challenges recruiting physicians to its community. Without L+M providing mission support to these physician practices, certain specialty services would not be available in the community.

While NEMG and L&MPA have reported losses from an accounting perspective, medical foundations are key strategic initiatives of integrated health systems that provide a number of benefits, including but not limited to: (i) development of stronger clinical integration among various medical disciplines and operating units of the health system allowing for management of the patient continuum of care within the health system; (ii) development of greater focus on evidence-based quality measures in primary care and specialty physician services; and (iii) management of the transition from traditional volume-based reimbursement to alternative payment models with government and commercial payers. Thus, focusing solely on the accounting results of NEMG and L&MPA does not account for the benefits associated with patient access, continuum of care, preparedness for population health and community need fulfillment that NEMG and L&MPA provide to their respective systems.

**Hyde's Statement:**

"[A] list of peer-reviewed journal articles...shows that such economies [of scale] have not been achieved in similar health system acquisitions in the past, and that consolidation leads to significant price increases and resulting systemic cost growth...."<sup>8</sup>

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<sup>8</sup> See Page 2 of Hyde's Prefiled Testimony.

### **Applicants' Response:**

Hyde is clearly unaware of the significant cost savings achieved by Yale New Haven Hospital at the Hospital of Saint Raphael campus. Specifically, since 2012, Yale New Haven Hospital achieved over \$250 million dollars in cost savings from a hospital that was previously on the brink of bankruptcy, while upgrading its facilities and services. Hyde must also be unaware of the clinical and operational improvements that have been achieved by Bridgeport Hospital and Greenwich Hospital also discussed in the Applicants' application and prefiled testimony. If Hyde had read the Applicants' CON Application carefully, the substantial efforts by both Applicants to improve quality would be very evident. See Attachment II of CON application at page 645-722. Comparisons to other states are irrelevant when most would agree that Yale New Haven Hospital is nationally recognized by independent third parties for its exceptional quality.

### **Hyde's Statement:**

"Despite OHCA's request and the urging of legislators, the Applicants flatly refuse to provide comparative price data between L+M and the YNHHS hospitals. However, original analysis of Medicare payments submitted as part of this testimony shows that, almost uniformly, payments for services at Yale-New Haven (including low acuity services) are significantly higher than those at Lawrence + Memorial and much higher than other currently independent hospitals."<sup>9</sup>

### **Applicants' Response:**

As Applicants have previously explained, comparable risk-adjusted price data are not readily available and therefore could not be submitted. The so-called "original analysis" that is presented in Exhibit 3 of Hyde's prefiled testimony does not provide complete and/or useful information. It presents "prices" that are administratively determined by the Medicare program (CMS) rather than those that are the result of market-based negotiations between hospital systems and health insurers. Because these are administratively determined prices, the fact that Yale New Haven Hospital is paid more than most other hospitals in Connecticut reflects CMS' recognition that Yale New Haven Hospital incurs higher costs because of its teaching mission and the higher patient acuity (within a particular DRG) that it treats. But those administratively determined prices have no relevancy as to the cost efficiency of a hospital.

Notably, a hospital's Medicare DRG rate is not based on its specific costs or efficiency, but rather on standardized factors intended to reflect the typical costs of providing medical education, providing services to a disproportionate share of low-income patients, providing outlier services to patients requiring additional services, and not having the payments reduced for short stay transfers to other Medicare providers.<sup>10</sup> All of these

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<sup>9</sup> See Page 3 of Hyde's Prefiled Testimony.

<sup>10</sup> Specifically, Medicare's annual base DRG per discharge amount is uniformly set for all hospitals at national base payment rates for standardized amounts at each hospital. The final DRG payment rate at a hospital is then adjusted by the following: (i) the Hospital Geographic classification; (ii) an Indirect Medical

factors influence the DRG rate at Yale New Haven Hospital and Bridgeport Hospital both of which have substantial teaching programs. This aside, the emphasis on price differences between Yale New Haven Health, L+M Hospital, and other hospitals in Connecticut is entirely misplaced. In a market in which competitors are highly differentiated, it should be expected that they receive different reimbursement.

The same analysis offered by Hyde also presents gross charges across different hospitals, but these are also not informative as they do not reflect the prices actually negotiated by health insurers or paid by patients. Even if prices paid are sometimes based on a percentage of charges, the percentage discount is negotiated and can vary, so, again, a comparison of the gross charges by themselves is not indicative of relative payment amounts across hospitals. Moreover, even if there were some validity to an analysis based on gross charges as proxies for pricing power, then the data does not support a conclusion that Yale-New Haven Hospital possesses market power.

In connection with Hyde's claims that Yale New Haven Health affiliated hospitals are the most expensive in Connecticut, Hyde references 2013 CMS records of billing and payment by DRG by hospital for the top 100 DRGs in Connecticut Hospitals.<sup>11</sup> As noted above, the Medicare payments are set on national rates and national formulas; the Medicare payments are not based on the hospitals' actual costs. In describing these data, CMS states that "Users will be able to make comparisons between the amount charged by individual hospitals within local markets, and nationwide, for services that might be furnished in connection with a particular inpatient stay." CMS does not state that this information reflects on hospitals' costs or efficiency.

Moreover, Hyde appears to have cherry-picked his data. In reviewing the DRGs that Hyde selected, the Applicants noted the following:

- All the DRGs selected had relative weights above that of the typical discharge;
- None of the DRGs selected are provided by all 29 Medicare Acute Care Hospitals in Connecticut in 2013; and
- Yale New Haven Hospital had more residents as it has the largest teaching program in the state. It also has a high DSH adjustment and is the largest provider of services to Medicaid beneficiaries, along with outlier payments.

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Education add-on based on the hospital's Resident to Bed Ratio; (iii) a DSH add-on for hospitals that treat a disproportionate share of low-income patients; (iv) a DRG Outlier add-on for claims utilizing services beyond the outlier threshold established by CMS; (v) CMS' Transfer Reduction Policy for short stays that are transferred to other Medicare facilities.

<sup>11</sup> The data used by Hyde was published by CMS on their website at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient.html>.

The data published included the hospital-specific data for the more than 3,000 U.S. hospitals that receive Medicare Inpatient Prospective Payment System (IPPS) payments for Fiscal Year (FY) 2011, 2012, 2013, and 2014; 2014 was recently published.

Of the top 100 DRGs in the CMS data, Yale New Haven Hospital has the highest charge-to-Medicare allowed ratio for only 7 DRGs, which is less than Middlesex (44 DRGs), Stamford (10), Waterbury (8), and tied with Norwalk (Greenwich has the highest multiple for 13 DRGs, while Bridgeport Hospital has the highest ratio for only one DRG). Hyde also uses these data to argue that there is no evidence that the acquisitions of Greenwich and Bridgeport Hospitals produced savings for consumers. Again, because the Medicare data have nothing to do with pricing or costs, he has no basis for such a conclusion. Moreover, even if the data were valid, the pattern does not reflect any variation in cost or quality and therefore would not be dispositive.

Most importantly, even assuming that Hyde's analysis demonstrated that YNHH did currently negotiate higher prices than L+M, it does not follow that the affiliation will allow Yale New Haven Health to confer those higher prices on the services provided at L+M. Rather, the question is whether the proposed affiliation will increase the market power of Yale New Haven Health, which would allow it to negotiate higher prices for L+M. We have previously explained in the prefiled testimony of Monica Noether, our expert economist, that YNHH and L+M are not close competitors, and, as a result, the affiliation will not change bargaining dynamics with managed care companies or otherwise allow YNHH to increase the prices charged by L+M.

#### **Hyde's Statement:**

"[T]his acquisition will lead to extreme market concentration in the L+M service area, and intensify Yale-New Haven's market power from New York to the Rhode Island border. If this acquisition is consummated, Yale-New Haven Health Systems will account for 83% of discharges in L+M's primary service area, and nearly 60% of all inpatient discharges in the southern half of the state...."<sup>12</sup>

#### **Applicant's Response:**

We agree that, once L+M affiliates with Yale New Haven Health, as a system, Yale New Haven Health will account for over 80% of the discharges from L+M's primary service area ("PSA"). However, that is attributable to the strong presence that L+M already enjoys in its service area – of the post-affiliation share of approximately 75% in L+M's PSA, L+M already has approximately 67%.<sup>13</sup> That does not contradict the fact that it also faces competition from proximate competitors such as Backus Hospital.

Hyde also includes as an attachment a report that concludes the affiliation will exceed the FTC/DOJ *Horizontal Merger Guidelines*' thresholds for a change in the Herfindahl-Hirschman index ("HHI"). This report does not identify any authors or provide their qualifications for drawing such conclusions, or in any other way provide OHCA with enough information to determine whether this report is a credible source of factual information. Even assuming this report's reported HHI is calculated correctly, as with

<sup>12</sup> See Page 4 of Hyde's Prefiled Testimony.

<sup>13</sup> 64% to 67% does not include Rhode Island in that OHCA is interested in Connecticut. Please note that Monica Noether's prefiled testimony includes Westerly and is at 77%.

Hyde's discussion of the post-affiliation share in L+M's PSA, it is likely attributable to L+M's strong existing presence in its own service area, not because the affiliation will eliminate meaningful competition with YNHH. Most importantly, however, the HHI is only an initial screen; it is not dispositive. Indeed the FTC itself, which along with the Department of Justice issued the *Horizontal Merger Guidelines*, determined that there was no reason to investigate this transaction beyond the statutory filing period.

Also, OHCA should note that even this report acknowledges the economic imperative behind affiliations: "In Connecticut, the State Innovation Model (SIM) and 'shared savings' policies for Medicare and Medicaid are creating incentives for large combinations of hospitals and doctors that can accept risk for broad patient populations."<sup>14</sup>

This is correct and explains why community hospitals such as L+M that might have been successful historically as independent entities can no longer deliver care effectively on their own. The ensuing combinations into larger systems, however, are not anticompetitive. Rather they can benefit patients by providing more integrated care and allowing health systems to become accountable for the cost of delivering effective care, which in turn reduces incentives for excess utilization.

#### **Hyde's Statement:**

"The Applicants have offered no evidence that the acquisition of Lawrence + Memorial Physicians Association, L+M's 70-physician group medical practice, will create efficiencies with any meaningful return to patients and payers."<sup>15</sup>

#### **Applicants' Response:**

As discussed above, Hyde fails to understand the purpose and importance of the L&MPA and NEMG merger as discussed above with respect to maintaining access to primary and specialty care in the L+M service area. Once merged, there will be less duplication in medical services and greater coordination of care between treating physicians, more widespread use by former L&MPA physicians of evidence-based practices, and greater certainty with respect to the retention of L&MPA physicians. Without the continued presence of L&MPA physicians in the L+M community, patients would have to travel outside of the community and ultimately this will negatively impact access and the health of the community. Access to the combined infrastructure of L&MPA and NEMG will undoubtedly result in added efficiencies. Given the antitrust laws' restrictions against sharing sensitive information, and limitations on planning at this point, the Applicants' are limited in their modeling of cost savings.

As stated by the Applicants, it is the payer who designs health plans and determines the patient's deductible or cost sharing responsibilities. Hyde also decries the development of narrow network products that limit patient choice. As Hyde acknowledges, narrow network products are a vehicle that health insurers used to control costs because they

<sup>14</sup> See Attachment 4 from Hyde's Prefiled Testimony.

<sup>15</sup> See Page 4 of Hyde's Prefiled Testimony.

provide them with greater bargaining leverage over hospitals (through the threat to exclude hospitals from the narrow network). This is not anticompetitive, but rather is a procompetitive way to force hospitals to compete more aggressively to reduce costs that can also result in lower health plan premiums.<sup>16</sup>

**Hyde's Statement:**

“OHCA should view with skepticism the idea that installation of the EPIC electronic medical record system will generate efficiency or improve quality.”<sup>17</sup>

**Applicants' Response:**

Hyde makes statements critical of the Applicants purchase of Epic and plan to have affiliated entities on a common electronic health record platform. To support this position, he cites the implementation at other systems in other states, but that experience is inapposite – it is Yale New Haven Health's experience that is relevant. Yale New Haven Health's implementation of Epic was on time and nearly \$10 million dollars under budget. More importantly, having a single, integrated electronic health record (“EHR”) across multiple care settings is the key to enhancing quality and safety. A single platform for clinical care and revenue cycle operations affords synergies and economies of scale across the broad range of clinical services and geographic regions. These economies enable even smaller community hospitals in Yale New Haven Health to immediately access the clinical content developed in concert with its largest academic medical center. This would not be possible for a freestanding community hospital on its own. Yale New Haven Health has already reduced cost and made improvements by efficiently creating pathways, evidence-based decision support, and analytics tools that power the clinical decision making of the entire care team – Yale New Haven Health has created it once rather than multiple times, for a uniform, high standard of care. Specifically, it is this success and an effective clinical, business and analytics platform that Yale New Haven Health can offer to L+M at a cost they cannot achieve on their own even with another EHR vendor. What many, including Hyde, fail to realize is that greater than 80-85% of the cost of implementations is in the people – in Yale New Haven Health's case 29,000 doctors, nurses, and staff who collaborated on local decisions in configuration decision and training. None of this is achievable by L+M on its own.

**Hyde's Statement:**

“That access to primary and advanced specialty care will be greatly enhanced for the citizens of the Lawrence and Memorial hospital service area through the acquisition. This argument is contradicted by...[t]he example of Windham Hospital's acquisition by Hartford HealthCare...”<sup>18</sup>

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<sup>16</sup> Hyde also fails to acknowledge the driving force behind the merger – Connecticut state law requires that health systems may have only one medical foundation. Compliance with the law certainly constitutes “clear public need.”

<sup>17</sup> See Page 5 of Hyde's Prefiled Testimony.

<sup>18</sup> See Page 5 of Hyde's Prefiled Testimony.

**Applicants' Response:**

Yale New Haven Health and Harford HealthCare do not operate in the same manner, nor do they conspire to develop the same "playbook." It is completely irrelevant to discuss Windham Hospital in the context of this proceeding. Windham Hospital historically and currently is a very different hospital than L+M - it is in a different geographic area and not at all comparable in breadth and depth of services. Dr. Hyde's obsession with Windham Hospital is perhaps the result of his own tenure there, but OHCA should not allow his repeated references to Windham to obscure the fact that the affiliation before it involves a very different hospital and a very different health system.

**Hyde's Statement:**

"Changing governance and control will render local officials and L+M itself incapable of protecting local services."<sup>19</sup>

**Applicants' Response:**

This statement by Hyde demonstrates his misunderstanding of hospital governance and the terms of this transaction. Decisions regarding community services will only be made upon the approval of L+M. As a matter of governance, after the affiliation most significant decisions must emanate from the L+M board before the YNHHS board can act. Hyde continues to approach this application as if it were based upon nonexistent terms to the affiliation. It is also contrary to Yale New Haven Health's culture and philosophy to direct patients away from their community to Yale-New Haven Hospital for care that these patients can receive locally. Yale-New Haven Hospital has not done that with Bridgeport Hospital or Greenwich Hospital, nor does it have the capacity to take on the volume of patients that Hyde suggests in his prefiled testimony.

**Hyde's Statement:**

"Patient choice will be severely compromised, if not eliminated."<sup>20</sup>

**Applicants' Response:**

Quite the contrary, the entire proposal is about maintaining the financial stability and strength of L+M. Without the proposal, access to care in the L+M community will be restricted and only then, will patient choice be severely compromised.

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<sup>19</sup> See Page 6 of Hyde's Prefiled Testimony.

<sup>20</sup> See Page 6 of Hyde's Prefiled Testimony.

### **Hyde's Statement:**

“All of the hypothetical \$300 million appears to be contingent on future programs being consistent with the YNHHS strategic plan, mutually agreed upon (between YNHHS and L+M), and displaying a positive return on investment. In other words, there would be no new investment in the Greater New London community's health unless that investment earns Yale-New Haven Health System a profit....In fact, some or all of the \$300 million is supposed to come from efficiencies that lead to lower expenses in L+M's future operations...The application assumes that L+M will eliminate more than 200 jobs and more than \$130 million in wage and benefit expense during the first three years.”<sup>21</sup>

### **Applicants' Response:**

The notion that the affiliation will result in 200 job eliminations in the first year is inaccurate. The drop in FTEs noted on the document attached to Hyde's testimony is in part due to L&MPA becoming part of NEMG. These FTEs are not being eliminated, but instead are being transferred to another company (in this case NEMG). Another reason for the decline in FTEs, and subsequent stabilization in the out years, is that when the CON was filed it was based on the assumption that the affiliation would take place mid-year FY 16. Therefore, the number of employees transferred is only counted at 50% in that first year.

Regarding the supposed loss of \$130 million in wages and benefits, it appears Hyde is misinterpreting the financial statements from the Applicants' CON filing. Adding the columns for salary and benefits for the first three years after the transaction (note: given the timing, the columns for FYs 16, 17, and 18 really represent only 2 ½ years) found in the attachment to his testimony, the affiliation actually adds \$5.4 million in wages and benefits, rather than reducing them by \$130 million.

All information relative to the sources and uses has been outlined in the initial CON, and subsequent Completeness Question Filings.

\$85 million in investments by Yale New Haven Health will be made entirely independent of financial performance at L+M, or the generation of any “profit”. \$41 million of this investment will be spent in the following areas as stated in the Completeness Question Responses on January 5, 2016 (see response 28 a.).

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<sup>21</sup> See Page 7 of Hyde's Prefiled Testimony.

<b>Break-down of \$41 Million</b>	<b>Description</b>
\$14 million	Epic installation and other IT investments
\$10 million	Population health infrastructure and related services
\$15 million	Development of clinical programs and services for eastern CT and western Rhode Island
\$2 million	Rebranding and communication initiatives

Total: \$41 million

Of the initial \$85 million investment, the remaining \$44 million will be invested in further clinical programs in the L+M service area. Decisions regarding service programming will take place after the proposed affiliation is approved as part of the joint strategic planning process. The amount of detail that will be reviewed during that process will require the understanding of the strategic plan of L+M which cannot legally be shared prior to the proposed affiliation.

The programs invested in as part of the \$44 million will require mutual agreement. While a return on investment analysis will be performed, the services are not necessarily expected to generate a “profit” in the initial years, or at all - rather, the agreement requires only that the analysis be performed and that Yale New Haven Health and L+M have a multiyear understanding of the financial impact made during these investments. \$41 million of the \$85 million will come directly from existing funding at Yale New Haven Health.

After this initial \$85 million investment, an additional \$215 million will be made. The \$215 million investment will go to the further development in the Eastern Connecticut region. This can come in the way of new clinical programs, capital development, or any other use deemed consistent with improvement to care for our patients. While the detail of this spending will be developed during the strategic planning phase, the potential areas of investment were also shared during the Completeness Question Responses on January 5, 2016.

The sources of the \$215 million will be generated from the improved cash flow of L+M inclusive of the synergies generated by affiliating with Yale New Haven Health. It is for this reason that this funding will be dependent upon financial performance. Given the information we have today, the investment will be made in its entirety, but as payment models and sources of funding continue to change in our industry the future availability of these funds are uncertain. In the event that economic forces drive down the cash flows expected to fund these investments, the two organizations will work to either identify other sources of funding, or change the investment to best meet the missions of both organizations and the community at large. The notion that the entirety of the \$300 million will only be made if Yale New Haven Health generates a profit is entirely inaccurate. Rather, the parties will look to whether the business plan makes sense for L+M overall, in light of its then-current financial condition.

**Conclusion:**

Hyde seems to lay all the problems in our current health care system at the feet of hospital and health system consolidation generally, and consolidation at Yale New Haven Health in particular. Hyde pays little heed to the effect of declining governmental reimbursement, increased hospital taxes and the financial challenges posed by changes in health care reimbursement. It would appear that Hyde is trying to drive forward while following a path he sees in the rear view mirror. Health system consolidation is a response to these challenges and an attempt to meet the need for improved care at a lower cost, not a cause of further instability. Applicants believe that they have provided sufficient context to allow OHCA to assess Hyde's exaggerated, false, irrelevant, and inflammatory statements in his prefiled testimony. Having done so, it is our hope that OHCA can rightfully focus on the facts and the clear public need for the proposed affiliation rather than be distracted by misdirected personal agendas.

I adopt this supplemental Prefiled Testimony as my own.

A handwritten signature in black ink, appearing to read "Bruce D. Cummings", written over a horizontal line.

Bruce D. Cummings  
President & CEO  
Lawrence + Memorial Corporation

I adopt this supplemental Prefiled Testimony as my own.

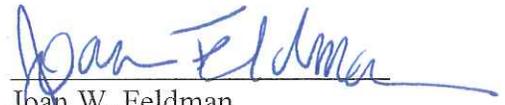
A handwritten signature in blue ink, appearing to read "Marna Borgstrom", written over a horizontal line.

Marna Borgstrom  
President & CEO  
Yale New Haven Health

CERTIFICATE OF SERVICE

I hereby certify that true and correct copies of the foregoing documents were sent via electronic mail the 6<sup>th</sup> day of July, 2016 to:

Henry F. Murray, Esq.  
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Hartford, CT 06105  
[hfmurray@lapm.org](mailto:hfmurray@lapm.org)

  
Joan W. Feldman

## Greer, Leslie

---

**From:** Martone, Kim  
**Sent:** Wednesday, July 06, 2016 3:50 PM  
**To:** Lazarus, Steven; Carney, Brian; Ciesones, Ron  
**Cc:** Greer, Leslie  
**Subject:** FW: L & M / YNHHS  
**Attachments:** 2016 7-6-Response to Pre-Filed Testimony of Dr - Monica Noether.pdf; intervenors cover letter response\_20160706104112669.pdf

### ***Kimberly R. Martone***

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Connecticut Department of Public Health  
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---

**From:** Henry F. Murray [<mailto:hfmurray@lapm.org>]  
**Sent:** Wednesday, July 06, 2016 3:13 PM  
**To:** Martone, Kim; Hansted, Kevin  
**Cc:** [jfeldman@goodwin.com](mailto:jfeldman@goodwin.com)  
**Subject:** L & M / YNHHS

Please find attached Intervenor's Response to the Pre-File testimony of Dr. Monica Noether.

Hank Murray

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July 6, 2016

**Via Email and First Class Mail**

Kimberly Martone, Director of Operations  
Kevin Hansted, Hearing Officer  
Office of Health Care Access  
Department of Public Health  
State of Connecticut  
410 Capitol Avenue  
Hartford, CT 06106

**Re: Certificate of Need Applications,  
OHCA Docket No. 15-32032-CON, Merger of L & M Physicians Association and  
Northeast Medical Group, Inc. and,  
OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial  
Corporation and Yale New Haven Health Services Corporation**

Dear Ms. Martone and Mr. Hansted:

Attached please find the Intervenor's response to the Applicants' Pre-file Testimony.  
Thank you.

Very truly yours,

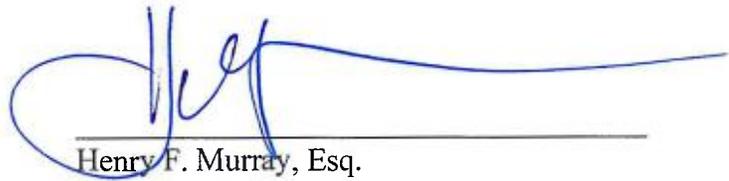
Henry F. Murray

HFM:vds  
Enclosure

## CERTIFICATION

This certifies that the Intervenor's Response to the Applicants' pre-file testimony was sent via email and First Class Mail, pre-paid, on July 6, 2016, to the following counsel of record:

Joan W. Feldman, Esq.  
SHIPMAN & GOODWIN LLP  
One Constitution Plaza  
Hartford, CT 06103-1919  
jfeldman@goodwin.com

A handwritten signature in blue ink, appearing to read "H. Murray", is written over a horizontal line. The signature is stylized and extends to the right of the line.

Henry F. Murray, Esq.

## Comments and Response to Pre-Filed Testimony of Monica Noether, PhD.

**Fred Hyde, M.D.**  
**57 Main Street**  
**Ridgefield, CT 06877**

**July 6, 2016**

### *Price Information, Historical Challenges in Examining Hospital Mergers*

Dr. Noether's pre-filed testimony and published articles discuss price information, the difficulty of obtaining that information, and of knowing what it means. This difficulty reflects the challenges facing OHCA generally in the evaluation of this application: the complexity of the field, the difficulties facing researchers in the field, but also the unwillingness of applicants (such as those now before OHCA) to share what they are able to. Dr. Noether noted this problem almost thirty years ago in a major report done with staff at the Federal Trade Commission.<sup>1</sup> Unfortunately, however, Dr. Noether's testimony does not recognize more modern work, in fact "breakthrough" information about hospital monopoly prices.

### *New Information on Hospital Prices*

Major changes have taken place in the intervening three decades since Dr. Noether's original work in this field.

First, Medicare payments have become available to the press and public, through the efforts of the Association of Health Care Journalists working with the Centers for Medicare and Medicaid Services. These comparisons have been offered by the Intervenor.<sup>2</sup> No mention is made of these differences in Medicare payments by Dr. Noether in her testimony.

Second, a major study of information gathered by the Health Care Cost Containment Institute<sup>3</sup> shows price disparities in payments by commercial health insurers. Dr. Noether faults this Cooper study<sup>4</sup> for not including Blue Cross information. Unfortunately, Blue Cross information which would complement that available through the Health Care Cost Containment Institute is not available. Dr. Noether does not dispute a finding of the Cooper report pertinent to this application, namely that New Haven, Connecticut, the home of the Yale-New Haven Health Services Corporation, is an *epicenter of extraordinarily high prices in both the private sector and for Medicare*.

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<sup>1</sup> Noether, M., "Competition Among Hospitals," Staff Report of the Bureau of Economics, Federal Trade Commission, 1987

<sup>2</sup> Exhibit Two,, Pre-Filed Testimony, Fred Hyde, MD

<sup>3</sup> Cooper, Z., et al, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," NBER Health Care Pricing Project, December 2015

<sup>4</sup> Noether, M., "Commentary on 'The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured,'" Charles River Associates, January 7, 2016

Third, information from the Department of Social Services in Connecticut will shortly be made available to a task force studying certificate of need in Connecticut. This information will directly impact one question, namely, to what extent does the State of Connecticut pay Medicaid rates which reflect monopoly pricing by Yale-New Haven?

Finally, Section 2(c) of PA 15-146 requires the Connecticut Department of Public Health and the Department of Insurance to have transmitted lists of the fifty most common inpatient and outpatient diagnoses and procedures and the twenty-five most common outpatient surgical and imaging procedures in the State to the Health Insurance Exchange and to the public. Under section 2(d), the Exchange is required to publish reports from insurance carriers showing prices – both billed and allowed amounts – for these procedures broken down by specific payer by specific provider on January 1, 2017.

The applicant therefore has two choices to demonstrate that it has been responsive to the information required by OHCA. The first would be to make known its prices, including those paid by Blue Cross. The second would be to voluntarily defer action until the hearing record can be completed. If the applicant takes neither route, we recommend that OHCA hold the public hearing record open until January to obtain the data that the applicant is not providing.

In summary, Dr. Noether's comments concerning pricing reflect challenges to regulators and the public generally, as well as to economists. Information made available more recently has been either not included in her testimony, or has been refuted on grounds (Blue Cross) of its incompleteness. Dr. Noether's concerns with regard to prices have been reflected in her writings over three decades, not however fully accommodating more recent information. The statute requires OHCA to make written findings to determine whether the applicant has "satisfactorily demonstrated that any consolidation resulting from the proposal will *not* adversely affect health care costs or accessibility to care." Given the volume of literature on the relationship between consolidation, provider prices and health care costs, OHCA's responsibility to obtain current information which will reflect the impact of monopoly pricing is clear.

### ***New Studies on Hospital (and Physician) Monopoly Behavior***

Dr. Noether has written that separate negotiations need not necessarily lead to monopolist behavior. However, again, Dr. Noether has not taken into account more recent work (see paper in Exhibit One by Gowrisankaran). Dr. Noether, a speaker at a February 2015 Federal Trade Commission and Department of Justice conference in which Gowrisankaran and colleagues presented their findings, does not address those findings or refute them.

Parenthetically, Dr. Noether's career-long writing is critical of certificate of need<sup>5</sup>, that is, that prices seem to be higher and/or increase in states with certificate of need. Her hypothesis has been that regulation creates market barriers and allows price increases to exceed what otherwise would have taken place. However, there is no legitimate control with which to evaluate that hypothesis, or "counterfactual." In addition, there are plausible alternative hypotheses: for example, that prices are higher in certificate of need states because the extent of that price

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<sup>5</sup> Noether, M., "Competition Among Hospitals," Staff Report of the Bureau of Economics, Federal Trade Commission, 1987

differential has created the political climate which made possible the passage of certificate of need legislation, and/or protection against CoN repeal by those who would rely on “market forces.”

In evaluating monopoly behavior, Dr. Noether, in support of the application, appears to take a position contrary to the majority of economists who have studied the merger of non-profit hospitals. The Intervenor has submitted an exhibit with extensive evidence that other economists have evaluated hospital mergers with traditional tools.<sup>6</sup>

Even current and former colleagues of Dr. Noether have taken the opposite position. For example, Seth Sacher of Charles River Associates and Michael G. Vita of the U.S. Federal Trade Commission have written on “The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study.” In that paper, in which non-profit competitors were reduced from three to two, Sacher and Vita found the following: “We find that the transaction resulted in significant price increases; we reject the hypothesis that these price increases reflect higher post-merger quality.”<sup>7</sup> Sacher and Vita indicate that “Studies using data from the mid-1980s and after” present this general relationship: “a *positive* relationship between concentration and price.”<sup>8</sup> In this paper, further reference to case studies indicated price increased for medical-surgical services of as much as 9%.

Moreover, Dr. Noether has commented<sup>9</sup> on the favorable results from a reduction in concentration. In a paper written during Dr. Noether’s tenure at the FTC, she says that reduction in concentration “may lead to an increase in both price and quality competition.”<sup>10</sup> [The word “quality” in Dr. Noether’s reports “is used to refer to all non-price aspects of competition,” not as we generally refer to quality in hospital and regulatory discussions today.<sup>11</sup> She notes “an increase in ‘quality’ is not necessarily welfare-enhancing...] In this paper, Dr. Noether goes on to note that “when concentration is reduced, prices (per unit of output, not adjusted for quality) are prevented from rising by a concomitant increase in price competition. This result implies that, for a given level of quality, price is lower in areas with less concentrated markets.” She concludes that “the hospital industry can be analyzed, for the most part, like other industries when, for example, applying the anti-trust laws.”<sup>12</sup> In her conclusion, Dr. Noether writes that, “The results suggest that hospital margins rise and expenses fall with increases in hospital industry concentration.”<sup>13</sup> Addressing one of the changes already underway by the 1987 publication of the FTC report, Dr. Noether writes that “This study also provides no evidence to support the conjecture that managed and system hospitals are more efficient than independent ones. Expenses for both former types appear to be greater.”<sup>14</sup>

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<sup>6</sup> Exhibit Two, Pre-file Testimony, Fred Hyde, M.D.

<sup>7</sup> Vita, M. and S. Sacher, “The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study,” 1999, page one

<sup>8</sup> Ibid, page six

<sup>9</sup> Noether, M., “Competition Among Hospitals,” Journal of Health Economics, 7, 1988, 259-284

<sup>10</sup> Ibid, at. Pg. 260

<sup>11</sup> Ibid, page one

<sup>12</sup> Ibid, page three

<sup>13</sup> Ibid, page 81

<sup>14</sup> Ibid, page 83

Questions remain that are not addressed in Dr. Noether's testimony. The first is: Will health plans be able to offer a marketable network to residents in the New London area that for whatever reason excludes Yale-New Haven Hospital, the Northeast Medical Group, the Yale Medical Group, and the other Yale-New Haven Health System entities? The Intervenor would answer unequivocally, "No."

Also, this question: Are there additional market factors that tip the balance of negotiating power in favor of the Yale-New Haven Health System? The Intervenor's answer to this question is, "Yes."

Indeed, the applicants have signaled that eliminating competition may be one of the goals of their transaction, for example, by cancellation of the Lawrence + Memorial affiliation with the Dana-Farber Institute, Partners' best-known cancer hospital.

New research (for example, the Dafny, Ho and Lee paper included in those submitted by the Intervenor) has analyzed the impact of cross-market mergers on prices.<sup>15</sup> Their findings are as follows:

*We find that hospitals gaining system members in-state (but not in the same geographic market) experience price increases of 6 – 10 percent relative to control hospitals, while hospitals gaining system members out-of-state exhibit no statistically significant changes in price. The former groups are likelier to share common customers and insurers. This effect remains sizeable even when the merging parties are located further than 90 minutes apart. The results suggest that cross-market, within-state hospital mergers appear to increase hospital systems' leverage when bargaining with insurers.*<sup>16</sup>

In summary, the proposed acquisition would appear to fit all of the criteria that Dafny, Ho and Lee find most closely associated with the risk of higher prices, that is, Yale-New Haven and Lawrence + Memorial occupy immediately contiguous markets, the anchor hospitals are less than 90 miles apart, they share common insurers who value both systems, and they share common customers who value both systems.

In fact, three of the organizations intervening in this transaction are themselves common customers of the two systems under these authors' definitions.

This research (Dafny, Ho, Lee) was presented at a conference organized by the Federal Trade Commission and the Department of Justice in February 2015. Dr. Noether, also a speaker at the conference, did not acknowledge this work in her pre-filed testimony. The weight of this paper, as well as the work of Cooper and Gaynor, makes clear that private sector pricing is the factor which best explains the continued unsustainable growth of U.S. health care costs.

Dr. Noether reflected some aspects of this issue in comments at the FTC/DoJ seminar<sup>17</sup> when she said that "patients who are using those hospitals don't overlap, and they're not going to travel

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<sup>15</sup> Dafny, L., et al, "The Price Effects of Cross-Market Hospital Mergers," NBER, March 18, 2016

<sup>16</sup> Ibid, page 1

<sup>17</sup> FTC Workshop Transcript, February 25, 2015, page 117

from one market to another. On the other hand, if they're both employed- and Leemore Dafny mentioned this- by the same employer, and that employer is looking for a single payer to cover all of its employees, then maybe the customer in this case is the employer or the plan who is contracting with the employer. And you need to kind of think about the whole market definition a little bit differently.”

### *Other Issues*

Finally, with regard to the “companion” application concerning physicians, Dr. Noether indicated in the February 25, 2015 FTC conference<sup>18</sup> that “a lot of those questions are relevant within what we would normally consider a single geographic market, when you’ve got a system, and – is there a bundled or tying kind of issue. And it can also happen between hospitals and physicians for example as well.” The potential for tie-in pricing—more services, more “linked services,” at higher prices—would be the result.

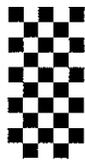
Another issue not addressed in Dr. Noether’s testimony is narrow networks and tiering, that is, the prospect that insurers would be compelled - - if these applications were approved - - to charge additional amounts for entry into the most favorable tier.

At the FTC/DoJ conference, Dr. Noether observes, “Of course, you need to have something that controls the providers from saying, you have to take me...But I think like in any kind of exclusive contract situation, if you’ve got competition to be part of that exclusive or narrow network, then that can certainly work.”<sup>19</sup> She points to the effectiveness of these narrow networks “for price-sensitive customers where they’re willing to forgo complete freedom of choice in return for having lower premiums.” It isn’t clear what Dr. Noether’s advice would be to those in New London who, for reasons of insurance, transportation or socioeconomic immobility, would be unable to participate in the new networks.

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<sup>18</sup> Ibid, page 117

<sup>19</sup> Ibid, page 130



## LEGAL & RISK SERVICES DEPARTMENT

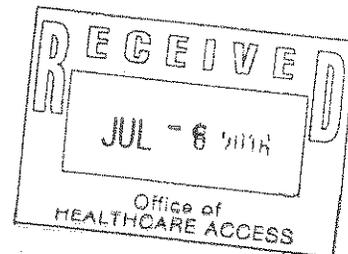
From:

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203-688-3324 (Fax)

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Date:

July 8<sup>th</sup>, 2016

To:

Kevin Hansted  
(Name)

State of CT, Dept. Public Health, Office of Health Care Access  
(Organization)

860-418-7053  
(Fax Number)

# OF PAGES: (including this sheet): 3

SENT BY: Gianna Roberts on behalf of Jennifer Willcox

COMMENTS:

Please see the attached two (2) Notices of Appearance regarding Docket No's: 15-32033-CON  
15-32032-CON

Thank you

- Gianna Roberts

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE	:	Docket No. 15-32033-CON
AFFILIATION OF LAWRENCE +	:	
MEMORIAL CORPORATION WITH	:	
YALE NEW HAVEN HEALTH SERVICES	:	
CORPORATION	:	July 8, 2016

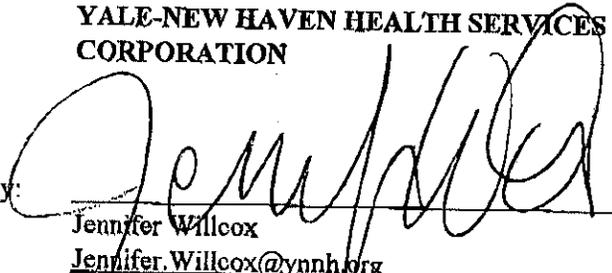
NOTICE OF APPEARANCE

Please enter the appearance of Jennifer Willcox of the Yale New Haven Health Legal and Risk Services Department on behalf of Yale-New Haven Health Services Corporation in the above entitled proceeding.

Respectfully Submitted,

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

By:



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 Deputy General Counsel  
 Yale New Haven Health  
 Legal and Risk Services Department  
 789 Howard Avenue  
 New Haven, CT 06510  
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 Its Attorneys

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE	:	Docket No. 15-32032-CON
PROPOSAL FOR MERGER OF	:	
L&M PHYSICIAN ASSOCIATION, INC.	:	
AND NORTHEAST MEDICAL GROUP, INC.	:	July 8, 2016

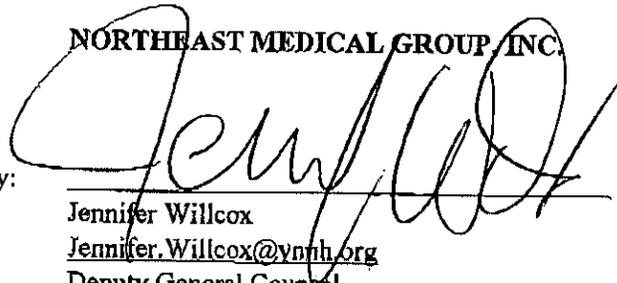
NOTICE OF APPEARANCE

Please enter the appearance of Jennifer Willcox of the Yale New Haven Health Legal and Risk Services Department on behalf of Northeast Medical Group, Inc., in the above entitled proceeding.

Respectfully Submitted,

NORTHEAST MEDICAL GROUP, INC.

By:



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 Yale New Haven Health  
 Legal and Risk Services Department  
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 Tel: 203-688-9966  
 Fax: 203-688-3162  
 Its Attorneys

## Greer, Leslie

---

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**Sent:** Monday, July 11, 2016 10:05 AM  
**To:** Riggott, Kaila; Carney, Brian  
**Cc:** Greer, Leslie  
**Subject:** FW: Intervenor Pre-file  
**Attachments:** ohca maritza bond testimony\_20160711095928164.pdf  
  
**Importance:** High

### **Kimberly R. Martone**

Director of Operations, Office of Health Care Access  
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**From:** Henry F. Murray [<mailto:hfmurray@lapm.org>]  
**Sent:** Monday, July 11, 2016 10:05 AM  
**To:** Hansted, Kevin; Martone, Kim; Lazarus, Steven  
**Cc:** [jfeldman@goodwin.com](mailto:jfeldman@goodwin.com)  
**Subject:** Intervenor Pre-file  
**Importance:** High

Please see attached letter and brief two-page pre-file testimony of Maritza Bond that was inadvertently not included in the Intervenor's pre-file testimony on July 1.

Hank Murray

Henry F. Murray, Esq.  
**Livingston, Adler, Pulda, Meiklejohn & Kelly PC**  
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*Please think about the environment before deciding to print this email.*

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WRITER'S DIRECT DIAL:  
(860) 570-4635  
EMAIL: hfmurray@lapm.org

July 11, 2016

**Via Email and Hand Delivery**

Kimberly Martone, Director of Operations  
Kevin Hansted, Hearing Officer  
Office of Health Care Access  
Department of Public Health  
State of Connecticut  
410 Capitol Avenue  
Hartford, CT 06106

**Re: Certificate of Need Applications,  
OHCA Docket No. 15-32032-CON, Merger of L & M Physicians Association and  
Northeast Medical Group, Inc. and,  
OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial  
Corporation and Yale New Haven Health Services Corporation**

Dear Ms. Martone and Mr. Hansted:

Attached please find the pre-file testimony of Maritza Bond, Executive Director of Eastern Connecticut Health Education Centers. Ms. Bond's testimony was inadvertently left out of the Intervenor's pre-file testimony submitted on July 1, 2016. We ask that OHCA accept the testimony. Ms. Bond is prepared to adopt this pre-file testimony at today's hearing or submit it at that time. Thank you.

Very truly yours,

Henry F. Murray

HFM:vds  
Enclosure

## CERTIFICATION

This certifies that the foregoing was sent via email July 11, 2016, to the following counsel of record:

Joan W. Feldman, Esq.  
SHIPMAN & GOODWIN LLP  
One Constitution Plaza  
Hartford, CT 06103-1919  
jfeldman@goodwin.com



Henry F. Murray, Esq.



**Mailing address:**

**Eastern Area Health Education Ctrs.  
Eastern AHEC, Inc.**  
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New London, CT 06320  
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Fax: 860-724-2568  
www.easternctahec.org

**Eastern Area Health Education Ctrs.  
Eastern AHEC, Inc.**  
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Phone: 860-465-8281  
Fax: 860-724-2568  
www.easternctahec.org

TO: Kimberly Martone, Director, Office of Healthcare Access  
Kevin Hansted, Hearing Officer

RE: Proposed Yale New Haven (YNH) acquisition of L+M Hospital, OHCA Docket #15-32032, and 32033

DATE: July 1, 2016

Dear Ms. Martone and Mr. Hansted,

As a local nonprofit organization who implements programs that aim to *enhance access to culturally and linguistically appropriate healthcare education and increase the diversity, quality, and distribution of future healthcare professionals within Eastern Connecticut*, I urge your agency to take the necessary steps to ensure that communities of New London County will not be negatively affected by the proposed Yale and Lawrence & Memorial Hospital merger. This community is primarily comprised of low socioeconomic status' including veterans and urban Hispanic residents who are primarily Spanish speaking. Regionalizing healthcare is not an adequate means to quality and equitable care.

Reducing, eliminating, our outsourcing health services is detrimental to communities' ability to access adequate and timely care, impact our health care workforce, and worsen health disparities among underserved communities. In Windham, we are already experiencing the impact of what can occur when hospital services are reduced following a merger. This past fall, a woman in her early 50s, with limited English proficiency suffered a minor stroke. When transported to Windham Hospital, the family was told they could not provide the care she needed because they did not have a neurologist on site. Instead, the woman was put in a Life Star helicopter and transported to Hartford Hospital. Thankfully, this woman's story didn't end tragically. The community in Windham County deserves quality health care that is delivered in a culturally and linguistic appropriate manner. Transporting patients to facilities over 30 minutes away can be catastrophic. In particular, the ability for ambulatory care to effectively communicate with patients that experience language barriers is nonexistent. With the CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham.

I raise this issue because when Hartford HealthCare bought Windham their application strongly suggested that they would not reduce services. Windham selling out to Hartford was supposed to “increase the services and technology offered locally,” and to “decrease the out-migration of patients.”<sup>i</sup> Hartford also said that “currently they will not be terminating any services.” But they also left the door open to reducing “duplicate” services. At the end, Hartford’s original CON was filled with broken promises.

Now, Yale is using almost identical language. We’re told the acquisition will bring expanded access to clinical programs, and that there are no “planned” reductions in services. But we’re also told that there may be a need to reduce “duplicate” services. Again, no guarantees, no real commitments.

It is critical your department carefully reviews this upcoming merger to ensure that communities within New London county’s health are not compromised. Thank you for the opportunity to submit public comment for the Health Care cabinet meeting. If you wish to discuss the detrimental impact hospital mergers, call (860) 465-8281 ext. 402 or [bond@easternctahec.org](mailto:bond@easternctahec.org)

Thank you for your consideration.

Sincerely,

A handwritten signature in cursive script, appearing to read "M. Bond".

Maritza Bond  
Executive Director

---

<sup>i</sup> Office of Health Care Access, Certificate of Need Application, Final Decision. “Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc.” p. 6-7.

## Greer, Leslie

---

**From:** Rosana Garcia <rgarcia@universalhealthct.org>  
**Sent:** Monday, July 11, 2016 1:07 PM  
**To:** User, OHCA  
**Cc:** Lazarus, Steven; Frances Padilla; Jill Zorn; Lynne Ide; Adam Chiara; Stephanye Clarke  
**Subject:** Public Comment for CON Hearing on L+M & Yale (Dockets 15-32032-CON & 15-32033-CON)  
**Attachments:** FINAL - L+M & YNHHS July 11 2016 Testimony (UHCF).pdf

To: Office of Health Care Access  
From: Universal Health Care Foundation of Connecticut  
Date: July 11, 2016  
Re: Public Comment for CON Hearing on L+M & Yale (Dockets 15-32032-CON & 15-32033-CON)

Please see attached (and text inline below) for Universal Health Care Foundation of Connecticut's testimony in regards to the CON Hearing on L+M & Yale (Dockets 15-32032-CON & 15-32033-CON).

Thank you,

**Rosana Garcia** | Policy Associate  
Universal Health Care Foundation of Connecticut  
203.639.0550 ext. 314 | [rgarcia@universalhealthct.org](mailto:rgarcia@universalhealthct.org)  
290 Pratt Street, Meriden, CT 06450

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**Testimony Concerning the L+M Hospital / Yale New Haven Health System Proposed Deal**  
**Frances G. Padilla, President**  
**Universal Health Care Foundation of Connecticut**  
**July 11, 2016**

Like politics, all health care is local. This is even truer in Connecticut, with our 169 towns and municipalities, and our parochial attitudes about local control. Health care is also intensely personal.

The Office of Health Care Access (OHCA) has an enormous responsibility in reviewing Certificate of Need applications, especially ones such as this, where one health system and medical group (L+M Hospital & Medical Group) is proposing to affiliate with another, larger, system (Yale New Haven Health & Northeast Medical Group).

As this Certificate of Need application is reviewed, it is important to consider the both parties' answers to the following questions:

- How will this affiliation between L + M and YNHHS help the greater New London community?
- How will the city of New London and its surrounding region be better off in terms of health care services, health outcomes, employment, and the social determinants of health?
- How will Lawrence and Memorial Hospital's ability to meet its mission and serve its community be strengthened?
- How will L + M remain connected to its community as a resource for health and health care?

We ask that OHCA consider the conditions urged by local residents and leaders. L + M and Yale must not only listen to the community, but satisfactorily demonstrate that they are addressing the concerns underlying the proposed conditions. The community has serious concerns about this proposed deal. As L + M should ultimately be accountable to the people and community it serves, this community deserves measures in place to directly address their concerns.

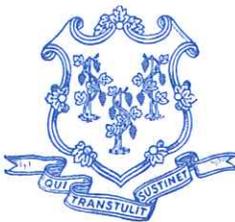
- Members of the community are worried they may lose essential services like behavioral and reproductive health. Where will decision-making about service elimination or addition reside, in the local community, informed by local priority needs and members of the community, or in the board room in New Haven?
- Population health should be the driving force behind affiliations and mergers, and OHCA's decision-making. Hospitals should use local health needs assessments as a roadmap for improved community health. Accountability should be built into any approval, so that the hospital(s) must demonstrate clearly and publicly what they have done to make a positive difference in the priorities identified by the needs assessment.
- Health care in Connecticut is unaffordable to many, many people. Hospital costs are a big part of this. How will affiliation demonstrably address affordability to the patient?
- Lower income people, the elderly, families with only one car, and others, struggle with transportation in Connecticut. Public transportation is unreliable. Auto insurance is expensive, particularly in low income urban areas. Health care reform has shifted delivery of care from inpatient to outpatient, often requiring travel and reliable supports to get you back and forth from procedures and appointments. Providing financial support for creative transportation solutions (in the short-term) and using hospitals' lobbying influence for improved public transportation should become an integral component of "community benefit." Moreover, accessibility to the target population must be a prime consideration of locational decisions.
- Local people do not trust that these institutions have their interests at heart. It is incumbent on the institutions to acknowledge and genuinely address this mistrust. Whether affiliated or merged, every hospital should have a robust local board of directors with true governance power. In L + M's case, their governing board must also be able to effectively influence the YNHHS board and not merely have an insignificant seat at the table. Moreover, the local hospital board should be accountable to an independent community body for demonstrated results on community benefit, progress on local needs assessment priorities and hospital financial stability. That independent community body should represent a cross-section of the public, private, nonprofit and resident population of the community.

**SENATOR MARTIN M. LOONEY**  
**PRESIDENT PRO TEMPORE**

**Eleventh District**  
*New Haven, Hamden & North Haven*

July 7, 2016

Hon. George Jepsen  
Attorney General, State of Connecticut  
55 Elm St.  
Hartford CT 06106



**State of Connecticut**

**SENATE**

Hon. Dr. Raul Pino  
Commissioner of Public Health  
410 Capitol Ave., P.O. Box 340308  
Hartford, CT 06134

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[www.SenatorLooney.cga.ct.gov](http://www.SenatorLooney.cga.ct.gov)

Dear Attorney General Jepsen and Commissioner Pino:

When the two applications were filed in regard to the affiliation between Yale New-Haven and Lawrence and Memorial, I (as well as several other legislators) urged OHCA not to proceed on the applications unless it was able to review both comparative prices between L+M and the Yale-New Haven System Hospitals, and prices at St. Raphael's, Bridgeport and Greenwich Hospitals before and after Yale-New Haven's acquisition of those facilities. I was pleased that OHCA in fact requested this data. Since that time, the Governor issued Executive Order 51 which creates a task force on Certificate of Need and restricts OHCA's ability to allow mergers and acquisitions until the Task Force has made its recommendations.

The Executive Order, among other things, seeks to "coordinate the state's regulatory oversight of its health care delivery systems with the broader goals of maintaining open, transparent, and competitive health care markets in the state that enhance access and quality of care and improve affordability without losing sight of the economic development impact of the hospital systems." These goals are impossible without access to hospital pricing and other hospital data. It is my understanding that Yale-New Haven has refused to provide the requested information and is claiming that risk adjusted prices do not exist, and that if they did exist, YNHH would refuse to provide them because they are proprietary. The claim that the data does not exist lacks credibility. Without such data, OHCA cannot achieve the goals of the Executive order and cannot plausibly find that the Applicant "has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care," as required by section 19a-639 (a)(12), in effect as of the date of the applications.

It would appear that under the terms of the Governor's Executive Order 51 OHCA could not decide either case until at least January 15, 2017 or it would be required to deny the applications if the statutory calendar requires a decision prior to that time. Regardless of the outcome of the Governor's Task Force, I believe that OHCA should not approve these applications at any point in the absence of credible price data. PA 14-168 and PA 15-146 strengthened the standards for review of the impact of the change of ownership of health systems, hospitals and physician practices to ensure that transactions like these by our state's biggest market actors are scrutinized to protect patients in terms of cost, quality and provider choice. This proposed merger would have an extraordinary effect on our health care system and the state must ensure that any allowed merger is in the best interests of our citizens.

Sincerely,

A handwritten signature in blue ink that reads "Martin M. Looney".  
Martin M. Looney

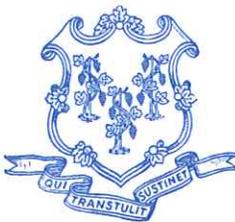
State Senate President Pro Tempore

**SENATOR MARTIN M. LOONEY**  
**PRESIDENT PRO TEMPORE**

**Eleventh District**  
*New Haven, Hamden & North Haven*

July 7, 2016

Hon. George Jepsen  
Attorney General, State of Connecticut  
55 Elm St.  
Hartford CT 06106



**State of Connecticut**

**SENATE**

Hon. Dr. Raul Pino  
Commissioner of Public Health  
410 Capitol Ave., P.O. Box 340308  
Hartford, CT 06134

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Sincerely,

A handwritten signature in blue ink that reads "Martin M. Looney".  
Martin M. Looney

State Senate President Pro Tempore



## State of Connecticut

### SENATE

SENATE MINORITY WHIP

**SENATOR PAUL FORMICA**  
TWENTIETH SENATE DISTRICT

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**RANKING MEMBER**  
ENERGY & TECHNOLOGY COMMITTEE

**MEMBER**  
APPROPRIATIONS COMMITTEE  
PUBLIC SAFETY COMMITTEE

July 11, 2016

To whom it may concern;

I write in my role as the State Senator of the 20<sup>th</sup> Senatorial District, which includes the main campus of the Lawrence and Memorial Healthcare System infrastructure in New London and its Cancer Center in Waterford.

The States position regarding funding cuts and excessive taxes on healthcare and hospitals in particular, have created an extraordinarily difficult problem for hospitals in our state.

Hospitals provide crucial health and related services to its local community, are large job creators with a highly skilled and trained workforce and attempt to do so in an industry that already faces many challenging and complex problems. The need to create efficiencies that result in service improvements and fiscal stability has seen many permitted mergers, affiliations and acquisitions here in Connecticut including 25 of our states 28 hospitals.

The proposed affiliation between Yale and L/M is being structured as an affiliation rather than a takeover or a merger in an effort to preserve its local identity in both of the communities in which they serve.

There are always concerns when service providers of any nature get larger; and hospitals are no exceptions. The need to preserve existing jobs to the extent possible by maintaining access and affordability to all the current services provided in both markets are of great concern. This seems to be addressed here as these two systems already have 6 clinical affiliations that work well and compliment each other while providing an expanded service portfolio to SE CT. Though there may be efficiencies created that combine some departments, there are assurances that the existing negotiated union agreements will continue. In addition, the infusion of a multi-million dollar capital investment and access to Yale's advanced technology would indicate a long term stabilizing win for L/M and our region.

If this affiliation were to be approved, I remain confident in the long term viability of L/M: that they will be able to continue to be locally controlled and managed with jobs sustained and services that remain both affordable and convenient to our residents. It is for these reasons I express my strong support.

Additionally I would offer to participate and/or facilitate in any discussions that work to satisfy those affected by this affiliation.

On a personal note my family has had the benefit one of L/M's partnerships with Yale. My wife was in need of complex cardiac care that resulted in trips to New Haven for treatments of a more specialized nature. We were grateful for that opportunity.

Thank you for your thoughtful service and for considering my comments.

Paul M Formica  
State Senator  
20<sup>th</sup> District

July 19, 2016



Ms. Kim Martone  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, Connecticut 06134

To Whom It May Concern:

I write today to strongly support the proposed affiliation between L&M/Westerly Hospitals and Yale New Haven Health System. As a member of the local community, I have personally witnessed the extraordinary work performed at L&M for friends, coworkers, and family members. As president of a local community bank that serves the same market area as L&M and Westerly, I have personally witnessed the tremendous impact the hospitals have on our local community, both economically and socially. As a member and officer of the L&M Healthcare's Board of Directors, I have witnessed personally the impact of changes in the national and in-state healthcare environment at large on our hospitals, and believe strongly that the key to our success in the future is through this affiliation.

I cannot put into words how impressed I have been with everyone I have come into contact with at L&M and Westerly hospitals. They are professional, compassionate, and innovative. They are dedicated first and foremost to their patients. In spite of their extraordinary efforts, the forces of change in healthcare that they face every day are such that going it alone seems impossible. I believe that the combination of two well-managed, locally focused hospitals, with access to the talent and resources available to a world-class organization like Yale New Haven Health is a powerful combination and a role model for the future of healthcare.

I strongly urge you to approve this affiliation as soon as possible to help strengthen our local healthcare system and our community.

Sincerely yours,

B. Michael Rauh, Jr.  
Resident of Mystic, CT  
President & CEO, Chelsea Groton Bank  
Secretary/Treasurer, L&M Healthcare



July 20, 2016

Ms. Kimberly Martone, Director  
Mr. Kevin Harsted, Hearing Officer  
Office of Health Care Access  
410 Capital Avenue  
Hartford, CT 06106

Reference: Certificate of Need Application, Docket # 15-32032 & Docket # 15-32033; Yale NH Affiliation

Dear Ms. Martone/Mr. Harnsted,

Lawrence & Memorial and Yale New Haven Hospital deserve great respect for what they do. I know many doctors who have provided extraordinary service and I know of many patients who have received extraordinary service from L & M and Yale NH. This should be the most important thing to continue because we can't live without it.

Having said that, there is great concern in modern economics about health care. I have been following health care since I wrote my thesis in 1973 – that thesis was on the unsustainable inflation in health care cost. At that time however, the concerns in economics did not include the impact we are living with today, of the loss of some 60,000 manufacturing facilities nationwide, thousands in Connecticut. The modern problem of not being able to pay our current health care bills has been severely compounded by the loss of these factories, where growth in income has lagged way behind growth in health care expense. Robert Kraft, the billionaire owner of the Patriots, in advocating for a Casino in Foxboro, spoke of the cultural changes resulting from closed factories, where a person once could get a job, buy a house, and join a community forever. Those days, he lamented, are gone with the hope a casino that can't be moved overseas, might replace some of that. Paul Krugman, the noted Princeton economist, has stated the continued extreme growth in health care expense will bankrupt this country.

While this is not the focus of this application, this awareness should present to local officials that how we manage health care going forward is critical and this affiliation could be critical in that as we deal in total with the cost of health care, this affiliation could result in the loss of L & M altogether. Why? Should we become part of Yale NH and they are forced to cut service, you can imagine they would cut services in Southeastern CT first.

With the above in mind, I want to make the following suggestions that reflect the thoughts of many, and would help to improve the confidence that this merger currently lacks:

- 1) The affiliation needs to include and give authority to a community Board of Directors governing L & M alone. The current L&M Bylaw changes give Yale NH Health total authority over L&M including the right to control the Board by having the right to provide and therefore control the list from which Board Members can be elected.
- 2) The Board of Directors should be defined by the State and should have authority over the actions of L&M even if the affiliation is approved. We cannot have a Board that can legally serve only the self-interest of the administration or Yale NH. Therefore a Board must include the

Administrator, Doctors, Employee representatives and Community members. The community members should be representatives from the Towns primarily served by the hospital as they have a very strong interest in making sure the hospital provides full and quality service at prices that reflect the local economy. The Board should also include an expert representative from the State since they represent the primary funding source.

- 3) The current administration and Board should recuse themselves from the negotiation to improve confidence.
- 4) Our Southeast Connecticut community needs the services and employment of L & M. This need includes the Doctors, administrators, nurses and technicians in full. We cannot afford transfer of services and employment to Yale NH.
- 5) The hospital needs to include the community need as its primary goal as with or without the merger - it is a basic need that we can't live without. Whether it returns to being a community based hospital or not, it will serve basic community needs without which it cannot and would not exist.
- 6) L & M assets total hundreds of millions of dollars that should not be turned over to Yale without restrictions that would return the assets to the community should Yale NH be found not to be serving the interests of the Southeast CT community.
- 7) Surplus funds created through operations should be returned to the community in the form of reduced rates, development of assets in the community, or other benefits approved by the Board.
- 8) The need to affiliate has not been proven. There is no evidence that supports any conclusion that L&M is losing money.

This affiliation represents a great risk of the loss of assets built over many years and loss of service and employment in Southeastern CT. Yale NH was written up in a Time magazine article titled 'Why Medical Bills are Killing Us' where they were included as a not-for-profit hospital, behaving as 'for profit', running up the bills and rewarding administrators much like a Wall Street corporation. Last count there were nine Yale NH administrators making over \$1 million a year.

Oddly many of the comments I have heard from people who have worked with L&M for decades suggest the current L & M administration has been behaving in the same manner as Yale NH administration. This country cannot afford to have the bills run up any more. The middle income group has suffered tremendous income loss due to the competition of cheap foreign labor based on favorable and sometimes manipulated currency exchange rates. While the banking industry is strong in NYC, and that has indirectly benefitted southwestern CT, the vast majority of middle income workers nationwide have suffered extremely and that includes Southeastern CT. As an example of this I can point to the small government entity I work for where our health insurance cost has gone from \$30,000 per month in 2008 to \$71,000 in 2017, over 200% growth. At the same time annual wage increases averaged just 3% and mostly covered the increase in the employee share of the health insurance premium. This is repeated in every town, every business, and is very much the reason for the unstable budgeting our state is suffering. If you do the math where will we be in another 8 years.

I hope the regional New London community will recognize the need to be proactive in protecting Southeastern Connecticut's very important asset, and with that in mind request the L & M / Yale NH affiliation be disapproved.

Sincerely,



Alfred Fritzsche  
15 Ice House Lane  
Mystic, CT 06355  
860-984-8338  
afritzsche4@gmail.com



Sheila Oddi  
310 Boston Post Rd #38  
Waterford, CT 06385-1965  
(860) 941-4093  
July 22, 2016

Kimberly Martone  
Office of Healthcare Access,  
Dept. of Public Health  
410 Capital Ave. MS. #13 HCA  
P.O. BOX 340308  
Hartford, CT 06134-0308

Dear Ms. Martone,

I am writing to you concerning the proposed merger/affiliation of L+M Hospital and Yale-New Haven Health system. Please excuse that this letter is hand-written, as I am penniless and have no computer access.

You ABSOLUTELY CANNOT allow this merger to happen and this is why: It will only make what they did to me even easier for them to do to others. I was a victim of diabolical medical malpractice and horrific patient abuse that occurred at both hospitals and was deliberately covered up by everyone involved. The lawyer I went to, Beth Hogan, failed to inform me that she was on L+M's corporate board and therefore had a conflict of interest. She pretended to take my case while actually working for the

other side, actually helping to make sure they would never get sued. They "cleaned-up" my medical records and threw away anything that could ever be used against them. Meanwhile, I could not get ANY follow-up care because I had become a "hot potato," no doctor connected with L+M would have anything to do with me. I am a medicaid patient, I am assigned to an area and can only go to the doctors in that area and connected to that area hospital. Their refusal to help me resulted in further malpractice including the development of multiple, progressive neurological conditions, one of which will eventually cause me to lose the use of my hands, arms, legs, lose control of bladder and bowels, and eventually work its way up my spinal nerve and shut down my breathing and kill me. To this day it is still not being properly treated because they don't want to admit it is caused by the two feet of bent, crooked, twisted rods in my spine. For about 12 or 13 years no doctor would even lift up the back of my shirt and LOOK at it no matter what symptoms I complained of, they just prescribed more narcotic pain pills even though they were already prescribing WAY beyond the prescribing guidelines. They would not send me to any specialists or order any tests even when I developed VERY RAPIDLY progressing neurological symptoms\* because

they did not want to generate any evidence. They were hoping I would overdose on opiates because only then would THEIR problem go away, I did not.

Beth Hagan waited out the two years of pretending to be my lawyer and then mailed me a letter saying she has decided not to take the case, with no explanation.

This of course left me no time to get another lawyer. Incidentally, she is now running for State representative. A true politician indeed, since her illegal actions are costing the taxpayers ALOT of money due to the fact that I now continue to qualify for medicaid, food stamps, (housing voucher, too, but lost that because nobody in this State can do their job correctly) and the extra malpractice is driving up the cost of my healthcare for the rest of my life.

She overlooked one detail: because she prevented a lawsuit, I never signed a non-disclosure agreement. Interesting very... (For the hospitals, it was never really about the money, it was about preventing the bad publicity from getting out. I wonder if they still care about that?)

To fully understand the gravity of the situation, you need to know the extent of my injuries and exactly what the malpractice and abuse was, and the toll it has taken.

The car accident resulted in a major concussion, several broken ribs, lung injury, temporarily paralyzed left arm due to a brachial plexus injury (doctors said it would be completely healed in about one year), and approximately 12 spinal fractures including a broken neck. At L+M they were not following proper procedures at all, re-injured my shoulder and now it will never fully heal. My shoulder is permanently partially paralyzed, and although I have use of my hand and arm (due to extensive physical therapy) it is very painful and weak and will deteriorate.

At Yale they put two feet of bent, crooked, twisted rods in my spine. Rods are literally poking right out of my back. After I was awoken from the surgery I spent two days without any pain medication because they put the button for the pain meds in my paralyzed hand, did not tell me about it, and I could not look because of the neck brace. I kept complaining of excruciating pain but they would not do anything about it. \*Next the brace specialist brought the back brace, telling me, "This is for physical therapy next week, try it on to make sure it fits," but he forgot to bring the tools to adjust it. He put it on me anyway. It shoved my head ten inches too far forwards injuring my broken neck (this is why I now have CONSTANT migraines). Then he told me to tell the nurse to remove the brace

4 \* then I would pass out from the pain. Repeatedly this happened.

and change me back into the neck brace and he left. The nurse refused to do that and proceeded to literally **TORTURE** me for the next six, or seven hours or so, so severely that I now have PTSD. She even claimed that because I asked her to remove the brace that I was supposedly trying to harm my self, using that as an excuse to **HANDCUFF** me to the bed. I literally thought I died and went to hell. None of this is in my records because they realized they were wrong by morning, when her shift ended and the doctors showed up and asked why I was wearing a physical therapy brace in bed\* when I don't start PT until next week - just like I had been saying all night, she just wouldn't listen because she was too busy **TORTURING** me.

(I'm just giving you the highlights, a lot more bad things happened, but you get the idea).

After being released from Yale I could not get follow-up care. At one doctor's office, Dr. Radin, in New London, where I was to have x-rays because the neck bone was so close to the nerve it could paralyze me from the neck down and I would die from not breathing - I was turned away. They said, "You're not his patient, he's not your doctor, you have to leave." Dr. Kelly, also of NL, refused to operate on a bunion even though I explained three times that it was interfering with my

\*PT brace is NOT supposed to be worn lying down, in bed.

ability to do physical therapy for my arm because they were all standing resistance exercises with exercise bands, and because my toes are completely crossed I would just wobble and fall over. He got up and walked out while I was mid-sentence. Some of the metal in my back stuck out so far I would actually knock things off of shelves behind me with them! That actually happened numerous times. The rods should have been taken out within a year or so of putting them in but these people did not want any other doctor to see what had been done for fear I would go to another lawyer. So they colluded to cover it all up. More than a dozen years later I went to a surgeon at L+M, Dr. Samuels, and she claimed removing the rods wouldn't help me. She did everything she could to talk circles around me. Recently I went to a GOOD surgeon, Dr. Paonessa, at Backus Hospital, who DID perform another surgery on my back. There was a long delay in even scheduling the surgery because we could not get the records we needed from Yale Hospital. Dr. Paonessa had to guess at which set of tools to use to remove the rods because Yale destroyed my records because they did not want to get sued, and consequently we could not get the right tools. Some of what is in my back, the worst of it, cannot be removed because we cannot identify the manufacturer of the

tools we need to do it, and the original surgeon refuses to return his calls, Some of the metal cannot be removed because so much time has passed that bone has grown over it and now it is too late.

Bone will eventually grow over the rest as well if that first doctor never tells us what we need to know. My fate is already sealed.

Before this happened, I was working as a professional seamstress and hairdresser, had tons hobbies, grew apple trees from seed, had a social life, wanted to volunteer at animal shelters, could bake the best Christmas cookies and cakes ever, and was about to start teaching bellydance. Now I am permanently disabled, weigh 88 pounds, live on about \$8,000 a year, take 16 different prescriptions, can't afford to buy food or anything else, have constant migraines, insomnia, nightmares, agonizing pain, two kinds of progressive neuropathy, my digestive system no longer works because of both the neuropathy and because I have been on narcotic pain drugs for 15 years, have depression, anxiety, and PTSD, and I'm not even going to include all the other medical problems I had before this.

Please, I am begging you, do not let them do this to anyone else. I have met DOZENS of other people who told me, "They did the same thing to me!" This is actually the root cause of the heroin epidemic - it starts with an injury or bad surgery and some type of medical malpractice which is ALWAYS



July 14, 2016

Kimberly Martone  
Director of Operations  
Office of Healthcare Access Division  
Department of Public Health  
410 Capital Avenue  
MS 13HCA  
P.O. Box 340308  
Hartford, CT 06134-0308



I am writing concerning the proposed affiliation between Lawrence + Memorial Hospital and Yale Health Systems.

We have been affiliated with Yale Stroke Service for over eight years. When we began, there was no stroke service, and now we have one of the leading primary stroke centers in the State of Connecticut. Currently, I am the director of the stroke service.

Our relationship has been extremely positive. I note that people have concerns that we be losing patients and business to Yale. Our affiliation with Yale has had the opposite effect. We currently keep 90% of patients that have had strokes at L+M Hospital. The affiliation has increased the quality of medical care for strokes with enhanced laboratory services, x-ray services, interventional radiology and increased rehabilitation services.

I can only speak positively of our affiliation with Yale and encourage that we proceed.

Daniel Moalli, MD  
Director, Stroke Service

DM:lst

August 18, 2016

The Honorable Raul Pino  
Commissioner of Public Health  
410 Capitol Avenue  
PO Box 340308  
Hartford CT 06134

Ms. Kimberly Martone  
Director of Operations  
Office of Health Care Access

Attorney Kevin Hansted  
Hearing Officer  
Office of Health Care Access

Dr. Pino, Ms. Martone, Attorney Hansted:

The undersigned constitute a majority of the New London City Council. We write to urge you to ignore the September 8 expiration of the Federal Trade Commission's approval in your deliberations on the proposed acquisition of L+M Health Corporation by the Yale New Haven Health Services Corporation and the merger of L+M Physicians Association into Northeast Medical Group.

Yale CEO Marna Borgstrom told the media that if the state doesn't approve the proposed takeover of our community hospital immediately, she'll have to spend \$250,000 getting re-approval from the federal government, and that will hurt patient care.

The FTC's approval is expiring for one reason only: Ms. Borgstrom and L+M Health CEO Bruce Cummings have stonewalled the Office of Health Care Access for 8 months, refusing to produce price data from the two hospitals so you and the public can understand the potential threat to consumers' wallets.

Yale says the data doesn't exist, and they wouldn't produce it anyway, even though their prices become public next year. The first claim lacks credibility. The second insults patients who depend on L+M.

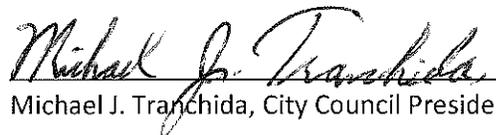
Renewing FTC approval takes all of 30 days, and the deal sailed through last time. As for spending \$250,000 so you can make sure we won't face price gouging, Yale can afford it – that's less than one month of Ms. Borgstrom's \$3.6 million annual compensation.

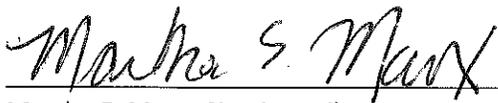
We also have unanswered concerns that Yale refuses to guarantee there will be no future service cuts, that most of Yale's supposed \$300 million "investment" is to be generated by L+M's own future profits, and the lack of specifics on how they will spend whatever they do invest. Finally, Yale's continued insistence that L+M will be locally controlled, when Mr. Cummings' sworn testimony and the plain language of their proposed bylaws directly contradict these claims, remains a mystery.

In the end, L+M and our community may benefit from an acquisition. But far too many important questions remain. The future of our hospital and health system is too important to be rushed. OHCA should insist on seeing all the data before making a decision, and take whatever statutory time is necessary to thoroughly evaluate all the information before it. Let Yale worry about the FTC.

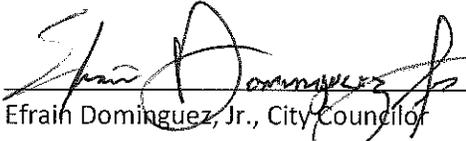
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Erica L. Richardson, City Council President

  
Michael J. Tranchida, City Council President Pro Tem

  
\_\_\_\_\_  
Martha E. Marx, City Councilor

  
\_\_\_\_\_  
Don Venditto, Jr., City Councilor

  
\_\_\_\_\_  
Efrain Dominguez, Jr., City Councilor

  
\_\_\_\_\_  
Anthony L. Nolan, City Councilor

  
\_\_\_\_\_  
John D. Satti, City Councilor



# City of New London

## Office of the Mayor

181 State Street • New London, CT 06320 • Phone (860) 447-5201 • Fax (860) 447-7971

August 25, 2016

The Honorable Raul Pino  
Commissioner of Public Health  
410 Capitol Avenue  
PO Box 340308  
Hartford CT 06134

Ms. Kimberly Martone  
Director of Operations  
Office of Health Care Access  
410 Capitol Avenue  
PO Box 340308  
Hartford CT 06134

Attorney Kevin Hansted  
Hearing Officer  
Office of Health Care Access  
410 Capitol Avenue  
PO Box 340308  
Hartford CT 06134

Dear Dr. Pino, Ms. Martone, and Attorney Hansted:

I am writing to express my appreciation for your consideration of the proposed affiliations of Yale New Haven Health Services Corporation with the L+M Health Corporation and Northeast Medical Group with L+M Physicians Association. You may recall that I testified at the first day of your public hearing in New London. I hope your deliberations, so critical to the delivery of healthcare in our city and region and to the future of our community hospital, will not be influenced or rushed by the September 8 expiration of the Federal Trade Commission's approval of the affiliation.

I am hopeful that an affiliation between Yale-New Haven and L+M will only strengthen the delivery of healthcare in the region and benefit our community hospital. However, I believe the intervenors have raised valid questions that should be answered and significant concerns that must be resolved by your commission. Evaluating the terms of the proposed affiliation is too important to be rushed.

Sincerely,

Michael E. Passero  
Mayor

cc: Bruce Cummings, President & CEO, L&M



## Greer, Leslie

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**From:** Martone, Kim  
**Sent:** Tuesday, July 12, 2016 11:56 AM  
**To:** Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Carney, Brian  
**Cc:** Greer, Leslie; Olejarz, Barbara  
**Subject:** FW: Docket Number 15-32032-CON and 15-32033-CON Public Information Testimony from Kathleen Stauffer  
**Attachments:** The Arc NLC\_Testimony YaleNH 2016 (2) (2).pdf

### ***Kimberly R. Martone***

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



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**From:** Karen Warfield [<mailto:kwarfield@thearcnlc.org>]  
**Sent:** Tuesday, July 12, 2016 11:02 AM  
**To:** Martone, Kim  
**Subject:** Docket Number 15-32032-CON and 15-32033-CON Public Information Testimony from Kathleen Stauffer

Ms. Martone,

Please see Kathleen Stauffer's written testimony regarding docket number(s) 15-32033-CON and 15-32033-CON. A hardcopy will be mailed to your office at:

Division of the Depart. Of Public Health  
410 Capitol Avenue, MS #13 HCA  
P.O. Box 340308  
Hartford, CT 06134-0308

If you have any questions, please contact me at the email below.

Thank you in advance,

Karen Warfield

Executive Assistant  
The Arc-NLC  
125 Sachem Street  
Norwich, CT 06360

T:860.889.4435 x126

E: [kwarfield@thearcnlc.org](mailto:kwarfield@thearcnlc.org)

[www.thearcnlc.org](http://www.thearcnlc.org)

***Achieve with us.***

11 July 2016

TESTIMONY RE: PROPOSED MERGER OF YALE NEW HAVEN HOSPITAL WITH L+M HOSPITAL

1. **THANK YOU.** The Arc New London County **thinks the panel for the opportunity to offer testimony.**
2. **WHO WE ARE.** The Arc New London County is a **64-year-old, grassroots agency in Southeastern Connecticut founded by families to support loved ones with Intellectual and Developmental Disabilities (I/DD).** Driven by a philosophy that every person deserves full inclusion, **The Arc walks with people as they live their best lives as independently as possible saving millions of taxpayer dollars each year.** Our sphere of influence – families served, employees, volunteers and Board members – number approximately 2,000 people in New London County.
3. **HEALTH AND WELLNESS. Of critical concern to The Arc NLC is the health and wellness of people with I/DD in Southeastern Connecticut.** *Healthcare supports for the vulnerable residents of SE CT must be measurably enhanced by this merger.* Special populations can be challenging in several respects: Healthcare providers too frequently are untrained in supporting fragile populations whose challenges can present physically, emotionally and behaviorally. It is essential that demonstrating a data-driven suitability and preparedness to serve vulnerable people, specifically people with I/DD, be a critical criterion for approval of this merger.
4. **NONPROFIT HOSPITALS AND COMMUNITY WELFARE.** The first hospitals in the United States were for-profit enterprises, established by doctors to serve wealthy clients. **As an understanding of public health, sanitation and prevention evolved, nonprofit hospitals were established to serve the public good.** Among the critical services nonprofit hospitals provide to a community:
  - **Community health.** Nonprofit hospitals are less likely to engage in turnkey services, shortening stays inadvisably for quicker profit.
  - **Community research.** Nonprofit hospitals are more likely to invest in research to find cures for disease.
  - **Community well-being.** Nonprofit hospitals readily serve patients whose services are Medicaid reimbursed and provide other critical supports such as community investment, rate caps to hedge against runaway costs, regional economic stability, jobs and facilities investment.

**Regrettably, over the last two decades, nonprofit hospitals have increasingly found it necessary to compete with for-profit entities to survive, behaving more like for-profit hospitals. For this reason, the above concerns require established remedies that are measurable, enforceable and ongoing to ensure that this merger benefits New London County and its residents rather than the deal-makers at the top of the healthcare food chain.**

5. **SOUTHEASTERN CONNECTICUT’S ECONOMIC WELL BEING. As one of the wealthiest states in America with the second-richest capital city in the nation, Connecticut will not be better off if this partnership does not leave New London County better off economically. As one of America’s 10 most economically distressed regions, New London County must benefit by this merger in the following, data-driven ways or the merger cannot and should not be permitted to happen: 1) A significant number of new, quality jobs must be created and maintained. 2) Demonstrated facilities investment in the region must be a part of this plan; 3) A demonstrated commitment to investment and wellness for the region for the next decade must be provided by means of a written plan. Penalties for falling short of these goals must be clear, enforceable and implemented as appropriate.**

Kathleen Stauffer, MPA  
Chief Executive Officer  
The Arc New London County

**Office of Health Care Access**  
**Proposed L+M Health Care and Yale New Haven Health Affiliation**  
**Public Hearing**  
**July 11, 2016**

My name is Catherine Zall and I serve on the L+M Healthcare Board. I am here today, however, in my capacity as the Executive Director of the New London Homeless Hospitality Center. In this capacity I have had the opportunity to see first hand the multiple health care challenges that face our neighbors experiencing homelessness. We deal every day with individuals with serious unaddressed health issues often made more acute by homelessness. Every day we also see the precious health care resources that are ineffectively used when people receive high quality medical care but cannot follow up on that care due to the challenges of homelessness.

We are already working with L+M Hospital to address multiple aspects of this issue. With funding from the hospital, we have established a special respite section of our emergency shelter that provides people facing both homelessness and a serious health crisis with access to emergency shelter specifically designed to meet their needs. We are jointly giving people a setting conducive to recuperation, helping people connect to follow-up medical care and providing a setting where people can follow the discharge instructions they receive on release from the emergency room or inpatient care.

This effort represents an important start toward improving health outcomes for a very underserved population. But there is so much more that needs to be done. Drawing on the growing body of evidence generated through population health research, we need to use data to identify individuals experiencing homelessness who could benefit from increase health engagement before they end up in an acute crisis requiring inpatient or emergency room care. We need to apply best practices in reaching people who have chronic conditions to be sure they have access to the basic resources they need to maintain health. We need an even more in-depth partnership between housing and health care providers to address the social determinants of health.

All of these efforts—respite and other health interventions—require access to sophisticated analytical tools and knowledge of population health interventions. Standing alone L+M Hospital has access to some of this expertise. The proposed partnership with the Yale New Haven Health System, however, would allow access far superior support in the effort to improve health outcomes. With help from Yale New Haven, L+M could more effectively utilize data and population health models to address health disparities thereby improving lives and reducing unnecessary costs.

A deeper partnership with Yale New Haven would also streamline care coordination as many of our guests experiencing homelessness touch both the L+M Hospital and the Yale health systems. Being part of a bigger system would allow us

to more effectively collaborate with colleagues in New Haven to test new models of delivering care and develop new best practices that could improve health outcomes across the state for people experiencing homelessness. Finally the proposed affiliation could free up additional community benefit resources that could, in turn, be invested in community based health improvement efforts.

Our neighbors experiencing homelessness need access to new tools to improve health outcomes. We all need to deliver health care more cost effectively by intervening earlier and improving continuity of care. The proposed affiliation would help achieve that goal. I urge the Office of Health Care Access to support the proposed affiliation.

Thank you.

Catherine Zall  
Executive Director  
New London Homeless Hospitality Center  
czall@snet.net

**Office of Health Care Access**  
**Proposed L+M Health Care and Yale New Haven Health Affiliation**  
**Public Hearing**  
**July 11, 2016**

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Thank you.

Catherine Zall  
Executive Director  
New London Homeless Hospitality Center  
czall@snet.net

***Achieve with us.***

11 July 2016

TESTIMONY RE: PROPOSED MERGER OF YALE NEW HAVEN HOSPITAL WITH L+M HOSPITAL

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**United Nurses &  
Allied Professionals**



Linda McDonald, RN  
President

**Statement to the Office of Health Care Access  
Re: CON application regarding Lawrence & Memorial Healthcare and Yale New Haven  
Health system**

July 11, 2016

Hello. My name is Jack Callaci, I live in Cranston, Rhode Island and I represent the employees of Westerly Hospital. I am here to state in the strongest and most unequivocal terms our support for the affiliation of Lawrence and Memorial Healthcare that includes Westerly Hospital with Yale-New Health System. I would like to make three major points.

First, this is not about this one transaction before you. The overwhelming pressures and trends nationwide in the healthcare industry including insurance companies, hospitals, visiting nurse services and doctor practices is towards affiliations and consolidations. The evidence of this is abundant here in Connecticut, in my home state of Rhode Island and around the country. The parties to this affiliation are not creating the nationwide pressures and trends. They are responding to them as best they can.

I wish that the trends did not exist and that we could return to a time of free standing nonprofit hospitals serving each community. Whether we like it or not that time is long gone. So the question is not, in my opinion, whether we can stop this particular transaction and roll back the clock, we can't, but what is the best way for Lawrence and Memorial Healthcare and Westerly Hospital to address these overwhelming pressures.

That brings me to the second point. If this proposal is killed, what is the alternative and is that alternative better than what is before us today? Killing this proposal does not mean that Lawrence and Memorial Healthcare and Westerly Hospital will remain as is. It only means that this particular option is foreclosed. Look at the alternatives out there. I am sad to report on many of the alternatives from our own experience.

Prospect Medical Holdings is about to purchase several hospitals in your state. They are a for profit, out of state entity backed by a venture capital firm. They are aggressively expanding in the east. In Rhode Island, they have reneged on agreements made after demanding and getting tax breaks and governmental benefits. You saw the article in the Manchester newspaper demonstrating the poor quality of care Prospect California Hospitals provide including quality concerns so severe that medicare closed some of their hospital units. Prime Healthcare also a California based for profit expanding in the East coast was recently been indicted for Medicare fraud. Steward Health Care Systems in Massachusetts closed a hospital after agreeing not to do so and have left a hospital and its community in the lurch by endless delays, endless demands on

top of demands and then finally deserting the hospital and its community without notice. My point here is this. Hospital consolidations are going to continue. So the issue is what is the best agreement to make?

I believe that an affiliation with a non-profit, Connecticut based entity with a Board that has members based in our communities and the standing and record Yale-New Haven Health Systems has is by far the best choice.

I have read about and listened to the concerns raised by those opposed to this affiliation. I think many or all of the concerns are legitimate and well thought out. It is those very concerns that lead me to say that those concerns are better addressed in an affiliation such as the one before you rather than killing this affiliation and taking the chances with another entity down the road. Again, perhaps this affiliation can be sunk. But the pressures to affiliate somewhere will not go away. The pressures in fact will build. Don't take my word for it. Look around your state, Rhode Island, Massachusetts and nationwide.

The third and last point I want to make is that with whom you affiliate makes all of the difference in the world. It was only a few years ago that sadly, in my opinion, the Westerly Hospital entered bankruptcy and ceased being the free standing hospital it was. Lawrence and Memorial Healthcare has made good and continues to make good on every commitment they made to the Westerly Hospital, the State of Rhode Island and the Westerly community. Many of those commitments have several more years to run and Yale New Haven Health System committed in writing to honor those commitments. I mentioned earlier Prospect has reneged on its commitments, Steward closed a hospital they committed to keeping open and Prime has been indicted for Medicare fraud.

If one thinks this is a matter of killing this affiliation and freezing all of the national trends in the healthcare industry in this relatively small community, good luck. But if you believe that the industry trends are bigger than all of us and accelerating as I do, then the challenge is what is the best affiliation we can effectuate and to my mind there is no doubt whatsoever that the affiliation of Lawrence and Memorial Healthcare and Westerly Hospital with Yale New Haven Health System is by far the best option for our respective communities and it should be supported.

Sincerely,

  
John V. Callaci

United Nurses and Allied Professionals  
Director of Collective Bargaining

July 19, 2016



Ms. Kim Martone  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, Connecticut 06134

To Whom It May Concern:

I write today to strongly support the proposed affiliation between L&M/Westerly Hospitals and Yale New Haven Health System. As a member of the local community, I have personally witnessed the extraordinary work performed at L&M for friends, coworkers, and family members. As president of a local community bank that serves the same market area as L&M and Westerly, I have personally witnessed the tremendous impact the hospitals have on our local community, both economically and socially. As a member and officer of the L&M Healthcare's Board of Directors, I have witnessed personally the impact of changes in the national and in-state healthcare environment at large on our hospitals, and believe strongly that the key to our success in the future is through this affiliation.

I cannot put into words how impressed I have been with everyone I have come into contact with at L&M and Westerly hospitals. They are professional, compassionate, and innovative. They are dedicated first and foremost to their patients. In spite of their extraordinary efforts, the forces of change in healthcare that they face every day are such that going it alone seems impossible. I believe that the combination of two well-managed, locally focused hospitals, with access to the talent and resources available to a world-class organization like Yale New Haven Health is a powerful combination and a role model for the future of healthcare.

I strongly urge you to approve this affiliation as soon as possible to help strengthen our local healthcare system and our community.

Sincerely yours,

B. Michael Rauh, Jr.  
Resident of Mystic, CT  
President & CEO, Chelsea Groton Bank  
Secretary/Treasurer, L&M Healthcare

June 17, 2016

Written Testimony Concerning Lawrence and Memorial Hospital and Yale New Haven Hospital Merger

To Whom It May Concern:

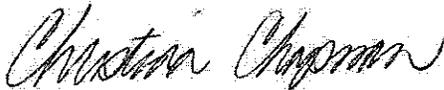
I am submitting testimony today to express my concern about the Lawrence and Memorial Hospital and Yale New Haven Hospital takeover. I am very concerned with the cost of care and how it will affect New London County, if this merger happens. Also, I have my own personal concerns on this matter.

I am concerned with the Yale New Haven Hospital Administration's practice of placing liens on client's homes for nonpayment of medical bills. Yale New Haven Hospital is a very profitable. I would prefer seeing this hospital focus its attention on working with its clients to create manageable budget plans. Many people in New Haven County have lost their homes for nonpayment. We do not want to see people in New London County losing their homes over nonpayment of medical bills.

I have worked at Lawrence and Memorial Hospital as a Registered Nurse for almost thirty years and have seen many positive changes. However, I have also seen many changes in business practices recently to cut costs to benefit upper management's salaries, while the workers and patients suffer. I believe this will be the case if there is a merger. Many thoughts are going through my mind regarding this possible merger. Will this merger bring less autonomy to the community hospital administration to effect decisions in the boardroom? Will the administration and local unions have less power to affect change in the workplace? I am very concerned with the quality of bedside care for my patients as well as my own financial future and future retirement opportunities as a result of this merger.

The outcome of this merger is not only important to me personally and professionally, but it will have a dramatic impact to the community in New London County. This is why I am passionate about being involved to create the best possible outcome for everyone in this area. Thank you for allowing me to share my testimony.

Sincerely,



Christina Chapman, RN, BSN, CRRN

7/26/16

L&M/Yale Merger Public Hearing

Dear Attorney Hanstead,

I am respectfully writing to you as a representative of Riverfront Children's Center, Inc. which is a non-profit child care program in Groton, CT. We have been following the merger on behalf of our 144 clients, and have a few concerns regarding the effects that a merger between Yale and L&M could have on our region.

L&M recently merged with Westerly Hospital, so that if Yale merged with L&M, all the Hospitals from New Haven up the coastline and into RI would be run by 1 entity. My experience with centralization is it causes a kind of monopoly on services. Thus, with no local competition for pricing, the cost generally goes up to consumers. Our concern with that is that the majority of our low to middle income clients (144 children) use the emergency room as their primary care medical home. A needs assessment study was recently done I believe by Ledge Light Health District and L&M Hospital and when I attended the meeting summarizing the findings of that report, it showed that a higher proportion of SECT families were seeking their primary care directly at the ER than anywhere else in the state. With many clients going off of HUSKY August 1, 2016 (especially parents), we fear that they will no longer get the health care they need and put off preventative care because of rising costs. With behavioral mental health and adult mental health in the high level of crisis that it is already in for our region, we fear that the outcome would be disastrous if the costs of medical care became prohibitive to our clients. Even small increases would prevent them from seeking care once they are off HUSKY.

In addition, we have noticed that in the past 2 years that more and more of the children and elderly needing medical care at L&M have had to be sent to Yale, CCMC, Hartford Hospital or another larger hospital more than 1 hour away for their care for things that might have previously been handled locally at less of a stress on the children and families. Personally, we were almost sent to Hartford for our daughter's broken arm because there may not have been a children's specialist available that day. After already driving to L&M by ambulance, we were lucky that the specialist was available, because our child suffers from high anxiety and would not have done well with an additional hour long transport after sitting with a broken arm for 2 hours. It is a concern that with the merger, more patients will be transported to the larger hospital hubs and fewer personnel (especially specialists) will be here locally at the L&M facilities. That could also mean lost jobs and economic impact that would hurt our clients who fill the roles of the service industry locally.

Overall, though we acknowledge that there could also be benefits from a merger such as this, we fear that the negative impacts will far outweigh the positives for our clients specifically. They are already marginalized, and barely making it by from day to day. Any increases in stress, costs or decreases in their health care would be highly detrimental to their overall life outcomes.

Sincerely,

Susan Corrice

Executive Director

The Riverfront Children's Center, Inc.

869-445-8151

476 Thames Street

Groton, CT 06340

Testimony

July 25, 2016

Dear Attorney Hansted:

My name is Susan Goldman. I have lived in Norwich for 27 years. I am a retiree member of AFSCME (local 2422), and I recently retired from my position as Program Assistant at the city of Norwich Office of Community Development where we administered all of the HUD grant funds.

I want to express my strong opposition to the Yale New Haven – L+M Hospital acquisition as currently proposed.

The City of Norwich, and many of its surrounding communities, are already experiencing significant economic challenges, with municipalities faced with eliminating core human service programs due to budget constraints, residents having difficulties securing good jobs, decent housing and putting food on the table. These issues are real, for families not only from traditionally "low-income" families, but are impacting a growing number of people further along the income spectrum. A few years ago, the United Way released a report on ALICE Households- an acronym for Asset Limited Income Constrained Employed families—powerfully illustrating the challenge for both low income and moderate income families. These families earn more than the US Poverty level, but less than the basic cost of living for the county. Combined, the number of poverty and ALICE households equals the total population struggling to afford basic needs. In New London County, out of a population of 105,801 there are 36,681 households struggling with providing basic human needs for their families.

It is within this context that I urge OCHA to be vigilant in their <sup>Review</sup> approval of this proposed acquisition. Yale New Haven Hospital and L+M Hospital are vital, critical community institutions providing essential services to the whole of the population residing within their service area. If there are significant changes/increases on cost and prices, access to essential health care services, loss of local control or an overall decline in our community's access to basic services, the impact on an already struggling population could be devastating.

**Cost & Price:**

It is my understanding that if and when this acquisition goes through, Yale New Haven will have 80% of the market share within the L& M service area. Studies show with this kind of market share, prices increase by at least 20%. This would severely impact access to health care services for a very large percentage of our population. Despite request by legislative and executive branch officials for data on impact of previous mergers on cost & pricing, YNHH has not provided this data. If there is no data, OHCA—given its charge and mission to protect consumers from rising health care costs—cannot reasonably or responsibly approve this proposal.

**Local Control:**

While YNHH & L+M have both claimed that full control of decision making would remain with the local board, recent review of the proposed by-laws reveal that YNHH would assume that power and authority. This revelation undermines Yale's veracity and commitment to engage in authentic and transparent negotiations with the community.

**Local Access to Health Care Services:**

What happened at Windham Hospital, through the decisions made by its parent company- Hartford Health Care, has had a chilling impact on many members of this community. We do not want our community hospital to be another Windham. YNHH and L+M must provide concrete guarantees to OHCA, to elected leaders and to community members that local access to health care services will not be impacted by this acquisition.

**Accountability:**

These vital issues require a signed, legally enforceable community benefits agreement between Yale New Haven and a broad cross-section of our community before we can even consider allowing control of our community hospital to change.

June 16,2016

To whom it may concern,

My name is Victoria Longo , I grew up in New London and have lived in New London. I presently live in Uncasville,Ct. I am a registered nurse and have been employed at Lawrence and Memorial hospital for 35 years.

The hospital has been a fixture in our shoreline community for over100 years, not only do I work there but all of my family members have been patient 's at the hospital at one time or another. Since we are a fairly small town I have seen familiar faces all the time using the services at our local hospital. For many people it is very comforting to see familiar faces when they come into the hospital and to know that while they are at the hospital they are still close to home.

I am cautiously optimistic about our pending affiliation with Yale New Haven Hospital.... I know that in the ever changing healthcare atmosphere certain changes have to be made. However I do not want these changes to be made at the expense of our employees,community, and our local hospital . I am concerned about access to care if services get moved closer to New Haven, and I am also concerned about the cost of procedures etc. going higher because of our affiliation with a larger hospital; as everyone knows healthcare is already very expensive. Our employees are dedicated hard working people who deserve to work for an employer that respects each and everyone of them and values them.

Thank you all for your consideration on the very important matter, I'm sure we all want to do what is in the best interest of everyone involved.

Respectively submitted ,  
Victoria Long

Mary Ellen Masciale

Secretary, Local 5051 L+M Hospital LPN/Technical Employee Union

Long term employee in Neurodiagnostics Lab for 26 years

Live with my family in New London, with other relatives in Waterford and East Lyme

Thank you for allowing me to be heard. I am terrified of public speaking, so this is something I feel very strongly and deeply about or I wouldn't be here this evening! I have some concerns about this affiliation and feel like we are being railroaded into it. I have concerns that our patients, and therefore our community, are pawns in a political game that is really about big business.

My department is responsible for performing nerve conductions on patients with peripheral nerve issues. We work closely with a physician who is either a neurologist or physiatrist. We have grown this service steadily over the past 5 years and serve about \_\_\_\_\_ patients a year. Last year, our main physician left for another state; there was no initiative from the administration to find another to take his place. We were able to get someone to take on the patient volume ourselves. After a year, she is also leaving for another state. There has again been no initiative to hire another doctor; I know this because we asked the physician recruiter. We typically have a 4 week wait for an appointment. Now we are only able to schedule 6 patients a week instead of 24, which will prolong diagnostics to at least a 3 month wait. Administration response to this is to "wait and hope Yale will be able to help us." I am very concerned that this aspect of my department will dwindle over the next 6 months and then get moved off site to Yale when the "affiliation" takes place.

I also have concerns that we will be forced to adopt some questionable clinical practices, which will lead to higher patient costs even if L+M does not fall under Yale's DRG rates. At L+M, and most hospitals, a 30 minute EEG tracing is standard. Yale runs a 63 minute EEG so that they can charge for a higher cost procedure, even if it is not clinically necessary.

I've watched over the last 7 years as this administration has ricocheted from one trend to another with limited commitment and success (durable medical equipment, Dana Farber Cancer Center affiliation, large orthopedic inpatient addition, ideas for outpatient pharmacy, "Pequot South", off site psychiatric facility, etc), and I am concerned that this deal is going to follow suit, but be a done deal.

I urge you to delay your decision on this case until the state has had time to review the laws that govern hospital mergers. There are big changes going on in health care, and once this deal gets done it cannot be undone. Let's make sure it is right for our community first!

Good afternoon,

My name is Kristen Powers. I have been an employee at Lawrence + Memorial Hospital for 29 years. I am also a life-long, local community individual that has entrusted all of my healthcare needs to L+M hospital for nearly 52 years.

I am here today to show support for and, **more importantly**, to encourage you to honor the Governors Executive order of delaying large mergers, affiliations or corporate associations amongst **our** Connecticut hospitals. Let the Governors committee do the work they have set out to do.

I ask this because I have read multiple articles regarding **“associations”** of this sort and **I am** concerned that this “affiliation” will, in the long run, lead to increased costs to our patients and our community.

I believe that if L+M **“affiliates”** with a larger entity like Yale, we, as a community hospital, may be fueling the “ever-growing fire” of rising health care costs. No one can dispute that the cost of healthcare is rising at a ridiculous rate; most people cannot even afford it! If L+M affiliates with Yale, Yale will become the dominant player along the CT shoreline from New York all of the way into RI. This means that if Yale becomes the dominant “player” in the game in our community, **and this is not a game**, they can set whatever prices they want or claim to need.

I have read many articles over the last several months about “hospital mergers” and have found that even the FTC is “wary of mergers by hospitals.” The New York Times<sup>1</sup> and the LA Times<sup>2</sup>, among others, have written articles about this subject and have found that, although the goal was to become more efficient and save money by merging or affiliating, costs have actually increased after the “deal was done.”

**I cannot accept this, you should not accept this, nor should anyone!  
It is time to reign in the madness!**

I **insist** that you take a very long, hard look at what this “affiliation” will mean to my patients, my community, my family and yours! You may or may not live in this part of CT, but your decision will have great impact and be far reaching for the rest of the citizens of CT.

Kristen Powers  
298 Lestertown Rd.  
Groton, CT 06340  
860-912-3138

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<sup>1</sup> <http://www.nytimes.com/2014/09/18/business/ftc-wary-of-mergers-by-hospitals.html>

<sup>2</sup> <http://www.latimes.com/hilzik-california-hospitals-20160613-snap-story.html>

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## Personal story on effects of Yale-New Haven Takeover of L & M

My name is Ken Rowland, and I live in Waterford, CT. I am a UAW member who is lucky enough to be offered decent health care coverage benefits through my employer. Until recently, I have been fortunate enough to say my family's health has been good and therefore healthcare costs were not a big concern. My company provides what would be considered as good coverage, at a fairly reasonable cost. Over the years, that coverage cost has evolved, though. Where once the employee had a small premium and a modest co-pay, coverages have changed to require higher premiums and deductibles. Co-pays are gone, now the employee is responsible for a deductible cost. Out of pocket expenses have increased greatly. That brings me to my story about competition, and why it is vital to the community.

Upon a recent diagnosis of a medical condition, the specialist ordered a CAT scan to provide more detail prior to surgery. Since he is affiliated with L & M, he suggested the test be performed there. I called and scheduled the test and later heard back from the billing department informing me of the anticipated cost. I was shocked to hear that after my insurance paid a portion of the cost, my responsibility for the 10 minute test would be over \$1500. That drove me to research what the typical price may be and if the procedure was provided elsewhere in the area. According to a medical cost website, the procedure should average around \$600 to \$800. I called Southeastern Imaging Center in Waterford to ask their price and their response was that they had been bought out by L & M and the cost would be the same as at the hospital, or the Pequot medical center, all of which had become consolidated under L & M. The procedure would be billed at \$2300 before I received the "discounted" rate of \$1520.

Under most current healthcare plans, the patient is responsible for a deductible cost, and out of pocket costs are higher than ever. We cannot afford another merger which would give Yale-New Haven Hospital a monopoly of services along a vast region of the shoreline from Rhode Island to New York. Competition is the key to holding down cost, which is either paid by individuals or shared by groups through higher and higher premiums. Recent studies have shown that high cost rather than excessive healthcare usage is the major driver in rising healthcare costs. More competition not less is needed to put the cost of services in line with market costs; less competition only lines the pockets of the Board of Directors at those mega healthcare institutions.

This is one facet of the story; monopolistic healthcare entities would also be free to move low returning procedures and facilities out of the communities they have served for decades. Let's keep Lawrence and Memorial a true Full Service Community Hospital.

To Whom It May Concern,

I am submitting testimony today to express concerns of the proposed Yale/ L&M take over.

I currently work at this community hospital. I currently use this community hospital. This is why I am writing to you. To help give a voice to the families and patients I serve at L&M Hospital. We do not want to become another Windham Hospital. We want to use our community hospital in our community. When referencing Windham Hospital, what I am referring to is the closing of the ICU/CCU. This was not part of the plan or CON process when originally looked at by Hartford Healthcare. Somehow they were able to close these 2 units without another CON process. This leaves those families stuck vulnerable. If their loved one needs increased care many can't travel to Hartford.

As a nurse, I have cared for many patients that start out on a regular, some type of complication, change in status occurs and we transfer them to the ICU/CCU. Depending on the status of the pt. Stay may be short, long or their last. Just imagine you loved one coming to the hospital without an ICU/CCU. First few shifts are uneventful, nightshift comes along. Change in status, your loved one now needs to be life flighted to Yale. You now can't go visit because you usually take the bus to L&M. The change in condition is so great your loved one goes from a full code to comfort measures only. Now your loved one is 50 minutes away from you only to die alone.

What I am asking is for you to have Yale/ L&M have answers. So far we have had community forums and came up with what we want to hold this takeover accountable for.

- 1) Accountability
- 2) Community Access and Well Being
- 3) Affordability
- 4) Workforce

Respectfully Submitted,

Jeanne Wehling

Uncasville Ct

**Testimony Regarding Yale New Haven Hospital Takeover of Lawrence and Memorial Hospital**

**July 26, 2016 Public Hearing**

My concerns regarding Yale New Haven's takeover of L&M is in regards to Yale's indication that the local board will retain control of L+M. I would like to know how that is possible. Doesn't Yale approve all board appointments? If so, can't Yale fire any local board member without cause? Doesn't the CEO work "at the pleasure" of Yale? Doesn't Yale retain the authority to make and/or approve all important decisions?

I would like see an open and true conversation about the future of our community hospital. Yale must give the community concrete, written, legally enforceable commitments.

Sincerely,

JoAnn Merolla-Martin

46 Clifton Place

Norwich, CT 06360

Testimony of Tom Swan, Executive Director of the Connecticut Citizen  
Action Group (CCAG)

On the proposed takeover L & M Hospital by the Yale Health Services  
Corporation

7/26/16

Good evening, my name is Tom Swan and I am the Executive Director of the CT. Citizen Action Group. My testimony today is on behalf of our members, including hundreds living in the L & M service area. CCAG has been working on health care issues for 45 years and has been very active on health care issues, including recent hospital consolidations.

CCAG strongly opposes the proposed takeover and urge you to reject it as Connecticut continues to work to design an adequate regulatory framework for a 21<sup>st</sup> Century health care system. The legislature has taken some positive steps over the past few years, but they are not enough to guarantee that people can get the care they need at a price they can afford.

I want to thank you for giving us the opportunity to address this proposed takeover. It is important for us to look at this in a larger context. Regulators and health care policy analysts are increasingly voicing alarm at the trend towards increased consolidation in health care. Just yesterday, the Guardian published a piece entitled: "Healthcare mega-mergers drive income inequality. They must stop." The piece pointed out that "since the mid-1990s more than 1,200 hospital mergers have resulted in larger hospital systems, which wield their market power to extract excessive prices."

It also referenced a recent report that estimated that in areas with significant hospital concentration, which the resulting corporation from

this proposal would have for virtually all of the Route 95 corridor in CT, hospitals charge prices that are 15 % higher than prices in more competitive markets. If this takeover is approved as proposed, we can expect significantly higher costs due to not just L & M being taken over, but also the increased control by the Yale New Haven Health Services Corporation of physician practices - particularly specialists.

The fact that the applicants have refused to share with you pricing data - that they will need to make available in less than 6 months – should be enough of a reason for you to reject this deal.

On a related note, I would like to point out that the US Department of Justice announced its intention to sue to block two large health insurance mergers on anti-trust grounds just last week. Attorney General Jepsen signed onto the Anthem-Cigna suit due to concerns about consolidation in the Connecticut health care landscape and its impact on cost. These same concerns must be part of any review of this transaction.

In closing, I want to touch on the loss of local control as another reason to reject this takeover. Input should not be confused with control and Yale New Haven Health Services Corporation saying otherwise is dishonest and needs to be rejected. Eastern Connecticut is already suffering the effects of a hospital conglomerate making promises to get a deal approved and then turning around and slashing services as we are witnessing with Windham Hospital. Our future regulatory framework needs to have our hospitals be more accountable to our communities not less.

Thank you for your consideration.

## Testimony for Hospital Merger or Affiliation or Take Over

I'd like to start by thanking everybody involved in this process to help all of us determine what direction the healthcare industry is going. The future of our community health care system is in the balance as this committee weighs the effects on our care and the need for these corporate takeovers to continue to take shape.

The facts aren't as clear for the general public about certain subjects when it involves healthcare choices. We try to understand the information presented by the pros and cons of affiliations and mergers, in our mind, not knowing but relying on others to help guide us. The facts aren't as clear when we see the fighting which takes place over the interests of profitability for Hospitals and Health Care Systems and the well being of Patients and the Services which are being provided.

The public has been lead to believe that our Community Hospital L&M is in good shape when we see the purchase of Westerly Hospital. The interesting part is we have a **NON PROFIT HOSPITAL** but a **For Profit** group running the Corporate, daily practices of Lawrence and Memorial in New London. I have yet to understand how that actually works. Then we see a bitter labor dispute, millions of dollars spent and lost, along with patient confidence deteriorating. The Management of L&M Hospital has driven some Doctor's in our community away to other hospitals along with bulling and strong arming them into a group practice called LMMG in order to survive. The concept of LMMG may be a necessity but were the Doctors even given a chance to be represented as to how they think things should be formulated? The hospital management took a building on Howard Street, renovated it

and told the doctors, "Staff is interchangeable here's your cubicle and your sharing it with a few other Doctors". I find this practice to be a very indignant act. These are people who provide the care and medical attention to our community. Doctors work long hours they are constantly giving and sacrificing themselves to patient care and I doubt any CEO or Corporate Executive would be delighted to sit and dictate reports or consult with clients and other team officers and corporate staff in a cubicle the size of a closet.

I see these quality care givers as our front line warriors. Their staffs are more than likely understaffed, overworked and probably underpaid due to fixed pricing for their services. The constant corporate mentality of work harder with less and our numbers will increase to streamline or services by paying our executives more bonuses and compensation is a normal modern day practice. I need not exam the true nature of miss information or the bitterness I felt when the Hospital three plus years ago refused to negotiate as the term goes "bargaining in good faith" in a contract negotiation with employees of L&M Hospital. What will happen next time with the interchangeable mentality of Corporate Health Care Systems? Will our Caregivers once again be put out in the streets to settle for less and pay in more money for their health benefits themselves? This has been the formula for Corporations all over our country.

I have done some homework as to the ever changing landscape of healthcare with mergers, takeovers or affiliations. The Yale Health Care Industry Symposium which took place this April of 2016 addresses the industry's Consolidation, Integration, and Competition. This is a great area for the public to review. I have read and re-read about the transformation of Hospitals acquiring other Hospitals as well as Doctors

practices. What troubles me more is they are also acquiring Insurance Businesses. They also seem to look at the management of all sectors of healthcare. The mentality of monopolizing all areas of health care services and looking at our health not as individual patients but in a model format is a bit troubling. The statement of fee-for-service and accountable care practice models are driving a market of Insurance mergers. Insurance companies are arguing their own mergers are necessary to counterbalance the excessive and growing **POWER of Hospitals**. The laws that legislators have created are in place to protect us as patients and to keep a free market in order for us to choose what's best for our health. I have seen what deregulation has done and its track record is quite clear. The Power Industry or the Cable and Phone Industry all have created increased wealth with mergers and takeovers and the public pays the price. The fact our choices are reduced and we have fewer options at higher costs seem to be a normal occurrence.

The question here is will consolidation improve patient care? The other question I ask is will the patient care and services be decrease in our Community hospital? The merging of departments and the corporate comfort words of streamlining and reduction of patient care and services are evident in many areas. Profitability with bigger corporate players leads to a lack of diversity in the health care industry. The bigger the corporation, the more layers of problems persist. The front line caregivers are the constant recipient of layoffs and increased health care premium increases. The pools of premiums with more group coverage should bring the rates down but this is not a guarantee. The fact is we see Departments in smaller Community Hospitals either closed or downsized due to profitability and don't think for one second

that all of this data isn't gathered before the takeover is even attempted. The outlook for health care remains hotly contested as stated in the reviews I've read. The statements I seem to read all focus on basic industry survival techniques. We are hearing that health care is in a crisis but the jury is still out. Economists and Industry leaders are at odds over the outcome of these changes Industry leaders see the modern move not only as necessary but beneficial to consumers and industry alike while economist critique consolidation for raising prices while reducing consumer choices and failing to improve outcomes. We also see little information about market changes on the most vulnerable populations, the everyday patient experience or the average physician and the scientific research and development within health care.

The completeness of the transformation of mergers needs to be an all or nothing proposal mostly due to cost and that many providers don't have the stomach or the resources to do what needs to be done. The cultural changes that are required for the Accountable Care approach may not be the kind of change that can happen in small steps or integrating old methods with new. This new model for profitability is here and we're in the middle of the road trying to not get run over on the superhighway of health care as it evolves. The complex issues of profitability in the Hospital Industry are quite perplexing. The Non- Profit to for Profit intermingling of Health Care groups and the laws governing anti-trust and Monopolies are even more confusing for the lay person. The "Horizontal Consolidations" and the "Vertical Integration" mergers across the board only better confuse the issues more than clarify the subjects involved in caring for the patients and families of those who are sick and infirmed. The Health Care Systems

seem to swallow their competition as the total population approach to care marches on. The fact Accountable Care is a difficult thing to measure only reflects on how prudent we should be to advocate such mergers. I would like to share some basic facts about the Industry leader in this merger and some research areas I have reviewed before I wrote my testimony today.

I've read various internet articles coming from "The Yale Health Care Industry Symposium, Chris Cheney Health Leaders media article, the Beckers Hospital Review, the Hartford Business Journal, the Yale New Haven Health Facts and Figures, along with the Yale New Haven Health Service Corporation Financials for the filing with the State of Connecticut.

1. \$3.4 billion dollar Health Care System
2. \$4.2 billion in assets
3. 27.1% of market share in the State now
4. 31.4 % with L&M and Milford mergers
5. 1.6 million people or 46% of state population is in YNHHS region
6. 150 million in spending cuts last year
7. CEO of Yale New Haven Health System (YNHHS) compensation and fringe benefits \$3,520,872 dollars

*9.16 with Law*

These are a few of the items that make me wonder if bigger is better. I have only one real concern and that is will we be cared for with dignity and respect or will the Money and Profits run this new model of Health Care. We have an obligation to each other to speak up and question this type of Affiliation or Merger or Takeover. This will affect our families and the future of our Doctors and Staff in each institution

that provides PROFIT CARE for People IN NON-PROFIT COMMUNITY HOSPITALS

Thank you for your time in addressing these critical matters which face our community

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Shawn Powers", is written over a solid horizontal line.

Shawn Powers

## Testimony

Submitted by State Representative Ernest Hewett, District 39, New London  
July 26, 2016

Good afternoon Attorney Hansted:

My name is Ernest Hewett, State Representative for District 39, representing the City of New London. As you can imagine, I have been keenly interested and concerned about the impact of this acquisition on the individuals and families that live and work in this city. Several months ago, I expressed my support for the Yale/L+M affiliation, based upon the facts and information at the time. Most importantly, I was concerned about the negative impacts this merger might have had on working families, and those employed at L+M Hospital. I agreed to support the proposed deal when I received assurances from the union and the hospital that job protections would be in place and secure.

Since that time, I have received new information that raises significant concerns about the benefits of this acquisition to the community, specifically related to local control, cost & price and sustained access of health care services to our community.

### Local Control:

In initial statements by Yale New Haven and L+M management, we were assured that a local board of directors will control L+M. I have recently learned that, in fact, according to the proposed by-laws for L+M Health Corporation, Yale New Haven is designated as the "sole corporate member" of L+M Health. In other words, Yale New Haven will have total control over membership, and will ultimately have control over the decisions made about our community hospital.

It is essential we have an honest, upfront conversation about what this acquisition means for our community. This newly revealed information about the power and authority held by Yale over our community hospital undermines our trust in the key players within this proposed deal, and calls into question Yale New Haven and L+M's commitment to transparency and authentic dialogue with this community.

### Cost & Pricing:

According to a report released at the beginning of this year, if this acquisition is approved Yale will control 60% market share from NY to RI, and more than 80% in L+M's primary service area. Consolidation in such markets can lead to price increases of 20% or more. This would be a significant blow to our community, and would further exacerbate challenges to accessing affordable health care services.

I understand that OCHA has asked Yale New Haven Hospital to provide data on how previous Yale New Haven mergers impacted prices in the case of Bridgeport, Greenwich and St. Raphael's acquisitions, helping us to potentially dispel some of these concerns. To date, Yale has not provided this data. It does not make sense for OCHA to move forward with this acquisition without this crucial data.

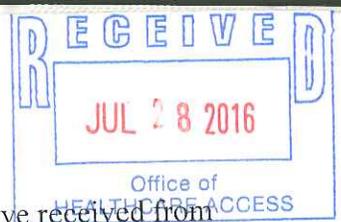
### Access to local services:

My colleagues who represent constituents in the Windham area recently briefed me on the changes made to critical health care services at Windham hospital. Several years ago, Hartford Hospital promised improvements and no cuts to services within that community. These promises were not kept

and Windham Hospital closed its critical care unit, necessitating patients to drive and fly on helicopters to get normal hospital care. What assurances do we have that this will not be our fate as well?

L+M Hospital is a vital and crucial institution within the community, and its continued service to the individuals and families residing throughout the New London area must remain secure. In order for me to have confidence in supporting this proposal, these issues must be addressed.

I strongly urge OHCA to require Yale New Haven Hospital and L+M Hospital to enter into a signed, legally enforceable community benefits agreement negotiated with a broad cross-section of our community before we move forward with allowing any kind of change in our community hospital.



On July 11, 2016 I gave a brief oral testimony regarding the excellent care I have received from the L&M medical system based out of New London, CT in both Connecticut and Rhode Island. To say that I would take all day to describe in detail this quality, in stark contrast to the deplorable medical care I received from other medical agencies, particularly in Rhode Island, was understandable, and after talking with the board am fulfilling their request to put this detail in writing to be better understood.

I was born in Vermont and grew up in Connecticut, Rhode Island, New York, and Vermont and have additionally lived in Massachusetts, with my immediate family having owned residential property in Greenwich, CT, Yonkers and Westchester county NY, and Shelter Harbor and Bradford, RI. My paternal grandfather and namesake ran two medical facilities in Yonkers and Mount Vernon, NY from the 1940's until his death of tuberculosis on January 4, 1968. I attended Waterford High School from 1993-6, after being expelled from Chariho school system in Rhode Island in 1992 and meeting further problems at Harmony Hill and Briggs in the same state 1992, and I am familiar with the excellent reputation CT has in terms of quality of life, as that change of placement, and subsequent sojourns in New London county CT, have helped me greatly in times of crisis.

It was on August 3, 2013 that I first experienced the excellent quality of the L&M medical system. I had been released from prison in Rhode Island after serving a 7 2/3 month sentence, including 5 months in solitary confinement where I had lost 1/4 of my body mass. On that particular morning I was found around 3:30 AM passed out at the MGM Grand at Foxwoods. Three hours later I took the seat bus to exit 92 and began walking south down Rt 2 in Stonington. After a half hour of walking slowly then pain I was experiencing was so intense as soon as I arrived at the Henny Penny I asked the clerk to call 911. Paramedics and the Stonington PD arrived, and being shocked at my physical state, transported me to L&M's hospital in Westerly. I was greeted in the emergency room by Dr. Fred Jaccarino, who was familiar with my walks around NL county and my beach workouts. He remained calm, examined me, and noticed that I was experiencing severe dehydration and severe constipation as a result of prison neglect, and for the first time in my life I was put on IV fluids for four hours. Even though I have a long list of allergies to prescription, as well as illicit, drugs, much of that info had been misplaced as the last time I had experienced that type of medical problems was as a juvenile, and my records were under my adopted name, however Dr. Jaccarino prescribed miralax to help with my constipation, and to address any potential effects requested the contact info of Doctors I was already seeing in RI and MA should something occur. Once I was well enough to walk unassisted the staff at L&M Westerly helped me get to the Westerly train station where I boarded a train for Kingston station.

Several weeks later that month, four days after I began using the miralax, I was experiencing a burning pain in my back around my kidneys. I had an appointment with Dr. Richard Robin that day and went to see him. I had seen Dr. Robin first in June 2012 in order to fulfill a court request for a psychiatric evaluation, and on September 28, 2012 Dr. Robin intervened after he noticed I was experiencing complications from a life saving operation performed the previous day in Stoneham, MA to remove an infection from my jaw as the result of a bullet wound from July 21, 2002 which had become seriously infected. It was during that intervention that Dr. Robin made me realize that even though I do not have a major mental illness, I do have situations in my life in which intervention would assist. That afternoon when I experienced that pain and described it to Dr. Robin I found out he was part of the L&M system, the quality of treatment I was receiving from him should have been a tip-off, and he contacted

L&M Westerly and told me to walk to the emergency room there or he would call 911. Once there Dr. Jaccarino noticed I was having an allergic reaction to the miralax, stopped the prescription, and managed to stabilize me.

The quality of treatment in August 2013 made me a L&M patient. Previously I had experienced one incident after another of deplorable medical treatment in Rhode Island. That included Dr. Frank Gencarelle treating the wrong eye as a juvenile until 1995, and as a result I receive a disability check from the government solely for the visual impairment which I have as a result of this mistreatment. This involved a botched operation on my right foot at Westerly hospital in 1991 long before L&M took it over which required specialized treatment by L&M's Dr. Lawrence in 1992 to correct the damage, and doctors at Bradley Hospital prescribing medication without properly obtaining my medical records in October 1992 which required treatment in Washington County VT to correct the damage in 1992-3, and attempts by South Shore Mental Health in 1995-6 to coerce me into treatment that was unnecessary at the urging of a stepdad, and this attempt was stopped by Dr. James Greer, with the assistance of the faculty at Waterford High School, in 1996 one it was noticed that the stepdad and I were involved in a dispute over the substantial estate of my biological grandmother/adoptive mother, and bad experiences with court ordered mental health counselling in 2008-9 and 2011-2 before dealing with Dr. Robin.

I later found out to my disgust that L&M subcontracts with South Shore in Rhode Island on November 6, when Dr. Robin's staff noticed I had been in a confrontation with someone I had issues with in prison, and they did an emergency certification to L&M Westerly. I was released after four hours. L&M Westerly helped prevent any adverse experience. They did this by verifying in August 2013 and keeping on their records my association with Dr. William Beeman, my former dept. head at Brown University. Other mental health agencies claimed my knowing him was a grandiose delusion, however they were able to work with him to verify my statements regarding my history and family, partly as my closest living relatives in America are my relatives from Iran, who were Gilanshahi members of the Imperial Iranian court who have trouble understanding English. By L&M documenting this the staff at South Shore was prevented from calling this delusional. They also noted that the inmate I beat up was a violent individual who would create a conflict until compelled to stop, and L&M Westerly has worked with L&M facilities in CT to help me obtain treatment so I do not have to deal with menacing individuals like that.

I also had L&M assist me when I received malicious treatment from Thundermist and Fellowship Rhode Island in the summer of 2014. In June 2014 when experiencing pain from unknown marks on my ankles I went to Thundermist for treatment. Once they saw the condition of my feet the staff screamed, diagnosed scabies without performing any tests, and wrote a prescription for an overelaborate treatment. The staff at Fellowship Rhode Island, who I had been court ordered to see for mental health counselling by Judge Jabour in Rhode Island as part of probation terms to replace Dr. Robin, who had discharged me and most of his patients in November 2013, repeated what Thundermist said and tried to coerce me into taking this overelaborate treatment. I sought a second opinion from Dr. Kevin Torres at L&M Westerly in July 2014. Within two minutes of examining my feet and legs he determined that it could not be scabies as the marks remained under my knees, and the foot injuries L&M Westerly treated me for in May 2014 were healing, which were inconsistent with scabies. When Thundermist and Fellowship Rhode Island further attempted to coerce me in August 2014 into this unnecessary treatment, including filing charges after I confronted their attempt to coerce this treatment. L&M

worked with me to successfully beat those charges and to disassociate myself from those organizations who would have harmed me by their incompetence.

I received quality care once again from L&M in 2015. In January 2015, after a Cranston detective and doctors matthews and ottowicz at fatima hospital lied to judge hastings, who stated on the record that she would allow hearsay testimony, at a mental health court hearing in rhode island and gave me drugs which continue to cause me serious health problems, the people at L&M worked to get me discharged from that facility. When I experienced severe chest pain and breathing trouble as a result of the drugs given to me at fatima hospital shortly after being discharged there Dr. Keith Hilliker stabilized me and stopped the prescription that was given to me at fatima, particularly as the staff at fatima would not release the names of all drugs given to me there. I did experience problems when L&M attempted to discharge me, as it was 6PM, I can not get a drivers license in RI because of my visual impairment, then last bus leaving Westerly in RI had left, all buses in CT were going to the casinos, I could not get a ride, and the pain I was experiencing was so severe I asked the staff "not to discharge me too soon" upon which they brought someone from south shore mental health who could not understand my request and had me transported to butler hospital. I spent one week there with violent patients who the staff had to keep away from me, making the work Dr. Furman did with me more difficult, however once he noticed I was not seeking conflict he concurred with Dr. Hilliker and released me. Had L&M in rhode island not affiliated itself with a deplorable association I would not have been deprived of my freedom simply because someone could not understand a simple phrase.

I received excellent care from L&M again from May-December 2015 for a foot infection I received in April 2015 while serving 30 days in rhode island prison for beating up the arsonist who destroyed the place I was staying at. When Dr. Torres saw me in the L&M Westerly emergency room on May 3-4 he focused on my stabilizing my heart which was experiencing a serious palpitation, yet noted the condition of my foot. From then until September 2015 the staff at L&M New London, Stonington, and Westerly worked to stabilize my foot, even dealing with the staff at Backus Hospital when I was brought there on labor day weekend after having a bad fall on a greyhound bus, and with Quinnipiac Medical, as the student intern from there who examined me at L&M Westerly helped solve the problems I had finding a podiatrist and in obtaining the prescriptions I needed to treat the foot, the former by tirelessly and creatively working to arrange an appointment for my treatment, the latter by calling up the pharmacy I was to obtain my prescription from, as L&M Westerly has no dispensary, and form me to receive the prescription upon my ID being verified in order to prevent prescription theft/fraud. The podiatrist that student intern referred me to worked successfully with me, and when treatment became disjointed in December 2015 the staff at L&M Stonington worked not only to see that my foot was healed by the end of that month.

The treatment became disjointed after an incident on a bus in rhode island, two days after receiving successful treatment for that foot injury on November 11, 2015 where my foot brace snagged on some punk's backpack, and the bus driver called 911 claiming I tried to assault that punk. As the bus had stopped on the uri campus when this occurred the campus pd pulled me off the bus and beat me while handcuffed, causing me to experience a narcoleptic attack later that night, and when campus pd brought me to south county hospital they continued to beat me while handcuffed to the stretcher. Even though the prison staff noted the marks on me as a result of the beating they did nothing to treat me. Even though the L&M podiatrist was the only physician to respond in a timely manner to the court, it was enough to demonstrate I had a medical condition which effected my actions during that incident and that imprisonment would only make things

worse, securing my release. The day after my release the staff at mario's pizzeria noticed I had trouble eating, and when I went into the nearby cumberland farms to use the bathroom I was on the toilet for over 30 minutes, and when I got up there was blood everywhere, and as that store was crowded I rushed across the street and called 911. I was brought to L&M Westerly where Dr. Wendy Witt and her nurses treated my condition. They were able to restore my digestion, noting I had been dehydrated and as the food I had was with me they examined it and noted it was not the cause of my troubles. When I had to use the bathroom they brought a commode over and had me use it while they watched. Dr. Witt noted the blood in my shit was small, however a contusion from the beating I received at south county hospital while handcuffed was bleeding profusely and had been neglected in prison and they treated that injury stopping the bleeding. When I tried following through with my primary care Dr. stuart he was more worried about the fact I had to walk over a mile in pouring rain to the stop than about the injury. I reported his behavior to L&M Westerly, who referred me to L&M Stonington, who assisted me with follow on treatment and referred me to Dr. Brandon Luk with my first appointment on March 1, 2016. Even though Dr. Luk is new, he has been working with me to obtain all my medical information, the only problem at this time his being overbooked and as a result not being able to get info from all my doctors, and ones I have and continue to have malicious experiences with respond rapidly and inaccurately.

Having described the good quality of treatment I shall now elaborate on the deplorable treatment I mentioned briefly earlier. I shall first describe the bad experience I continue to have with gateway health, as I am currently on probation in rhode island on two charges, one which expires in September, the other expires in December, and I have been court ordered to undergo mental health counseling on the former sentence, which has become a frequent practice in rhode island that people like myself who do not have a major mental illness are asked to undergo this as a preventative measure, yet it only has created more problems for those undergoing the counseling. I had mentioned earlier how L&M had worked with fatima hospital to get me discharged, especially after RI mental health advocate Jackie Burns learned how I was behaving violently as a result of the drugs given to me at fatima, and noting prominently that I had not been violent until given those drugs worked with fatima on psychiatric referrals. The staff at fatima made me an appointment with someone at gateway in Johnston before L&M could respond, and L&M advised me to at least visit them, and if things became bad they would work on finding another referral. Once at gateway the doctors were over insistent on my taking drugs even before I had signed my releases. Once I signed the releases I knew the doctors at gateway were lying, as they claimed that Dr. Robin had prescribed medication for me when in fact he never had, partly because of my physical health issues, and that they obtained my records from the providence center, when in fact I had obtained all my records from there in 2007, nine years after I terminated my services with them. The only reason I remained with gateway was I ended up on probation in April 2015, and part of the terms was court ordered counseling, and the staff at L&M only said to contact them for a referral if problems persisted with gateway, and as they have I brought them to Dr. Luk's attention. Even though he does not have all my medical records yet, he did note that gateway was not working with ALL my doctors and that after spending five days doing an emergency move after walking from Stonington to Richmond on the Sunday before Memorial Day Dr. Luk noted that gateway should have examined me more thoroughly.

I should also note the treatment at fatima I received there prior to my bad experience at gateway had been the most malicious I have yet received as a adult. I noted earlier how a

Cranston detective had lied to do an emergency certification on me, and dr.s veronica matthews and bill ottowicz would not allow me to sign medical releases for essential information. When dr. matthews filed a mental health court petition it occurred around the same time she had to leave fatima hospital. Not only did dr. ottowicz continue her petition he blatantly lied in court, even claiming my being shot in the head in July 2002 was a delusion, despite the fact that the bullet wound on my nose is visible once my prescription glasses are removed, and I had to have the other would operated on by Dr. Hamid Esbah in Stoneham, MA on September 27, 2012 when it became infected, and I am currently working working with Dr. Mohammed Mobasherat of Medford, MA as I require specialized followup care. As it turned out I was not the only patient who experienced maltreatment by dr. ottowicz, as another patient, a paralyzed Vietnam veteran named Craig Sampson who had served with Rob Simmons, had been treated so badly that he and I talked with other patients about notifying our next of kin if we were to die, and I notified Rob of what I and Craig experienced when I saw him again in October 2015. As it turned out the deplorable treatment I, Craig, and others received at fatima led to that hospital being sold, and a check of their website shows that ottowicz and matthews are no longer there, and I already detailed how Dr. Hilliker, then later Dr. Furman agreed that I received unnecessary treatment there. However as a result I have continued to experience violent palpitations, and narcoleptic attacks, and my vision has become worse.

Prior to that I had another involuntary experience at roger williams hospital in providence on May 3, 2014. I had been swarmed by the ppd based on malicious lies they had spread about me, even claiming I was homeless when I was living in Watertown, MA. Once at roger williams dr peter kirk refused to deal with the staff at L&M regarding my records and had me restrained, then drugged. Once on the unit Dr. Findley was able to verify my address in Watertown and prove that the ppd acted on lies, and had me released, however I continued to have adverse effects from those drugs.

Even though the other bad mental health experiences I had mentioned above were brief the bad treatment I received as a juvenile needs mention. In 1991 my stepdad had me see the staff at south shore mental health around the time my biological grandmother/adoptive mother was dying, and the staff there recommended I keep seeing them. In October 1992 when facing assault charges I was placed in bradley hospital, where dr grapentine and dr neeper put me on a thorazine treatment which almost killed me, partly because they neglected to note the behaviors of my stepdad and biological father, the latter having a lengthy criminal history, much of it drug related, in New York, Vermont, Connecticut, and Rhode Island. It was the interventions first of my teachers at Waterford High School in 1993, then when my stepdad placed me in RI DCYF custody the actions of Dr. Alan Mark at the Kent Center and Dr. James Greer at the Providence Center that determined that the problems was due to my being in a hostile environment caused by my stepdad, and that treatment was unnecessary as I suffered from no major mental illness.

Also I received malicious treatment to my eyes as a juvenile from dr. francis gencerella, who from 1993-5 deliberately treated the wrong eye. This mishap was caught by Dr. Harry Pass of Providence, in 1998, and as a result I have been receiving a disability check solely for this visual mishap, and I continue to use Dr. Pass's clinic.

Now I will describe my concerns about Yale-New Haven. In April 2014 I had to get a former classmate of mine under control who was overintoxicated, and part of it involved telling her I would find out what happened to an elementary school High Incentive teacher we had, Joanne Holberton, partly as many had not seen her in almost two decades and many assumed she was still alive. Finding her obituary was a shock. I had known about her heart transplant and her

retiring after her husband died, however the fact that she was maltreated by assisted living/daycare staff, promised excellent treatment at Yale New Haven, and not only did not get it but due to maltreatment at YNH died there on June 20, 2001. It should be noted that Joanne was a direct descendant of Roger Williams and started RRI's first High incentive program for elementary school students, and could not get essential treatment in RI. Just as shocking was the fact she died exactly ten days after my fiancée was murdered by a doctor and she was buried in a location I had passed by thousands of times without realizing she was there, and only located her burial spot because of her husband's WWII service record. When I broke the news to our former classmates they shared my distress.

I have also felt unsafe and insulted while on Yale campus by the behavior of the students and faculty. There the students regularly ride bikes, skateboards, scooters, and other objects into people with clear physical disabilities and nothing is done to stop them. When attending a conference at the Middle East studies dept the staff had to separate me from a professor who made a slanderous remark about one of my ancestors, despite the fact the speaker had studied under my former dept. Head at Brown and noted it during the conversation leading up to that confrontation. If one thinks I am alone in feeling this way consider the fact that few people venture onto Yale campus because they feel unsafe there.

In conclusion, the treatment I have received at L&M has been excellent, partly because whenever something happens they work to fix the issue. This makes them unique in Rhode Island and is one reason for the patient overload there, specifically people fleeing the deplorable treatment in the rest of the state. I was glad to learn that L&M is upgrading its info sharing network to prevent me and other people experiencing medical mishaps. I do express concern that L&M in Rhode Island has subcontracted with South Shore, as many continue to get horrendous treatment there, and would be better sending people to New London for evaluations, as the staff there are more professional. Were L&M to merge with Yale New Haven that would give YNH a presence in a community bitter at their maltreatment of a beloved teacher. Even though L&M would get immediate cash relief from YNH, it would not address the underlying issues and cause long term damage.

Peter Zendran II  
780 Reservoir Ave # 181  
Cranston, RI 02910

**PUBLIC HEARING**  
**APPLICANT** *General Public*  
**SIGN UP SHEET**  
July 11, 2016  
3:00 p.m.

Docket Number: 15-32032-CON  
Northeast Medical Group, Inc. L&M Physician Association, Inc.  
Acquisition of L&M Physician Association, Inc. by Northeast Medical Group

PRINT NAME	Phone	Fax	Representing Organization
✓ John Brady	860-908-9711		AFT Connecticut
✓ MARK KOSNOFF for Ocean Pellett	203-494-8426		UNITED ACTION CT.
✓ NANCY GRANT	860 625 7638		—
✓ JANET K. ANDERSON	860-789-9805		
✓ Stephanie R. Clarke	860.984.7155		

Duplicate ✓  
✓  
✓

Northeast Medical Group, Inc. L&M Physician Association, Inc.

PRINT NAME	Phone	Fax	Representing Organization
✓ Debbie Wysocki	860 705 8787	860 537-1322	AFT 5049
✓ MaryEllen Masciale	860 271 9974		AFT 5051
Not speaking ✓ <del>Kristen Bowers</del> * written testimony	860-912-3138		AFT 5051
✓ Sharon Palmer	860-447-0662		

Northeast Medical Group, Inc. L&M Physician Association, Inc.

PRINT NAME	Representing Organization
✓ Nancy Nakas 860 912 0231	Local 217
→ Tony Rescigno 203-510-7801	New Haven Chamber
✓ Curtis Hill 203-410-3679	Concepts for Adaptive Learning
✓ Ginny Kozlowski 203 785 1000	Economic Development Corp of New Haven,
→ Rachel Pond	AFT 5049
→ Sharon Palmer	AFT/ resident DOL comm.

Northeast Medical Group, Inc. L&M Physician Association, Inc.

PRINT NAME	Representing Organization
✓ SHAWN POWERS 298 LESTERBURN Rd Groton, CT 06340	Community SELF
✓ Peter Zander 441-7387	patient L&M

Northeast Medical Group, Inc. L&M Physician Association, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Sara Lesson Bohanoff	866-991-7103		/
JOEY SHERIDAN	860 701 9113		Chamber of Commerce Ect.
Cherie Poirier	860 208 6502		Eastern CT AHEC
Thomas A. Meme, Jr	860 465 6834	—	myself
DAN FLANAGAN	203 915-1332		TEAMSTERS UNION
DAN BRANNEGAN	858 337 8673		self
Tucker Leary	203 676 4748		self, local resident
John Cellegi	401 831 3647		untd Nurses & Allied professionals
Q. Llewellyn Poff	860 287-2167		self
CHRIS SOTO	860-501-4800		39th District - NL

(DUPLICATE)

Northeast Medical Group, Inc. L&M Physician Association, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Jean Jordan	860 439-1423		NL NAACP
ROBIN LOOD STAUFFER			TAB AND NLC
Peter Cooper	(914)907-7834		N/A
DEVINIS LONG MD	860 912 9140		Self
Ryan Henowitz	860-705-0891		Democratic Candidate for State Senate
Mitchell Ross	860-437-7994		L+M Techs / AFT-CT 5051
HARRY RODRIGUEZ	860-772-2383		L+M HEALTHCARE WORKERS
Barbara Sadowski	860 544-8145		L+M RN
Dale Cunningham	860-857-0943		L+M RN AFT Local 5049
LISA D'AMORSCA	860-389-6620		AFT LOCAL 5049

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~~Elected Officials / Agency Reps~~ pg. 1

**PUBLIC HEARING**  
**GENERAL PUBLIC OFFICIALS**  
**SIGN UP SHEET**

July 11, 2016  
 3:00 p.m.

Docket Number: 15-32032-CON  
 Northeast Medical Group, Inc. L&M Physician Association, Inc.  
 Acquisition of L&M Physician Association, Inc. by Northeast Medical Group

PRINT NAME	Representing Organization
* Thomas Royce	City of New Haven, Mayor's Office
* Bruce Fox	Town of Groton Mayor
→ STEPHEN GREENE	WESTDALE HOSPITAL
→ JAMES MITCHELL	L+M Hospital BOARD
↳ Lisa KONICKI	ocean Community Chamber of Commerce

NOT SURE HOW THESE  
 3 ARE ELECTED OFFICIALS

\* ↳ state rep. kathleen MCCARTHY  
 \* ↳ Brett Mahoney  
 \* ↳ Dr Brian Camb  
 \* ↳ Senator Art Linares

connecticut General Assembly  
 Watford Chief of Police  
 state senator

**PUBLIC HEARING  
PUBLIC OFFICIAL  
SIGN UP SHEET**

July 11, 2016  
3:00 p.m.

Docket Number: 15-32032-CON  
Northeast Medical Group, Inc. L&M Physician Association, Inc.  
Acquisition of L&M Physician Association, Inc. by Northeast Medical Group

	PRINT NAME	Phone	Fax	Representing Organization
*	ERICA Richardson	860-910-8207		New London City Council President
*	Michael Passero	860-447-5201		Mayor, New London
	Martha Marks			city council

# PUBLIC COMMENT

<u>NAME</u>	<u>ORGANIZATION</u>	<u>EMAIL</u>
✓ Erica Richardson	New London City Council	ericarichardson37@gmail.com
✓ John V. Callaci	United Nurses Creator	JCallaci@UNAP.org
✓ JERARD BARBER	New Haven Clergy Association	jeroldbarber@comcast.net
✓ Bill Kilpatrick	New Haven NAACP	WKilpata@981.com
✓ Karen DelVecchio	BRBC	
✓ ROBERT TOBIN	TCORU	RD TOBIN@TCORU.COM
✓ VIANCY STANT	MOM	NP6325@gmail.com

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Raul Pino, M.D., M.P.H.  
Commissioner

Office of Health Care Access

July 15, 2016

The Honorable Paul Formica  
Senator – 20<sup>th</sup> District  
State of Connecticut  
Legislative Office Bldg., Suite 3400  
300 Capitol Ave.  
Hartford, CT 06106-1591

Re: Certificate of Need Docket Numbers: 15-32033-CON and 15-32032-CON  
Yale New Haven Health Services Corporation and L+M Corporation, Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation. Northeast Medical Group, Inc. L&M Physician Association, Inc. acquisition of L&M Physician Association, Inc. by Northeast Medical Group

Dear Senator Formica:

On July 8, 2016, the Department of Public Health (“DPH”) received your letter concerning the Certificate of Need (“CON”) for the aforementioned dockets.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application dockets. Please be advised, once a decision has been rendered it will be posted and available on OHCA’s website at [http:// www.ct.gov/dph/ohca](http://www.ct.gov/dph/ohca). Meanwhile, OHCA’s website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

A handwritten signature in cursive script that reads "Janet M. Brancifort".

Janet M. Brancifort, MPH, RRT  
Deputy Commissioner



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.  
Commissioner



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

July 15, 2016

The Honorable Martin M. Looney  
President Pro Tempore – 11<sup>th</sup> District  
State of Connecticut  
State Capitol  
Hartford, CT 06512

Re: Certificate of Need Docket Numbers: 15-32033-CON and 15-32032-CON  
Yale New Haven Health Services Corporation and L+M Corporation, Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation. Northeast Medical Group, Inc. L&M Physician Association, Inc. acquisition of L&M Physician Association, Inc. by Northeast Medical Group

Dear Senator Looney:

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If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

A handwritten signature in cursive script that reads "Janet M. Brancifort".

Janet M. Brancifort, MPH, RRT  
Deputy Commissioner



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ORIGINAL

1

STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS



YALE-NEW HAVEN HEALTH SERVICES CORPORATION  
L & M CORPORATION

ACQUISITION OF LAWRENCE & MEMORIAL CORPORATION  
BY YALE-NEW HAVEN HEALTH SERVICES CORPORATION

DOCKET NO. 15-32033-CON

AND

NORTHEAST MEDICAL GROUP, INC.  
L & M PHYSICIAN ASSOCIATION, INC.

ACQUISITION OF L & M PHYSICIAN  
ASSOCIATION, INC. BY  
NORTHEAST MEDICAL GROUP

DOCKET NO. 15-32032-CON

JULY 11, 2016

3:15 P.M.

HOLIDAY INN  
35 GOVERNOR WINTHROP BOULEVARD  
NEW LONDON, CONNECTICUT

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

HEARING RE: YALE-NEW HAVEN & NORTHEAST MEDICAL GROUP  
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1 . . .Verbatim proceedings of a hearing  
2 before the State of Connecticut, Department of Public  
3 Health, Office of Health Care Access, in the matter of  
4 Yale-New Haven Health Services Corporation, L & M  
5 Corporation, Acquisition of Lawrence & Memorial  
6 Corporation by Yale-New Haven Health Services Corporation  
7 and Northeast Medical Group, Inc., L & M Physician  
8 Association, Inc., Acquisition of L & M Physician  
9 Association, Inc. by Northeast Medical Group, held at the  
10 Holiday Inn, 35 Governor Winthrop Boulevard, New London,  
11 Connecticut, on July 11, 2016 at 3:15 p.m. . . .

12  
13  
14

15 HEARING OFFICER KEVIN HANSTED: Good  
16 afternoon, everyone. Can everyone hear me? Is this  
17 working? In the back, can you hear me okay? Good.

18 This public hearing before the Office of  
19 Health Care Access, identified by Docket Nos. 15-32032-  
20 CON and 15-32033-CON, is being held on July 11, 2016 to  
21 consider two applications.

22 One is for Northeast Medical Group, Inc./L  
23 & M Physician Association, Inc., the acquisition of L & M  
24 Physician Association, Inc. by Northeast Medical Group,

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1 and the second application is Yale-New Haven Health  
2 Services Corporation/L & M Corporation for the  
3 acquisition of Lawrence & Memorial Corporation by Yale-  
4 New Haven Health Services Corporation.

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

10 My name is Kevin Hansted, and I have been  
11 designated as the Hearing Officer for both of these  
12 matters.

13 The staff members assigned to this case  
14 are Kaila Riggott, Steven Lazarus and Brian Carney to my  
15 right. The hearing is being recorded by Post Reporting  
16 Services.

17 In making its decision, OHCA 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 Yale-New Haven Health Services Corporation  
22 and Northeast Medical Group have been designated as  
23 parties in this proceeding.

24 In addition, the Intervenors in this

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1 matter, in both of these matters, with full rights are  
2 AFT Connecticut, Connecticut Citizen Action Group, Unite  
3 Here Connecticut, National Physicians Alliance in  
4 Connecticut, Connecticut Health Policy Project, United  
5 Action Connecticut and New England Health Care Employees,  
6 District 1199, SEIU, and, again, they've all been  
7 designated as Intervenors with full rights.

8 At this time, I will ask staff to read  
9 into the record those documents already appearing in  
10 OHCA's two Table of the Records.

11 All documents have been identified in the  
12 Tables for reference purposes. Mr. Lazarus?

13 MR. STEVEN LAZARUS: Good afternoon.  
14 Steven Lazarus. For the record, we're going to enter  
15 Exhibits A through U for Docket No. 15-32032-CON and  
16 Exhibits A through CC for Docket No. 15-32033-CON.

17 HEARING OFFICER HANSTED: Counsel, would  
18 you identify yourselves for the record, and let me know  
19 if you have any objections to either table?

20 MS. JOAN FELDMAN: Joan Feldman on behalf  
21 of the Applicants. I have no objections.

22 HEARING OFFICER HANSTED: Thank you,  
23 counsel.

24 MR. HENRY MURRAY: Henry Murray for the

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1 Intervenor, and I have no objection.

2 HEARING OFFICER HANSTED: Thank you,  
3 counsel.

4 MR. MURRAY: Mr. Hansted?

5 HEARING OFFICER HANSTED: Yes?

6 MR. MURRAY: May I be heard for one  
7 minute?

8 HEARING OFFICER HANSTED: Yes.

9 MR. MURRAY: We filed this morning with  
10 your office a pre-filed testimony, which was  
11 inadvertently left out of our filing, and we would ask  
12 that it be included in the record or as an after-filing  
13 document.

14 HEARING OFFICER HANSTED: No, we will  
15 include that in the record. Mr. Lazarus, was that one of  
16 the ones you included?

17 MR. LAZARUS: No, it will be included.

18 MS. FELDMAN: Attorney Hansted, I would  
19 like to make an objection. I received that pre-filed  
20 testimony at 10:15 this morning, 11 days after it was  
21 supposed to be filed, and I believe it's irrelevant, in  
22 that, at the end of the pre-filed testimony, it was  
23 stated it was for the purpose of the Governor's Health  
24 Care Cabinet, so I don't really believe it's relevant to

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1 this proceeding, and it doesn't comply with OHCA's rules.

2 HEARING OFFICER HANSTED: Okay, counsel,  
3 I'll give it the weight it's due, therefore, your  
4 objection is overruled, so we'll add it to the record.

5 MS. FELDMAN: Thank you.

6 HEARING OFFICER HANSTED: You're welcome.  
7 And, this evening, we're doing things a little bit  
8 different. We are going to, given the large amount of  
9 public in the room, we are going to allow public comment  
10 first.

11 We'll defer to any elected officials that  
12 may be present. We'll let them speak first, and then  
13 we'll go to the public comment sign-up sheets.

14 For those of you, who wish to speak,  
15 please make sure that you've signed up on the sign-up  
16 sheets that are outside of the room, because we will be  
17 calling individuals up to speak in the order that you've  
18 signed up.

19 After that, we will first hear the  
20 Applicant's presentation under Docket No. 15-32033-CON,  
21 followed by the Intervenor's presentation on that same  
22 docket number.

23 Then, when those presentations are done,  
24 I'll allow Cross-Examination by both parties. When that

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1 is completed, we will hear from the Applicants on Docket  
2 No. 15-32032-CON, followed by the Intervenors'  
3 presentation on that docket number and Cross-Examination  
4 to follow.

5 Upon completion of both of those docket  
6 numbers, OHCA will have its questions. And, again, once  
7 OHCA is completed with its questions, I'll allow another  
8 public comment period.

9 Those folks that are giving comment in the  
10 beginning of this hearing may not do so at the end of the  
11 hearing.

12 At this time, I would ask any individuals,  
13 who are going to testify here today, not including public  
14 commenters, to please stand, raise your right hand, and  
15 be sworn in by the court reporter.

16 (Whereupon, the parties were duly sworn  
17 in.)

18 HEARING OFFICER HANSTED: Okay. Would all  
19 those folks that were just sworn in please, one-by-one,  
20 identify yourselves for the record?

21 MR. MURRAY: How would you like us to  
22 start, Mr. Hansted? On this end?

23 HEARING OFFICER HANSTED: However you  
24 wish. I'd like the Applicants to go first, though,

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1 please, Attorney Murray.

2 MR. BRUCE CUMMINGS: Bruce Cummings, the  
3 CEO from Lawrence & Memorial Healthcare.

4 MS. MARNA BORGSTROM: Marna Borgstrom,  
5 CEO, Yale-New Haven Health System.

6 DR. TOM BALCEZAK: Tom Balcezak, Chief  
7 Medical Officer, Yale-New Haven Hospital.

8 DR. MONICA NOETHER: Monica Noether,  
9 Economist with Charles River Associates.

10 MR. JOE CRESPO: Joe Crespo, Chairman of  
11 the Board of Yale-New Haven Health System.

12 DR. ROSS SANFILIPPO: Ross Sanfilippo,  
13 Lawrence & Memorial Healthcare Board.

14 HEARING OFFICER HANSTED: Do we have any  
15 other folks on this side? I know there were some that  
16 stood up. Just feel free to come up to the microphone  
17 and just identify yourselves.

18 MS. FELDMAN: For this application?

19 HEARING OFFICER HANSTED: Yes, for both of  
20 them.

21 MS. FELDMAN: Oh, for both.

22 HEARING OFFICER HANSTED: Do it all at  
23 once.

24 MR. CHRIS LEHRACH: Chris Lehrach,

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1 President of the Lawrence & Memorial Medical Group.

2 DR. PRATHIBHA VARKEY: Prathibha Varkey,  
3 CEO, Northeast Medical Group.

4 DR. ARNOLD DoROSARIO: Arnold DoRosario,  
5 Chief Medical Officer, NEMG.

6 MR. KEITH TANDLER: Keith Tandler,  
7 Executive Director Finance, Yale-New Haven Health System.

8 MR. SETH VAN ESSENDELFT: Seth Van  
9 Essendelft. I'm the Chief Financial Officer for L & M.

10 MR. VINCENT TAMMARO: Vincent Tammaro,  
11 Chief Financial Officer for Yale-New Haven Health System.

12 MS. GAYLE CAPOZZALO: Gayle Capozzalo,  
13 Chief Strategy Officer, Yale-New Haven Health System.

14 MR. WILLIAM ASELTINE: William Aseltyne,  
15 general counsel, Yale-New Haven Health System.

16 MS. NANCY LEVITT-ROSENTHAL: Nancy Levitt-  
17 Rosenthal, Vice President, Yale-New Haven Health System.

18 DR. ALLEN HSIAO: Allen Hsiao, Chief  
19 Medical Information Officer, Yale-New Haven Health  
20 System.

21 MR. BRETT PERRONE: Brett Perrone,  
22 Director of Financial Planning, Yale-New Haven Health  
23 System.

24 MR. KEVIN MYATT: Kevin Myatt, Chief Human

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1 Resource Officer, Yale-New Haven Health System.

2 MS. TINA DiCIOCCHIO: Tina DiCioccio, L & M  
3 Hospital Corporate Controller.

4 MR. JIM PULLA: Jim Pulla, Deloitte  
5 Transactions and Business Analytics.

6 MS. DONNA EPPS: Donna Epps, Vice  
7 President, Human Resources, Lawrence & Memorial Hospital.

8 MR. MATTHEW TASSONI: Matthew Tassoni,  
9 Deloitte Transactions and Business Analytics.

10 MS. SHRADDHA PATEL: Shraddha Patel,  
11 Director of Planning, L & M Healthcare.

12 MS. AMY RICHARDS: Amy Richards, Director  
13 of Planning, Yale-New Haven Health System.

14 MS. TARA ESTABROOKS: Tara Estabrooks,  
15 Associate Director of Business Development for Yale-New  
16 Haven Health System.

17 MS. AMANDA SKINNER: Amanda Skinner,  
18 Executive Director of Clinical Integration and Population  
19 Health, Yale-New Haven Health System.

20 DR. DANIEL RISSI: Daniel Rissi, Chief  
21 Medical Officer, L & M Hospital.

22 MS. AUGUSTA MUELLER: Augusta Mueller,  
23 Community Benefits Manager for Yale-New Haven Health.

24 MS. LYN SALSGIVER: Lyn Salsgiver, Vice

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1 President for Strategic Planning and Community Health  
2 Improvement for Yale-New Haven Health System.

3 MR. ART LINARES: Art Linares, State  
4 Senator for the 33rd District.

5 MS. KATHLEEN McCARTY: Kathleen McCarty,  
6 State Representative for the 38th District.

7 MR. ABE LOPMAN: Abe Lopman, Executive  
8 Director of Smilow Cancer Hospital.

9 MR. STEPHEN GREENE: Stephen Greene, Board  
10 Chair, Westerly Hospital.

11 MS. LISA KONICKI: Lisa Konicki,  
12 President, Ocean Community Chamber of Commerce.

13 MR. JAMES MITCHELL: James Mitchell, L & M  
14 Board Member.

15 MS. JANE LASSEN BOBRUFF: Jane Lassen  
16 Bobruff, community member.

17 MR. TONY SHERIDAN: Tony Sheridan,  
18 President of the Chamber of Commerce of Eastern  
19 Connecticut.

20 MR. JACK CALLACI: Jack Callaci, United  
21 Nurses and Allied Professionals.

22 HEARING OFFICER HANSTED: Okay, I think we  
23 have everyone on this side. Attorney Murray, do you want  
24 to do the same for your side?

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1                   Again, the folks that are here for public  
2 comment, please do not identify yourself at this time.

3                   DR. FRED HYDE: Fred Hyde for the American  
4 Federation of Teachers.

5                   MS. STEPHANIE JOHNSON: Stephanie Johnson,  
6 President of the LPN Techs for AFT Connecticut  
7 representing L & M Hospital employees and a sleep tech.

8                   MS. ELLEN ANDREWS: Ellen Andrews for  
9 Connecticut Health Policy Project.

10                   MS. MARITZA BOND: Maritza Bond, Executive  
11 Director for Eastern Area Health Education Center.

12                   MR. JASON PELLETIER: Hi. I'm Jason  
13 Pelletier. I am a shop steward for Local 217 Unite Here.

14                   HEARING OFFICER HANSTED: Do you have  
15 anyone else, Attorney Murray?

16                   MR. MURRAY: Not on our list of witnesses,  
17 Attorney Hansted.

18                   HEARING OFFICER HANSTED: Okay, thank you.  
19 At this point, we're going to go to -- actually, before  
20 we get to the public comment section, Attorney Feldman,  
21 did you want an opportunity -- I'm happy to give you an  
22 opportunity to respond in writing to the pre-filed  
23 testimony that was filed today with my office. Did you  
24 want that opportunity?

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1 MS. FELDMAN: No, thank you.

2 HEARING OFFICER HANSTED: Okay and, so, we  
3 will go to the public comment section at this point, and  
4 we'll start with the elected officials. I believe we  
5 have a list up here.

6 And for those of you, who do not hear your  
7 name called, just let us know once we get through the  
8 sign-up sheet, and we can take you at that time.

9 MR. TOMAS REYES: Good afternoon. My name  
10 is Tomas Reyes, and I'm representing Mayor Toni Harp from  
11 New Haven. I serve as her Chief of Staff, and I'm going  
12 to read a prepared statement, which I will then leave  
13 with you.

14 I'm here on behalf of Mayor Toni Harp of  
15 the City of New Haven to lend our strong support to the  
16 proposed affiliation of Lawrence & Memorial Health with  
17 the Yale-New Haven Health System.

18 As a city dedicated to building better  
19 lives, we understand the value of developing and  
20 sustaining strong working relationships with our  
21 employers.

22 Over the years, we have cultivated a  
23 healthy and productive working relationship with Yale-New  
24 Haven Hospital and its more than 12,000 employees.

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1                   We view this relationship as mutually  
2                   beneficial, acknowledging that a strong educational and  
3                   medical foundation has contributed to a stable economic  
4                   environment and has made New Haven a success story.

5                   For its part, Yale-New Haven has stepped  
6                   up as a strong and consistent partner with the city and  
7                   the community. It has been a longstanding supporter of  
8                   important community-driven programs, such as New Haven  
9                   Promise, ConnCAT and New Haven Works.

10                  Each of these initiatives provides  
11                  opportunity for residents of New Haven through access to  
12                  education and jobs for the future.

13                  Additionally, Yale-New Haven has been an  
14                  advocate for the City of New Haven. It has sponsored  
15                  important programs that project the positive image of the  
16                  city to broader audiences, including their role as a  
17                  major sponsor of the Connecticut Open Tennis Tournament  
18                  and a founding partner of Market New Haven.

19                  Yale-New Haven has been a member of our  
20                  community for nearly 200 years. It has grown with New  
21                  Haven and provided us with national recognition and local  
22                  access to exceptional health care.

23                  It has been a catalyst for new development  
24                  and investment, such as the decision by Alexion to locate

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1 their corporate headquarters in our city. We firmly  
2 believe that a strong Yale-New Haven makes the City of  
3 New Haven, itself, stronger.

4 Finally, we recognize that the current  
5 environment has provided enormous challenges for health  
6 care providers, like Yale-New Haven and Lawrence &  
7 Memorial.

8 Uncertainty and complexity define the  
9 future, and that is why affiliations, such as the one you  
10 are considering today, are so important.

11 We are proud of our partnership, and we  
12 are here today to support this affiliation. We ask the  
13 Office of Health Care Access to approve this application,  
14 and we urge you to do so in a timely manner. Thank you.

15 HEARING OFFICER HANSTED: Thank you.

16 MS. KAILA RIGGOTT: Bruce Flax.

17 MR. BRUCE FLAX: Thank you. Good  
18 afternoon, members of the panel. My name is Bruce Flax.  
19 I am the Mayor of the Town of Groton, the single largest  
20 municipality in eastern Connecticut.

21 To say that ours is a diverse community  
22 would be an understatement. We are proudly the Submarine  
23 Capitol of the world, hosting a U.S. Navy Submarine Base,  
24 the USS Nautilus Museum and the world's leading

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1 manufacturer of nuclear submarines and the region's  
2 largest employer, the Electric Boat Division of General  
3 Dynamics, but there's much more.

4 The City of Groton is located within the  
5 Town of Groton. So is the borough of Groton Long Point  
6 and the well-to-do villages of Noank and Mystic.

7 The City has its own utility company and a  
8 large division of Pfizer, the world's largest  
9 pharmaceutical company, is also located here.

10 Different parts of our community are as  
11 different as the busy mall line commercial strip in the  
12 middle of our town is from the quaint little shops in  
13 historic Downtown Mystic.

14 There are million-dollar homes along the  
15 waterfront, and there is subsidized housing. We are a  
16 community of marinas and a long-anticipated new water  
17 taxi.

18 We have education at every level, from our  
19 seven elementary and magnet schools to a technical  
20 school, Fitch High School, home of the undefeated, number  
21 one ranked Falcon's girls' softball team, to the Avery  
22 Point branch of the University of Connecticut.

23 I could spend a lot of time going on about  
24 so many of the other interesting and different qualities

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1 of our community, but I'll stop there to talk a little  
2 bit about what the vast majority of us, young and old,  
3 middle age, black, white, Asian and Latino, wealthy and  
4 those struggling to make ends meet, organized labor and  
5 management at major industry and small business, have in  
6 common.

7 We receive our health care at Lawrence &  
8 Memorial. Whether it's L & M's Pequot Health Center just  
9 off Interstate 95 here in Groton, one of L & M's primary  
10 care practices also located in Groton, the main L & M  
11 Hospital campus across the Thames River in New London,  
12 where four of my children were born, Westerly Hospital  
13 just across the border in Rhode Island, or from the  
14 Visiting Nurses Association based in nearby Waterford,  
15 most of our town's approximately 40,000 residents rely on  
16 L & M for their care.

17 So, as the Mayor of this town, I get  
18 concerned when I learn that our region's leading health  
19 care provider and one of its leading employers is  
20 experiencing financial difficulty.

21 As a town suffering through millions in  
22 State funding cuts ourselves, we know the challenges  
23 associated with this kind of urgent distress, especially  
24 when it's something over which we have little or no

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1 control.

2 We know that, in L & M's case, this  
3 downward financial trend cannot continue, especially if  
4 those, who have relied on L & M for health care for many  
5 years, expect to find the same level of programs,  
6 services and staffing available to them, as have been  
7 available for generations.

8 L & M and Yale-New Haven are already  
9 affiliated in six different clinical areas; cardiac,  
10 cancer, stroke, pediatrics, pediatric emergency and  
11 neonatal care.

12 Some of their physicians practice here,  
13 and some of L & M's practice there. A full affiliation  
14 would make great sense from every perspective; access to  
15 and range of clinical offerings, financial stability,  
16 logistical and strategic.

17 I hope you will concur that this  
18 affiliation between two quality health care systems is in  
19 the best interests of their employees and the patients  
20 they treat from their respective service areas. Thank  
21 you.

22 HEARING OFFICER HANSTED: Thank you.

23 (Whereupon, the public spoke.)

24 HEARING OFFICER HANSTED: At this point,

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1 we have an individual, who needs to testify on behalf of  
2 the Applicants and needs to leave, so I'm going to allow  
3 that. Attorney Feldman, if you want to give your opening  
4 statement on the applications and then present your  
5 witness?

6 MS. FELDMAN: Thank you, Attorney Hansted.

7 HEARING OFFICER HANSTED: You're welcome.

8 MS. FELDMAN: As OHCA is well aware,  
9 during February, Governor Malloy issued Executive Order  
10 No. 51, which directed OHCA to either delay a decision on  
11 this application or to make three adverse findings with  
12 respect to this application.

13 The Applicants believe that the Executive  
14 Order 51 is void and unenforceable, as it relates to this  
15 application, and we strongly believe that the application  
16 should be considered and judged against the proper  
17 legislatively-prescribed criteria, along with the  
18 testimony that you will hear today.

19 We've heard now almost four hours of oral  
20 testimony, and what is very clear is that much of the  
21 public testimony and the position of the Intervenors is  
22 very consistent with the position of the Applicants.

23 The Applicants are very invested in making  
24 sure there is access in the L & M community, diversity of

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1 providers in the L & M community, that there are  
2 efficiencies, that there is a commitment to quality care.  
3 None of that is divergent from what we heard today, so I  
4 really do not think that there's much controversy with  
5 respect to this application.

6 That having been said, there are multiple  
7 agendas here that are completely unrelated to this  
8 proceeding and the issues at hand.

9 It is my hope that this proceeding can  
10 focus on the issues that OHCA is legislatively mandated  
11 to consider in determining whether or not to grant this  
12 application. Thank you.

13 HEARING OFFICER HANSTED: Thank you.

14 MS. FELDMAN: Mr. Crespo, who is Chairman  
15 of the Board of Yale-New Haven Health, would like to give  
16 his pre-filed testimony.

17 HEARING OFFICER HANSTED: Okay, thank you.

18 MR. CRESPO: Thank you. Good afternoon,  
19 Attorney Hansted and members of the OHCA staff.

20 HEARING OFFICER HANSTED: Good afternoon.

21 MR. CRESPO: My name is Joe Crespo, and  
22 I'm Chairman of the Board of Trustees of Yale-New Haven  
23 Health System. I'm a volunteer and dedicate a lot of the  
24 time to the governance of the Yale-New Haven Health.

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1 First of all, I would like to adopt my  
2 pre-filed testimony, as you have it.

3 HEARING OFFICER HANSTED: Thank you.

4 MR. CRESPO: The Boards of our hospital  
5 are composed of community, business and position leaders  
6 from the communities that they serve. Our Boards are  
7 diverse, active and engaged.

8 These Boards are critical to Yale-New  
9 Haven Health's success, as their input helps frame our  
10 strategies.

11 Yale-New Haven Health and L & M are  
12 committed to maintaining a local Board that ensures the  
13 needs of its community, that the needs of its communities  
14 are represented, as well, and well-served when  
15 considering both local and system strategies.

16 Now I want to clarify one point. I  
17 understand that there may be some confusion about the  
18 governance of L & M if this affiliation is approved, and  
19 I would like to take this opportunity to explain our  
20 governance philosophy.

21 As in the case with all the hospitals in  
22 Yale-New Haven Health, one Board member will be appointed  
23 by the system to the local Board, and that Board member  
24 will have one vote, just like the rest of all of the

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1 members on the L & M Boards.

2 While some decisions that affect the  
3 entire system will be made by the Yale-New Haven Health  
4 Board, most significant decisions, including regarding  
5 clinical problems, will require L & M approval.

6 L & M has chosen to form a relationship  
7 with Yale-New Haven Health that will allow us to address  
8 community needs, ensure continued access to leader  
9 services, and enhance the efficiency of healthcare  
10 systems in the State.

11 Therefore, I urge you to approve this  
12 application and to allow Yale-New Haven Health and L & M  
13 to forge a partnership that will be truly beneficial for  
14 all involved. Thank you.

15 HEARING OFFICER HANSTED: Thank you, Mr.  
16 Crespo. And, at this point, I want to take a 15-minute  
17 break, so please report back here promptly, so we can  
18 continue the hearing in 15 minutes. Thank you, all.

19 (Off the record)

20 HEARING OFFICER HANSTED: Okay, we're  
21 going to get going again here. Okay, Attorney Feldman,  
22 if you would like to continue with your case in chief?

23 MS. FELDMAN: Thank you, Attorney Hansted.  
24 Bruce Cummings would like to provide his pre-filed

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1 testimony.

2 HEARING OFFICER HANSTED: Absolutely.

3 MR. CUMMINGS: Good evening.

4 HEARING OFFICER HANSTED: Good evening.

5 MR. CUMMINGS: Good evening, Attorney  
6 Hansted and OHCA staff. I'd like to adopt my pre-filed  
7 testimony as my own.

8 HEARING OFFICER HANSTED: Thank you.

9 MR. CUMMINGS: My name is Bruce Cummings,  
10 and I am the President and CEO of Lawrence & Memorial  
11 Corporation, which is the parent entity for Lawrence &  
12 Memorial Hospital, the Westerly Hospital in Rhode Island,  
13 the L & M Physician Association, and the Visiting Nurse  
14 Association of Southeastern Connecticut, collectively  
15 known as the L & M Health Care System.

16 On a personal note, I live in New London.  
17 This has been my home for 11 years. L & M is my  
18 hospital, and the L & M Medical Group is my physician and  
19 that of my wife, and I'm happy to report that one of my  
20 grandchildren was born at L & M two years ago, and number  
21 two will be born this summer in August, so I'm grateful  
22 to have this opportunity to speak with you and to convey  
23 my reasons for recommending to you that it approve the  
24 CON application now before you, allowing L & M Health

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1 Care to affiliate with Yale-New Haven Health.

2 We've heard from a number of people in the  
3 audience bandying about terms like merger, acquisition,  
4 and, certainly, in particular, pejorative takeover, none  
5 of which are applicable here in relation to L & M Health  
6 Care and Yale-New Haven Health.

7 It is an affiliation. To be sure, you'll  
8 hear later about a proposed merger between the L & M  
9 Medical Group and the Northeast Medical Group. That is a  
10 true merger, but, for L & M Health Care and Yale-New  
11 Haven Health, it is an affiliation, not an acquisition.

12 The two entities have a long history of  
13 clinical collaboration and support. We have  
14 complimentary missions, visions, philosophies and values  
15 around patient care and community service.

16 During the past 10 years, L & M has turned  
17 to Yale-New Haven Health to provide a number of needed  
18 services within the L & M primary service area to promote  
19 access, a theme that you'll hear us articulate and  
20 restate on a number of occasions about promoting access  
21 in the areas of heart and vascular care, medical and  
22 radiation oncology, pediatric and neonatal services and  
23 neurosurgery and stroke.

24 You heard this afternoon from Dr. Brian

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1 Cambi, who offered a case study around emergency and  
2 elective angioplasty, a capability available in L & M by  
3 virtue of our connection to the Yale-New Haven Heart and  
4 Vascular Center, but I wanted to mention two others.

5 A Telestroke Program, we were actually the  
6 first community hospital in Connecticut to develop and  
7 implement such a program, and that, again, was made  
8 possible, because of a relationship with Yale-New Haven  
9 Hospital that has resulted in saving literally hundreds  
10 of lives, and only late last year new pediatric  
11 hospitalist service, at a time when most community  
12 hospitals have abandoned completely offering pediatric  
13 services, we moved in a different direction, thanks to a  
14 relationship with Yale Children's Hospital, Yale-New  
15 Haven Children's Hospital, that resulted in a team of  
16 well-trained pediatric hospitalists coming to our  
17 community and reestablishing hospital-based inpatient  
18 pediatric care.

19 These clinical collaborations have not  
20 been sufficient to address all of the challenges in  
21 health care today.

22 Other market forces have created other  
23 imperatives for L & M that make this proposal a necessity  
24 rather than a luxury.

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1                   As health systems undertake this  
2 transition from a traditional fee-for-service or volume-  
3 driven environment to a value-based or outcome-oriented  
4 delivery system, they will need access to all the  
5 components of a fully integrated health care delivery  
6 model.

7                   This shift that I'm describing requires  
8 alternative care models and access to affordable capital  
9 to fund the new generation of technology and resource  
10 development, along with data analytics, to improve the  
11 health of the population served, a capability that simply  
12 we do not have as a small community controlled health  
13 system.

14                   When you couple these imperatives with  
15 aging infrastructure, a growing population of older and  
16 sicker adults and demands for more effective medical  
17 treatments and technologies, it becomes clear that the  
18 challenges are daunting on many levels, not the least of  
19 which is financial.

20                   One significant driving force between L &  
21 M's decision to affiliate with Yale-New Haven Health has  
22 been our progressively declining financial performance  
23 over the past three fiscal years.

24                   During those past three fiscal years, L &

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1 M has experienced a significant decline in its revenues.  
2 This decline has been the result of many factors; the  
3 State of Connecticut budgetary rescissions and the  
4 Medicaid supplemental pool, along with hospital taxes  
5 increasing.

6 This has gone in 2013 from a tax of \$1  
7 million to \$18 million this past year, with about \$5  
8 million restored late in the legislative session, so all  
9 together an adverse impact of \$13 million on a one-year  
10 basis.

11 There have been no updates, no payment  
12 increases for Medicaid since 2008. Indeed, when I came  
13 11 years ago to New London, L & M was paid about 65 to 70  
14 cents on the dollar. Today, it's half that, and, at the  
15 same time, the percentage of our patient population has  
16 gone from around eight percent on Medicaid to more than  
17 18 percent on Medicaid, a doubling of the population and  
18 a halving of the payment levels.

19 We've seen the 75 percent reduction in  
20 federal disproportionate share payments, payers  
21 increasing the shift away from fee-for-service to value-  
22 based payments, an unwillingness on the part of  
23 commercial payers to bear the burden of insufficient  
24 government funding, and, last, but not least, reductions

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1 in inpatient hospital utilization. Put plainly, we've  
2 seen a huge shift at virtually every hospital, especially  
3 in community hospitals, on the part of Medicare moving  
4 what used to be considered inpatient acute admissions to  
5 observation status.

6 All of these factors have a cumulative and  
7 detrimental impact on our financial status, and, in May  
8 of this year, our bond rating was downgraded by Standard  
9 & Poor from an A+ rating just three years ago to a triple  
10 B+.

11 S & P's rating agency attributed three  
12 factors to that downgrade; the Connecticut State Hospital  
13 Tax, inpatient softness with a mix to these observation  
14 patients, and a weakened balance sheet.

15 Unfortunately, our demand for capital to  
16 meet our community needs to enhance access is the  
17 greatest it has ever been.

18 Healthcare reform requires innovative  
19 responses to meet the demands for higher quality care at  
20 lower cost. L & M is without the capacity or the capital  
21 to take on such challenges on its own, a conclusion that  
22 our Board began to come to in January 2015 and completed  
23 its independent internal assessment and ultimate decision  
24 to affiliate with Yale-New Haven Health in June of 2015.

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1                   Yale-New Haven Health and L & M have  
2                   agreed on a commitment of \$300 million to enhance and  
3                   support both clinical and operational initiatives,  
4                   consistent with the needs of the Eastern Connecticut  
5                   Region.

6                   Without a capital infusion, a financial  
7                   downward spiral is very likely. Such financial downturn  
8                   for L & M would be counter-productive, hard to recover  
9                   from, and negatively impact access to care for the  
10                  financially disadvantaged and underserved and most  
11                  vulnerable members of the L & M community.

12                  If approved, the Applicants together  
13                  intend to meet the needs of the region through a jointly-  
14                  developed strategic plan, with a focus on greater access  
15                  to primary care, cost-effective alignment of service  
16                  lines, such as oncology, cardiology, neurosurgery,  
17                  emergency medicine, surgery, orthopedics and behavioral  
18                  health, along with enhancements to operational  
19                  infrastructure.

20                  Let me take a moment to clear up a  
21                  misconception that some may hold about this \$300 million  
22                  investment. It is not dependent on Yale-New Haven Health  
23                  making a profit, rather, 85 million of this 300 million  
24                  investment is already committed, and the remaining 215

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1 million in investments will be made over five years,  
2 based upon mutually agreed upon business plans and the  
3 financial performance of L & M.

4 This is a rational and prudent approach to  
5 ensuring the financial stability of L & M and its  
6 continued presence in the community.

7 In the event this application is not  
8 approved, it's my opinion and belief that many of the  
9 programs discussed in our application will be in serious  
10 jeopardy and will force us to make the type of difficult  
11 decisions that will inevitably and negatively impact our  
12 community benefit program clinical offerings and,  
13 consequently, jobs.

14 For all the reasons discussed in our  
15 application and the testimony provided today, I urge OHCA  
16 to approve this application without delay.

17 Let me introduce Dr. Tom Balcezak, the  
18 Chief Medical Officer. Are you going next, or Ron is  
19 going to go next? Okay. Turn it back to you, Joan.

20 MS. FELDMAN: Dr. Ross Sanfilippo will  
21 provide his pre-filed testimony. He's a member of the L  
22 & M Corporation Board of Directors.

23 DR. SANFILIPPO: Good evening, Attorney  
24 Hansted and the OHCA staff.

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1 HEARING OFFICER HANSTED: Good evening.

2 DR. SANFILIPPO: My name is Dr. Ross  
3 Sanfilippo, and I am a member of the Board of Directors  
4 of the Lawrence & Memorial Corporation. I adopt my pre-  
5 filed testimony as my own.

6 I am very appreciative of this opportunity  
7 to speak to you today on behalf of my fellow Board  
8 members and recommend to OHCA that it allow L & M to  
9 affiliate with Yale-New Haven Health.

10 I've been in private practice in New  
11 London and on the staff of the Department of Surgery here  
12 at L & M for over 20 years.

13 My family receives healthcare here from  
14 both my L & M and Yale-New Haven colleagues, and, like  
15 many others, my children were born here at L & M.

16 Since the passage of the Affordable Care  
17 Act, it has become very clear to the Board that past  
18 assumptions and approaches to the delivery of health care  
19 would no longer serve us well.

20 We endeavored to reduce expenses, but that  
21 was not enough. Given the associated costs with data  
22 analytics, IT platforms, population health and  
23 coordination of care, our Board knew that we needed  
24 access to capital and a greater scale.

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1 L & M has historically enjoyed a very  
2 positive working relationship with Yale-New Haven Health  
3 Services. We are excited about the potential to be  
4 associated with their brand, their quality, their  
5 standards and recruit the best and brightest physicians  
6 to our L & M community from Yale-New Haven Health System.

7 If OHCA does not approve this application,  
8 I am here to say that there will be negative consequences  
9 to our L & M community. Indeed, some of which may not be  
10 reversible and may even result in less access to care,  
11 less diversity of providers, and, even worse, a less  
12 healthy community with programs that have to be cut.

13 OHCA should also know that the L & M Board  
14 will remain in place and continue to govern locally. Our  
15 Board is and will remain fully engaged in our community.  
16 We live and work here.

17 I also want to remind everybody that this  
18 -- we are very excited about this continuing role, and I  
19 must point out that this is in stark contrast to how  
20 other systems in the State govern and relate to their  
21 community Boards. This is not going to be a  
22 Hartford/Windham situation. Our Board made sure of that.

23 I must tell all of those in the room today  
24 that my fellow Board members and I consider ourselves

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1 fiduciary of the community, and we would not be here  
2 recommending this proposal if we did not think it was in  
3 the best interest of our community with respect to  
4 providing not only high-quality, but, also, affordable  
5 care.

6 For all these reasons, I urge OHCA to  
7 consider our testimony today and allow us to form this  
8 relationship with Yale-New Haven Health, as we are  
9 committed to the future and to the success of L & M here  
10 in our community. Thank you.

11 HEARING OFFICER HANSTED: Thank you.

12 DR. BALCEZAK: Good afternoon, Hearing  
13 Officer Hansted and the entire OHCA staff. My name is  
14 Tom Balczak. I'm the Chief Medical Officer at Yale-New  
15 Haven.

16 On a personal note, I'm also a lifelong  
17 resident in the State of Connecticut, trained here in  
18 both medical school at the University of Connecticut and  
19 my residency at Yale-New Haven Hospital and have lots of  
20 colleagues at the hospitals across the State of  
21 Connecticut.

22 I ask that you please adopt my pre-filed  
23 testimony. As outlined in that pre-filed testimony and  
24 as Bruce Cummings just noted, there's a long history of

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1 clinical collaborations between L & M and Yale-New Haven  
2 Hospital, but those relationships can only go so far, and  
3 if this application is approved, I would look forward to  
4 working with my colleagues at L & M to enhance the  
5 clinical offerings available in the area, as we have done  
6 with both Bridgeport and Greenwich Hospitals.

7 Yale-New Haven Hospital's interest here is  
8 not in filling Yale-New Haven Hospital's beds, nor are we  
9 interested in moving clinical programs or patients to  
10 Yale-New Haven.

11 For one, we currently don't have the  
12 space. We routinely operate at or above our capacity,  
13 and, second, it's not the approach of Yale-New Haven  
14 Health, rather, we seek to enhance the clinical offerings  
15 in the community, so that we can ensure high-quality  
16 patient care provided locally here with these local  
17 physicians.

18 And, again, on a personal note, that's not  
19 just our philosophy as an institution. It's also my  
20 personal goal, since both my parents live in this  
21 community, my brother and his family live in this  
22 community and works at Electric Boat.

23 They get their local care here. They've  
24 had procedures here, GI procedures, surgical procedures,

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1 and it is, I believe, in all of their best interests, as  
2 well as this community, that we continue to provide that  
3 care and continue to enhance it.

4 I understand that in another context it's  
5 been suggested to OHCA that physicians associated with  
6 the Yale Medical Group practicing at L & M have been  
7 sending patients to Yale-New Haven Hospital for cardiac  
8 procedures, rather than performing them at L & M.

9 We have looked at this, and I want to  
10 assure OHCA that we have not seen an increase in cardiac  
11 procedures from the New London area and that only those  
12 cases that cannot be performed safely at L & M are  
13 appropriate and have been transferred to Yale-New Haven  
14 Hospital.

15 That's the principle we currently follow,  
16 and it's a principle that we would continue to follow,  
17 even if this affiliation is approved.

18 Transfers to Yale-New Haven would only be  
19 appropriate for the most complex and high-risk patients,  
20 and given the transition that we are seeing nationally  
21 from payment systems that reward volume to those that  
22 reward value is, in fact, in Yale-New Haven Health's and  
23 Yale-New Haven Hospital's best interest to seek the  
24 lowest cost care setting for patients whenever possible.

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1           This point is also demonstrated by our  
2 track record in Bridgeport and Greenwich, where we have  
3 increased the services available in those communities and  
4 collaborated with physicians and executives from those  
5 hospitals to improve care and reduce costs.

6           For this reason, I urge OHCA to approve  
7 this application. I would now like to introduce Monica  
8 Noether, who is an economist from Charles Rivers  
9 Associates and has worked in the field of health care  
10 economics for a number of years, and we asked her to  
11 provide her expert testimony on this affiliation.

12           DR. NOETHER: Good evening, Attorney  
13 Hansted and members of the OHCA panel. First of all, I  
14 adopt my pre-filed testimony as my own, and while I can't  
15 claim to be a resident of Connecticut currently, I did go  
16 to high school and college here, and my parents actually  
17 taught at the University of Connecticut for a couple of  
18 decades, so I do have some connections here.

19           I've been asked to contribute to this  
20 proceeding as both a resource to OHCA and to respond to  
21 issues related to access, diversity of providers and  
22 costs.

23           I can also explain how the antitrust  
24 agencies that have jurisdiction over things like

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1 monopolies and acquisitions or affiliations likely  
2 determine that they should not challenge this  
3 affiliation.

4                   There are four main points that I'd like  
5 OHCA to take from my pre-filed testimony. First, prices  
6 will not increase as a result of this transaction.  
7 Because Yale-New Haven Health and L & M largely serve  
8 different customer bases, their affiliation does not  
9 change the competitive landscape significantly.

10                   As you know, they're 50 miles apart, and  
11 we've heard how difficult it is to travel between the two  
12 and the fact that there isn't that much travel really  
13 between the two.

14                   Second, Yale-New Haven is, at least the  
15 hospital, is an academic medical center, focusing on high  
16 end cases, whereas L & M has traditionally been a  
17 community hospital serving the local community.

18                   Second, diversity of health care providers  
19 and patient choice will, therefore, not be negatively  
20 impacted by the proposed affiliation.

21                   Third, to the contrary, given the  
22 increasing financial weakness of L & M, which we've heard  
23 quite a bit of testimony about, without the affiliation,  
24 residents of L & M service area will likely face reduced

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1 choice and access as L & M is forced to cut services.

2 And, finally, the affiliation will allow L  
3 & M to achieve greater efficiencies, enhanced services,  
4 and position itself to meet the challenges of healthcare  
5 reform that we've also heard several people talk about  
6 this afternoon while maintaining jobs as services are  
7 increased.

8 I also need to rebut three statements made  
9 by Dr. Hyde in his response to my pre-filed testimony.  
10 Perhaps most importantly, Dr. Hyde's assertions about  
11 Yale-New Haven's current crisis and its ability to  
12 increase prices through affiliations misplaced.

13 It's not clear on what basis Dr. Hyde  
14 describes, quote, "New Haven as the epicenter of  
15 extraordinarily high prices." Certainly, the information  
16 presented in the Cooper Study that he references does not  
17 support that conclusion.

18 In fact, New Haven average commercial  
19 hospital price is, of 12,300 or so, is over six percent  
20 below the national average, which is over 13,000,  
21 according to data used by Dr. Cooper and reported in the  
22 press, and, on the Medicare side, New Haven ranks 40th  
23 for Medicare spend across different hospital referral  
24 regions across the country, nor does Dr. Hyde's assertion

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1 that Connecticut Medicaid rates are attributable to,  
2 quote, "monopoly pricing by Yale-New Haven" have any  
3 basis. Prices are set by the State and, as you well  
4 know, do not cover costs.

5 Hyde also claims that I, quote, "appear to  
6 take a position contrary to the majority of economists,  
7 who have studied the merger of non-profit hospitals."

8 That's actually not the case, rather, the  
9 literature to which he refers does not apply to the  
10 proposed affiliation that OHCA must currently rule upon.  
11 That literature is concerned with the effects of mergers  
12 that actually enhance market power, and for all the  
13 reasons that I outlined just now and in my pre-filed  
14 testimony, the proposed affiliation does not create or  
15 enhance market power.

16 The FTC and the DOJ have never challenged  
17 affiliations of combinations of hospitals that are 50  
18 miles apart, and, therefore, it's not necessarily  
19 surprising that the FTC and the Connecticut Attorney  
20 General both closed their investigation of this proposed  
21 affiliation about a year ago.

22 Finally, on price information, Dr. Hyde  
23 acknowledges that it's difficult to obtain reliable price  
24 information, but then proceeds to disagree with himself

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1 by citing several irrelevant sources. For example,  
2 administered prices set by Medicare and Medicaid.

3 Applicants explain in their supplemental  
4 pre-filed testimony why there are no readily available  
5 price data that accurately distinguishes the complexity  
6 of services provided by academic medical centers, such as  
7 Yale-New Haven Hospital.

8 Dr. Hyde cites a study of mine, in which I  
9 use charge data as evidence that price data can be used,  
10 but I need to point out that that study was based on data  
11 from 1977 and '78, i.e., nearly 40 years ago, when the  
12 healthcare world was a bit of a different place.

13 It was a time when individuals and  
14 insurers actually paid consisted multiples of charges, so  
15 that charges, in fact, had some meaning to them. In  
16 fact, DRGs or any other of the features of Medicare's  
17 current payment system on which many private payment  
18 systems are also based didn't exist, and managed care was  
19 in its infancy everywhere, except perhaps California.

20 And I think that, with that, that's  
21 probably enough, given the hour. I appreciate your time  
22 today, and I'm obviously available to answer any  
23 questions.

24 HEARING OFFICER HANSTED: Thank you.

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1 MS. BORGSTROM: Great. Thank you. My  
2 notes say good afternoon, but I'll say good evening,  
3 Attorney Hansted and the rest of the OHCA staff with  
4 incredible stamina.

5 My name is Marna Borgstrom, and I'm the  
6 President and Chief Executive Officer of Yale-New Haven  
7 Health Services Corporation. I also adopt my pre-filed  
8 testimony as my own and appreciate the opportunity to  
9 share with you a couple of points of view, and some of it  
10 will build on other testimony that you've had.

11 The application that we put together is  
12 intended to support a value-driven affiliation designed,  
13 as was said earlier, to improve access, to enhance the  
14 quality of care, and reduce the costs through scale.

15 In fact, about two years ago, the Yale-New  
16 Haven Health System Board adopted the following mission  
17 statement. Yale-New Haven Health System seeks to enhance  
18 the lives of people we serve by providing access to high  
19 value, patient-centered care in collaboration with  
20 others, who share our values, and that was a very big  
21 move for us and very important, because it recognizes  
22 that the world is changing, that volume is not going to  
23 be the basis on which we're paid, that we really need to  
24 be focusing on how to make our communities stronger and

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1 healthier, and no one organization can do that, so  
2 collaboration and partnership is going to be critical if  
3 we're really going to start to change the way health care  
4 is actually provided.

5 As a result, the culture and the evolution  
6 of the Yale-New Haven Health System has not been and is  
7 not to grow for the sake of growth.

8 When we look at our system, until the  
9 acquisition of the hospital of St. Raphael, which was a  
10 very different form of transaction, Yale-Haven's size has  
11 not changed materially since the 1990s.

12 Yale-New Haven Hospital formed the Yale-  
13 New Haven Health System in 1996. Bridgeport Hospital  
14 joined. Bridgeport then and in the subsequent few years,  
15 as we were getting the system together, was losing money.  
16 They were losing patients. They were losing physicians.

17 If you fast forward to today, Bridgeport  
18 is the lead player in the geography they serve. They  
19 have among the highest patient satisfaction, physician  
20 satisfaction, and the growth in their patient services  
21 has been remarkable, and that is a very poor community.

22 And part of the way that they've grown is  
23 they have brought specialists into the Bridgeport  
24 community that they couldn't have brought in previously,

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1 and those specialists are providing care in Bridgeport  
2 doing their procedures and their services at Bridgeport  
3 Hospital.

4                   Greenwich Hospital joined the Yale-New  
5 Haven Health System about a year later in 1997, and,  
6 similarly, in addition to cost position improvement, has  
7 been home to the expansion of services, notably, the  
8 Smilow Cancer Hospital and the Yale-New Haven Heart and  
9 Vascular Center.

10                   And I think, if you talk to Board members  
11 at both of those organizations, they would say both  
12 organizations have been enhanced as a result of their  
13 affiliation with the Yale-New Haven Health System, which  
14 is identical in form to the one that we're proposing for  
15 Lawrence & Memorial.

16                   A different form of transaction, almost  
17 four years ago, because it was significantly distressed,  
18 Yale-New Haven Hospital actually purchased the Hospital  
19 of St. Raphael, and, at the time, and that was a much  
20 more difficult transaction to work through with the  
21 Federal Trade Commission, there were a number of  
22 requirements put on that, and we have met, exceeded all  
23 of those.

24                   We were asked to save \$250 million in

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1 costs. That has been exceeded. We've realized over \$400  
2 million in capital cost avoidance, because Yale-New Haven  
3 Hospital, which, as Dr. Balcezak said, has been running  
4 full, did not have to build additional facilities.

5 As important, more important, we've made  
6 \$100 million investment in infrastructure on the St.  
7 Raphael's campus since the acquisition, and, as you heard  
8 in public testimony earlier, all 3,000 jobs were  
9 preserved on that campus.

10 Employees benefitted from pension plans  
11 and wage increases that they had not enjoyed previously,  
12 and, as you've also heard, we have enjoyed a very  
13 positive and productive relationship with the Teamsters,  
14 who represented a number of employees on that campus.

15 We can do the same, we believe, for  
16 Lawrence & Memorial as we've done for Greenwich and for  
17 Bridgeport and as a result of the St. Raphael's  
18 transaction and the community served by Lawrence &  
19 Memorial, but if we don't have this opportunity, I think  
20 you've also heard that it's likely Lawrence & Memorial  
21 will face some disruption, some instability and  
22 potentially reduced access to care.

23 And I'd like to just take a minute to  
24 address a few of the misconceptions about our system.

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1 Our corporate focus is not one of control, but it is of  
2 creating a unified system, a unified strategy. We want  
3 to enhance performance, we want to set standards for  
4 quality and value, and we want to achieve cost reductions  
5 through economies of scale and economies of skill.

6 Our corporate focus is on local  
7 governance, with real authority, and Mr. Crespo spoke to  
8 that earlier. The Yale-New Haven Health System has the  
9 opportunity to name one member of the Lawrence & Memorial  
10 Board, and that person has one vote, and, with the  
11 exception of system-based decisions, decisions related to  
12 any changes in services, additions, subtractions, changes  
13 come from the Lawrence & Memorial Board, not from the  
14 Yale-New Haven Health System Board.

15 It's in no one's interest to drive up cost  
16 or increase prices to make healthcare less affordable to  
17 consumers. We do not and we have never negotiated rates  
18 as a system.

19 The rates negotiated for Greenwich  
20 Hospital, for Bridgeport Hospital and for Yale-New Haven  
21 Hospital are separate, independent, and they reflect the  
22 cost of doing business at those organizations, and we  
23 expect that that will continue with Lawrence & Memorial.

24 We will work with Lawrence & Memorial to

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1 provide additional primary care and surgical specialists  
2 in the area to enhance the medical services available and  
3 to reduce the need for patients to travel to New Haven,  
4 except for highly-specialized services.

5 As I mentioned, if you look at what's  
6 happened in Greenwich and Bridgeport, in fact, both of  
7 those organizations have seen a growth in local  
8 healthcare volume, because there is more business being  
9 done in those communities that appropriately can stay  
10 there.

11 Finally, I understand that there is  
12 concern, and we heard it in some of the public testimony,  
13 that this affiliation will have the same effect as some  
14 other system activities in this State.

15 Please remember that we do not negotiate a  
16 single price for our system, that we operate in very  
17 different local communities, and each one of those  
18 communities has specific needs.

19 In addition, and you've already heard  
20 this, it's very difficult to negotiate increased prices  
21 anyplace, because the third party payers are finding  
22 that, with employees and employers paying more and more  
23 of the healthcare bill, they can't afford to do that  
24 anymore.

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1           Our health system has worked very hard on  
2 cost reduction. Over the last several years, we have  
3 saved \$300 million on an annualized basis across the  
4 health system. The original plan and strategy had been  
5 to use that to lower some of the negotiated commercial  
6 rates to make certain services more affordable as people  
7 were paying more out of pocket.

8           In the last four years, however, between  
9 taxes and payment reductions from the State of  
10 Connecticut, we have lost almost \$300 million in revenue  
11 from the State of Connecticut, and, so, effectively, as  
12 we have reduced costs, those have gone to subsidize what  
13 would have been provided by the State of Connecticut.

14           I believe that this application has  
15 delayed or denied the opportunity for Yale-New Haven  
16 Health to help make a positive difference, and the  
17 Greater New London and Westerly communities will be  
18 diminished or worse. It could be lost.

19           Put simply, the alternative to this  
20 application may be the eventual closure, the reduction,  
21 or termination of services, lost jobs and reduced access  
22 to care, so I strongly support OHCA and the Deputy  
23 Commissioner of the Department of Public Health approving  
24 this application. Thank you.

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1 HEARING OFFICER HANSTED: Thank you.

2 MS. FELDMAN: That completes our pre-filed  
3 testimony.

4 HEARING OFFICER HANSTED: Okay. Attorney  
5 Murray, if you want to proceed with your case in chief?

6 MR. MURRAY: Thanks very much.

7 HEARING OFFICER HANSTED: You're welcome.

8 MR. MURRAY: Good evening, Hearing Officer  
9 Hansted and staff of the Office of Health Care Access.

10 As you know, I represent a coalition of  
11 Intervenors, who were granted Intervenor status in this  
12 particular proceeding.

13 These specific applications involve the  
14 acquisition of Lawrence & Memorial Hospital here in New  
15 London and the acquisition by Yale-New Haven Hospital  
16 Health Care System and the merger of L & M's physician  
17 practices with Yale's Northeast Medical Group.

18 The Intervenors, as we will more  
19 specifically detail in the testimony today and have  
20 provided in our pre-filed documents, have raised some  
21 serious reservations about the proposed acquisition and  
22 merger and believe that they will put at risk Lawrence &  
23 Memorial Hospital's patients in the Greater New London  
24 area, both from escalating costs of medical care and

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1 decrease in access to affordable and quality medical  
2 services that we believe are a result of this acquisition  
3 and merger.

4 In the interest of time, I will actually  
5 ask permission. I have a written opening statement,  
6 which kind of lays out the theory that the Intervenors  
7 have, and I'd just like permission to supply it to you in  
8 written format.

9 MS. FELDMAN: I object.

10 HEARING OFFICER HANSTED: Would you supply  
11 a copy to the Applicants?

12 MR. MURRAY: Absolutely.

13 HEARING OFFICER HANSTED: Would you just  
14 let them look at it right now before, and then I'll rule  
15 on the objection.

16 MR. MURRAY: Well I can put it on the  
17 record.

18 HEARING OFFICER HANSTED: Why don't you  
19 just read it into the record?

20 MR. MURRAY: Okay. Nothing in the  
21 application, in the applications, provide any assurance  
22 at all that the interests of low-income, at-risk and  
23 minority communities within the Lawrence & Memorial  
24 service area will be adequately protected or that they

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1 will be continuing community involvement and oversight of  
2 L & M's provision of health and medical care in  
3 Southeastern Connecticut.

4 The Connecticut General Statute 19a-639a-  
5 12 requires the Applicants to satisfactorily demonstrate  
6 that their resulting consolidation will not adversely  
7 affect healthcare costs or accessibility to care in the  
8 service areas.

9 We believe they have failed to do so, and,  
10 as a result, OHCA must reject these applications, as  
11 currently filed.

12 Our coalition witnesses today will focus  
13 on the serious inadequacies of these applications in  
14 addressing these major statutory areas of concern  
15 regarding price of, access to and quality of medical care  
16 after the proposed mergers and acquisitions, and I'll let  
17 our witnesses, basically -- I'm not going to summarize  
18 their testimony. I'll let them do it themselves.

19 In a minute, I want to introduce the  
20 members of our coalition to provide evidence for the  
21 Department today, as well as adopting their pre-filed  
22 testimony.

23 Each of the witnesses and coalition  
24 members will tell you that they share a deep skepticism

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1 that the applications before you satisfy the statutory  
2 criteria for approval with respect to both cost and  
3 access.

4           Rather, these witnesses will tell you that  
5 the two applications will lead to increases in the price  
6 for health care in the L & M service areas, a decrease in  
7 access of needed services, including specialty services,  
8 and elimination of alternative service providers in Rhode  
9 Island and Massachusetts, which are now available to the  
10 L & M patient population.

11           Of particular importance in this process  
12 is the unwillingness of the Applicants to provide  
13 historic price information from previous acquisitions at  
14 Bridgeport and Greenwich Hospitals.

15           This raises serious concerns that the  
16 Applicants cannot meet their statutory burden of  
17 demonstrating that the acquisitions and mergers will not  
18 adversely affect the healthcare cost in the L & M service  
19 areas post-acquisition by the Yale system.

20           These issues will be more substantially  
21 addressed by our witnesses today. There is a document  
22 that will be referenced by at least one of our witnesses,  
23 which I will either put on the record now or supply to  
24 the agency, and I'll represent to you it is a document

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1 that we receive from the Office of the State Controller,  
2 and it details for the period of time from May 1, 2014 to  
3 April 30, 2015 the cost of certain inpatient and  
4 outpatient cost for inpatient and outpatient services  
5 provided by Yale-New Haven Hospital and L & M for State  
6 employees, who are part of the State Employee Health Care  
7 System.

8 And I know that Dr. Hyde is going to be  
9 referring to this. I'm happy to provide this to the  
10 Applicants now or do it as a late file exhibit.

11 HEARING OFFICER HANSTED: Do you have the  
12 document with you?

13 MR. MURRAY: I have copies of it here for  
14 both you and the Applicant.

15 HEARING OFFICER HANSTED: Why don't you  
16 let the Applicants review it? Attorney Feldman, let me  
17 know if you have any objection.

18 MS. FELDMAN: At this point, it's very  
19 difficult to review a one-page document without knowing  
20 the source or the context of the document, where the  
21 information came from, or whether it's reliable  
22 information, so I'm going to have to object to its entry  
23 into the record at this point.

24 MR. MURRAY: We can certainly provide

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1 testimony. I understand that we may be having another  
2 hearing date. We can certainly provide testimony, as to  
3 the source of the information and whether or not it's  
4 reliable. It was provided by Kevin Lembo.

5 HEARING OFFICER HANSTED: Okay and you  
6 said Dr. Hyde will refer to this document?

7 MR. MURRAY: He's going to refer to this,  
8 but we can put an individual on the next time we have a  
9 hearing, who can testify to how they acquired it and how  
10 it was given to them by Comptroller Lembo.

11 HEARING OFFICER HANSTED: Yes, I'd like to  
12 have that done. So we won't accept it at this point. As  
13 you refer to the second hearing date, we'll take it at  
14 that point if you properly introduce the document into  
15 the record.

16 MS. FELDMAN: Yes. Attorney Hansted, I'd  
17 also like to object on the basis that, as mentioned in  
18 the Intervenor's opening comments, if you read our pre-  
19 filed testimony, it becomes very clear that almost 80  
20 percent of our payments are government payers, and I  
21 really don't understand the relevance of this document  
22 being introduced now at this late date, and I think this  
23 whole issue of costs going up post-affiliation is a bit  
24 of a guise, in that we made it very clear that we don't

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1 have the ability to negotiate almost 80 percent of our  
2 payments from governmental payers.

3 HEARING OFFICER HANSTED: I can appreciate  
4 your position, but, at the same time, I'd like to receive  
5 evidence from the Intervenors on what they feel their  
6 position is.

7 Now, as I stated, we're not accepting this  
8 document at this time, but if Attorney Murray properly  
9 introduces it at the next hearing and we hear testimony  
10 on it, I will accept it at that time, and you will be  
11 given the opportunity to object at that point.

12 MS. FELDMAN: Thank you.

13 MR. MURRAY: Just for the record, also, we  
14 are actually not talking about, even though this is the  
15 State of Connecticut's Employee Healthcare Plan, which  
16 I'm sure all the members up there participated, it's  
17 hardly a government payer, as we understand that term in  
18 this hearing.

19 HEARING OFFICER HANSTED: Correct.

20 MR. MURRAY: It's essentially a third  
21 party payer. The State of Connecticut is self-insured  
22 and provides those payments for those services that it  
23 negotiates with hospitals throughout the State.

24 HEARING OFFICER HANSTED: Correct. Okay,

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1 so, be prepared to enter it at the next hearing date.

2 MR. MURRAY: I'll do that. At this time,  
3 the Intervenors would like to turn the microphone over to  
4 Dr. Fred Hyde.

5 HEARING OFFICER HANSTED: Okay.

6 DR. HYDE: Mr. Hansted, members of the  
7 panel, ladies and gentlemen, my name is Fred Hyde, and I  
8 adopt my pre-filed testimony.

9 HEARING OFFICER HANSTED: Thank you.

10 DR. HYDE: And would like, given the hour,  
11 merely to underline parts of it that I think may be of  
12 some help to you.

13 The essence of our presentation is that,  
14 as Mr. Murray indicated, we have really two different  
15 applications here. One application can be embraced or  
16 endorsed by everyone or almost everyone in the room, and  
17 that is that Yale-New Haven is a great hospital.  
18 Lawrence & Memorial is a gem. People have gotten good  
19 services from these hospitals.

20 All of the efforts that have been put  
21 forward by the witnesses can be embraced happily, and the  
22 real question is at what cost?

23 I'm here on behalf of the American  
24 Federation of Teachers, whose President, Randi

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1 Weingarten, has embraced the campaign, known as Patients  
2 before Profits.

3 Part of that campaign is to highlight the  
4 actions that we all need to take that will attempt to put  
5 some brakes on what appears to be a runaway system, a  
6 system, which is consolidating into more and more  
7 expensive and less and less accessible corporate  
8 headquarters.

9 We have tried to make a line of reasoning  
10 or an argument in our pre-filed testimony that goes  
11 something like this.

12 Yale-New Haven has a tremendous position  
13 in the market and attachment for, I believe, which is a  
14 study of the markets of the various hospitals in South  
15 Central and Eastern Connecticut, shows what a tremendous  
16 concentration would take place, notwithstanding testimony  
17 from the Applicants.

18 The only recent study that shows  
19 concentrated power within the same State concludes that  
20 it really doesn't matter if they're overlapping markets.

21 It's the reason why we think, when Mr. Jon  
22 Leibowitz was expressing his frustration as Chairman of  
23 the Federal Trade Commission in March of 2012, he said,  
24 if you want to get a handle on health costs, you have to

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1 challenge anticompetitive hospital mergers.

2 Now the Applicants have pointed out that I  
3 seem to put all the problems of the healthcare field at  
4 the doorstep of this application. I apologize if that  
5 appears to be what I did.

6 What I did was to say this is the  
7 application in front of you. It's the one thing we can  
8 do something about. It's not all of the problems in the  
9 field, but it certainly is a powerful driver of problems  
10 in the field, and we'll give you a late file exhibit  
11 citing exactly where in-State competition, different  
12 markets, exactly where Gaynor and Cooper and exactly  
13 where Yale-New Haven's market historically, 75 percent of  
14 which is essentially community hospital.

15 A big part of the way you prosper is to  
16 charge academic medical center rates for community  
17 hospital services, so we'll pullout from the morass of  
18 information. We've given you those things that we think  
19 will help.

20 So we have the two different applications,  
21 and it's not up to the Intervenor, if I may say so, to  
22 prove that the Applicant is wrong. To the contrary, it's  
23 up to the Applicant to prove that there will be, under  
24 number 12 of your statutory requirements, there will be

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1 no adverse economic impact on hopefully the State, the  
2 hospital, the patients.

3 Let's take a look at, if you would with  
4 me, take administrative notice of the audited financial  
5 statements, which are within your possession. Let's take  
6 a look at 2015 and see what happened with Lawrence &  
7 Memorial.

8 The hospital made money. It made almost  
9 \$5 million, and, yet, if you use 19 million of that to  
10 transfer to affiliates, the doctors in Westerly, you are  
11 going to lose money.

12 The hospital made money, notwithstanding  
13 the fact that it had a very unfortunate recent history.  
14 People, who are in positions of authority and  
15 responsibility in this field, know that the nurses and  
16 clinical personnel are critical. The way you treat them  
17 is the way they'll treat the patients, and, so, almost a  
18 one, two, three blow.

19 And if you look at your annual report, you  
20 can see that Lawrence and Memorial for the last four  
21 years, before 2015, have profits from operations from I  
22 believe nine to \$22 million.

23 The one, two, three blow is you tell your  
24 nurses they're locked out and you're going to transfer

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1 services. You acquire a bankrupt hospital in a  
2 neighboring state, and you subsidize your doctors at the  
3 tune of \$20 million, which is understandable. If you're  
4 the doctors, it works very well.

5 I won't go into the prices problem, except  
6 to acknowledge something, which has been said I think by  
7 us, as well as by the Applicant.

8 Getting price information in this field is  
9 astonishingly difficult. It's difficult, because those,  
10 who have it, do not want to disclose it, not because  
11 somehow it's abstruse.

12 We can look at the hospital as a whole.  
13 If you look at Greenwich and at Bridgeport and at Yale-  
14 New Haven and at Lawrence & Memorial, you'll see that the  
15 current ratio, a key index of liquidity and, therefore,  
16 of solvency, is easily two and a half to four, depending  
17 on the year recently.

18 I do a lot of work in other states. There  
19 are many states. New York is one of them, where 1.75 is  
20 the statewide average. People would be astonished to  
21 find what might be labeled crocodile tears going on with  
22 regard to the under reimbursement of Medicaid for  
23 hospitals that still have current ratios over two, or two  
24 and a half, or three, or four, as was one year with L &

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1 M.

2 So we're not unmindful of the distress  
3 that Lawrence & Memorial has found itself in, but our  
4 narrative entertains the theory that it's largely self-  
5 inflicted.

6 Therefore, whatever the remedy might be is  
7 within the power of Lawrence & Memorial. There is no  
8 case that this acquisition, and that's what it is, when  
9 you become the sole corporate member, you acquire  
10 control, no matter how many members you have on the  
11 Board, and to pretend otherwise is dissimulation.

12 When you become the sole corporate member  
13 and are the controlling body, that's a different kind of  
14 fix.

15 Now what we worry about with Bridgeport  
16 and Greenwich is not that they haven't benefitted from  
17 Yale-New Haven's participation, but that they've  
18 benefitted too much.

19 If you look at the profitability of these  
20 hospitals as far back as your records go and, therefore,  
21 as far back as we can deduce, you'll see that they are  
22 consistently pretty good performers. How good?

23 If you were the Applicant, if you were the  
24 owner, if you were the system that had responsibility for

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1 these, you could very well put together an adjusted cost  
2 per patient day, an adjusted revenue figure that would  
3 show very clearly here's the before and here's the after.

4 You know, I don't have to tell you, but  
5 perhaps the audience doesn't know, that the legislature  
6 has actually asked for this information to be made public  
7 and plans to do so.

8 We can understand to some extent, if price  
9 is a sensitive issue, why, therefore, this application is  
10 being rushed along, why it has to get done now, before  
11 January 1 of 2017, when all of this information, at least  
12 in terms of how the legislature has set things up, will  
13 be public.

14 How do we get expensive? How do we get to  
15 be very, very expensive in this field? There's no simple  
16 answer. Years ago, I was Vice President for Planning at  
17 Yale-New Haven, a long time ago, so long ago we only had  
18 five Vice Presidents, and subsequently was the organizing  
19 first Director of the Faculty Practice Plan.

20 It's nobody's fault. These things are not  
21 -- they don't happen, because of one particular decision,  
22 but we focus on one area for a reason.

23 When I served as in-house counsel for the  
24 Hospital Association, I was irritated at your agency

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1 collecting information about the top 10 compensated  
2 officials, because it was meant to be a source of  
3 secrecy, privacy. Why would you invade my privacy?

4 Even one of the witnesses indicated this  
5 is irrelevant. It's not irrelevant. Here's why it's not  
6 irrelevant.

7 We need all of us. I don't believe  
8 there's anybody in this room, who can say they're  
9 thoroughly exposed to the calamity of medical cost. I'm  
10 on Medicare. I'm not exposed, but there are people, and  
11 you stand for them.

12 That happens to be your challenge. What  
13 do you do with people, who are going to be out of luck  
14 financially, avoiding medical care, not just avoiding  
15 paying the bills, avoiding medical care, who are immobile  
16 for socioeconomic reasons, who might like to go here  
17 instead of there, but don't have a doctor, who is here,  
18 who are not connected? That's really the audience that's  
19 not in the room.

20 There's a second reason. It's a message.  
21 If I tell you, as shown in our attachment eight, that the  
22 top 10, and I know you know this, but the audience may  
23 not know this, you publish every year the total  
24 compensation of the top 10 individuals, whoever they are,

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1 and if I tell you that the compensation of the top 10  
2 individuals at Yale-New Haven is \$15 million a year, you  
3 can do the math.

4 If I tell you that it increases faster  
5 than other hospitals, you can perhaps appreciate what  
6 that looks like, in terms of a message.

7 One group that gets the message are the  
8 doctors. When they discover that paper-pushers are  
9 earning more than they are, it adjusts their relative  
10 cupidity in some cases. Let's put it that way.

11 So here's what attachment eight comes down  
12 to over a nine-year period. If you are with Bridgeport,  
13 you've got a 7.3 percent increase not necessarily in  
14 individual, but the top 10 people, most of whom are the  
15 same.

16 If you were in, oh, let's say Greenwich,  
17 you had 2.8 percent on average. If you were in Lawrence  
18 & Memorial, you had .6 percent on average, .6. If you  
19 were at Yale-New Haven, you had 11.2.

20 I feel like I'm channeling Rob Reiner's  
21 mother in Harry Met Sally, when I say I'll take what  
22 she's having. It's a motivation. It's not the only  
23 motivation, but it's a motivation. It's the American  
24 way. We earn as much as we possibly can.

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1                   So for those three reasons, that more and  
2 more Americans are not insulated, as hopefully all of us  
3 in this room are, that it's a message to others, and that  
4 if you are -- if your mentality with regard to strategic  
5 planning, which is what I teach in Columbia business  
6 school, if your mentality is service, let's do a better  
7 job here, you're going to act in a certain way.

8                   If your mentality is commercial banking,  
9 the ship is not doing too well, let's find someone to  
10 sell it to, you're going to act in a different way.

11                   Let me conclude with just a couple of  
12 items, in terms of these exhibits. My little variation  
13 in Medicare exhibit was criticized and I think in some  
14 ways legitimately so.

15                   This is not a peer-reviewed research  
16 paper. This is from the top 100 DRGs from the MEDPAR  
17 file, some particularly outstanding examples, so that,  
18 for example, on the first page, with septicemia, if you  
19 were at Yale-New Haven in 2013, the average Medicare  
20 payment was \$85,000, and, as the patient, you were on the  
21 hook for 10,000.

22                   At Lawrence & Memorial, you were on the  
23 hook for \$721. I think that makes a difference. If the  
24 Applicants don't think it makes a difference, that may be

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1 revealing, but I think it makes a huge difference,  
2 because the Medicare beneficiary with regard to out-of-  
3 network, out-of-pocket deductibles, co-payments and so  
4 forth is paying more than \$1,000 per hospital discharge,  
5 and when we get to the Comptroller's information, you may  
6 find that of interest, as well, but I don't pretend that  
7 any of this can't be criticized.

8 I'll tell you, looking through the top  
9 100, there was no place where the Applicants were at the  
10 bottom.

11 Finally, I'd like to close by talking a  
12 little about Massachusetts and this attachment, which is  
13 --

14 MS. FELDMAN: I have to object, both on  
15 the basis of time and the relevancy of talking about  
16 Massachusetts.

17 HEARING OFFICER HANSTED: I'll overrule  
18 the objection, in terms of time. Attorney Murray, do you  
19 want to respond, in terms of the relevance of speaking  
20 about Massachusetts?

21 MR. MURRAY: Attorney Hansted, this was  
22 part of our pre-file, Dr. Hyde's pre-file. I can't  
23 remember what exhibit it is. It's attachment six, which  
24 he made reference to, and I think it's just he's just

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1 going to make a brief point, in terms of a study that was  
2 done in Massachusetts. It seems to me that the agency  
3 needs to take information and lessons learned from as  
4 many places as it can.

5 Dr. Hyde is simply going to point that  
6 out, in terms of your staff looking at that particular  
7 exhibit that was attached and the lessons that can be  
8 learned from that. I think it is relevant.

9 MS. FELDMAN: In our supplemental pre-  
10 file, we objected on the same basis, that it was  
11 irrelevant information.

12 There's an enormous amount of irrelevant  
13 and contradictory information being thrown around, and we  
14 addressed all of that in our supplemental. I see no  
15 relevancy to this hearing today.

16 HEARING OFFICER HANSTED: I'm going to  
17 overrule the objection. We'll give it the weight it's  
18 due, Attorney Feldman. Dr. Hyde, please keep this brief.

19 DR. HYDE: Thirty seconds, Mr. Chairman,  
20 and thank you.

21 HEARING OFFICER HANSTED: I'm not a  
22 Chairman, by the way.

23 DR. HYDE: This particular study shows how  
24 the leverage acquired by the Massachusetts

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1 general/partners group has destroyed community hospitals  
2 in Massachusetts. Where did that leverage come from?

3 They've done us a great favor. Their  
4 Attorney General found, and everyone should be armed with  
5 subpoena power, that when you quiz hospitals, what makes  
6 a difference is not how many poor people we have, not how  
7 many residents, not how much research, but how much  
8 leverage we have.

9 This application would give the Yale-New  
10 Haven Health System more leverage by a very large  
11 significant amount, as outlined in the study of monopoly  
12 overlap here, and that's the entirety of our point of  
13 view.

14 If you give them more leverage, they will  
15 use it, and we will all be incrementally poorer, but some  
16 people will be much poorer. Thank you.

17 HEARING OFFICER HANSTED: Thank you.

18 MR. MURRAY: The Intervenors would like to  
19 now call Stephanie Johnson.

20 MS. JOHNSON: Good evening.

21 HEARING OFFICER HANSTED: Good evening.

22 MS. JOHNSON: My name is Stephanie  
23 Johnson, and I'm the President of AFT Connecticut, Local  
24 5051, which represents more than 270 LPN techs at the

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1 Lawrence & Memorial Hospital. I am also a hospital  
2 employee. I work as a polysomnography technologist,  
3 which is just a very fancy way to say sleep tech, and I  
4 am a resident of East Lyme, and I adopt my pre-filed  
5 testimony.

6 HEARING OFFICER HANSTED: Thank you.

7 MS. JOHNSON: You know, it's been very  
8 hard here that nobody really on the Union side is coming  
9 out and saying I'm absolutely against this, or I'm  
10 absolutely for this.

11 As the President of the Union, I've seen  
12 change for good reasons, and I've seen change for the  
13 sake of change, and, you know, our community relies  
14 heavily on the bus route, and we have a lot of people,  
15 who actually walk in on the main streets, which are Ocean  
16 and Montauk and surround on Lawrence & Memorial Hospital.

17 I'm very concerned that these patients  
18 will not be able to get the care that they need from  
19 their community hospitals, should this acquisition take  
20 our community hospital from us.

21 For years, the Unions at the hospitals  
22 have been fighting to keep access to quality service.  
23 It's the reason why we went on strike in 2013, but this  
24 is not a Union versus management issue. This is about

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1 allowing our community to receive the quality care that  
2 we have been delivering for more than 100 years.

3 Decisions that are going to be made about  
4 what care is going to be kept here are going to be made  
5 by Yale. I've read the bylaws. I've seen what it says  
6 about the member and the member substitution, and I can't  
7 be convinced otherwise.

8 I'm very, very concerned that decisions  
9 about what kind of care is going to be kept here at the  
10 main campus or at any other affiliate that Lawrence &  
11 Memorial has is going to be made from people 50 miles  
12 away that don't know what this community is.

13 I'm concerned that duplicate services will  
14 be phased out, since we both are hospitals, and that may  
15 include necessary clinical services that have been  
16 traditionally performed here by L & M.

17 I am very concerned that the profitable  
18 services will be removed or assumed by Yale, which  
19 charges a higher cost than L & M does.

20 There's been a lot of talk about L & M  
21 being in financial distress. L & M Hospital has a  
22 healthy margin and always has. It's the corporation, not  
23 the hospital, that's not doing well.

24 It's because the corporation makes poor

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1 business decisions, draining funds from our hospital; \$17  
2 million for locking out the employees in 2013, \$35  
3 million for buying Westerly Hospital, several million  
4 dollars on a now defunct McKesson electronic medical  
5 record system, and \$20 million per year to LMMG.

6 All of this money could have and should  
7 have been spent on patient care services. A few years  
8 ago, we were told that the purchase of Westerly Hospital  
9 was so that we could stave off being taken over by a for-  
10 profit.

11 Two years later, we were told that we were  
12 going to affiliate with many hospitals in the area to get  
13 this purchase buying power that was going to make it so  
14 that Yale couldn't take us over, and here we are today.

15 So transparency is what we're looking for,  
16 and these are the reasons that I can't support this CON  
17 going forward, as it's currently written.

18 I ask you to take our concerns and get  
19 truthful answers from Yale and L & M about their plans  
20 for continuing care here in New London where the \$300  
21 million is coming from, what it's going to, and what  
22 they're going to do to our little community hospital.  
23 Thank you.

24 HEARING OFFICER HANSTED: Thank you.

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1 MR. MURRAY: I'd like to now call Dr.  
2 Ellen Andrews, who is the Executive Director of the  
3 Connecticut Health Policy Project.

4 DR. ANDREWS: Good evening.

5 HEARING OFFICER HANSTED: Good evening.

6 DR. ANDREWS: I'm Ellen Andrews. I'm the  
7 Executive Director of the Connecticut Health Policy  
8 Project. We are a non-profit, non-partisan organization  
9 advocating for consumers with non-partisan policy  
10 analysis consumer education and assistance and capacity  
11 building, so that I can retire, and I adopt my pre-filed  
12 testimony.

13 HEARING OFFICER HANSTED: Thank you.

14 DR. ANDREWS: We have deep concerns about  
15 this acquisition, this application, for a number of  
16 reasons, both for the health of this community,  
17 especially the underserved, which is a particular  
18 emphasis for the Connecticut Health Policy Project.

19 Medicaid and uninsured and the growing  
20 number of people between those two were underinsured.  
21 The impact on State resources to support underserved  
22 community needs. I've learned that being a consumer  
23 advocate I've had to start to be an advocate for  
24 taxpayers, because the supports that go for the people I

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1 care about come from the general fund, and, if I don't  
2 worry about that, then, the people I care about are not  
3 going to get the resources they need.

4 Consumer choice and access to care, you  
5 can't have patient-centered care when there's only one  
6 option, and questions about the vague promise to invest  
7 \$300 million in this community.

8 First, New London and L & M service area  
9 include many fragile and underserved communities and  
10 residents that would be placed at risk by this  
11 acquisition.

12 Robert Wood Johnson Foundation estimates  
13 that there are 20,598 uninsured residents this year.  
14 That's after the Affordable Care Act and the Medicaid  
15 expansion in New London County and a growing number of  
16 even more people, who are underinsured, people with high  
17 deductibles and cost sharing, who are baring the burden  
18 of costs directly, at least up until thousands of  
19 dollars, and, for many of my clients, it might as well be  
20 a million, so that health care is becoming less and less  
21 affordable.

22 You heard in public comment a little about  
23 L & M's community health needs assessment, a requirement  
24 of the Affordable Care Act, one of the best kept secrets

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1 in the Affordable Care Act. It's required for non-profit  
2 hospitals, and they did include a great deal of data  
3 collection and engaged the community in identifying  
4 priorities.

5 The report found that one in four families  
6 with children in this county are living in poverty,  
7 almost one in three in the city. Asthma, diabetes, rates  
8 are high and even higher for people of color.

9 This was really especially important for  
10 these proceedings, that between six and 14 percent,  
11 depending on the survey, of residents in this area are  
12 already delaying care, because of cost. That's before,  
13 you know, we see higher deductibles and, also, higher  
14 costs, because of an acquisition.

15 It does say that, quote, "The demographic  
16 profile of the L & M service area correlates with a  
17 higher incidence of negative health outcomes," and that's  
18 before -- that's with the wonderful gem that you heard  
19 about already in this community.

20 The community health needs assessment  
21 outlines consensus priority areas for investment,  
22 including asthma, diabetes, tobacco use and health status  
23 and access, particularly around affordability.

24 The plan includes a roadmap for

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1 priorities, including social determinants of health, core  
2 investment issue areas, and access to care, and resources  
3 from that \$300 million would go a long way toward making  
4 a great deal of important contributions to fixing those  
5 problems, but we're hearing that those resources are  
6 going to be decided behind closed doors at a strategic  
7 planning session after this acquisition is already -- the  
8 ink is dry on it, and that's no way to make these  
9 decisions.

10 There already exists a community health  
11 needs assessment, and I think they should follow it. The  
12 decision should be made by communities rather than behind  
13 closed doors.

14 Let's see. New London area residents are  
15 already strapped and cannot afford higher prices for  
16 care, more out of pocket costs. If even more people are  
17 forced to delay, care prices and taxes for all of us will  
18 rise, and that brings me to my second point. We can't  
19 afford it either.

20 The State budget is in very serious  
21 deficit. I'm sure that hasn't escaped any State employee  
22 lately. And, because of that, as a consequence, over  
23 10,000 working parents are going to lose Husky coverage  
24 at the end of this month, in just three weeks. That is

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1 on top of provider cuts, the hospital cuts that you've  
2 heard about.

3 Medicaid has done a lot in the last four  
4 years. I have to say this is not a -- Medicaid has done  
5 a lot in the last four years to improve access to high-  
6 quality care for a rapidly-growing program that now  
7 covers 760,000 people.

8 It has controlled costs, as well. Fewer  
9 people are going to the emergency room for non-urgent  
10 visits. In the first year, after the shift to a care  
11 management system, 32 percent more physicians  
12 participated in the program, which is kind of a miracle  
13 in Medicaid, but costs went down at the same time, down,  
14 not off of trend, but down. They've been trending down  
15 every year for the last four years, but, last year, they  
16 were down 5.9 percent per person. I can't say that  
17 enough.

18 But the levers to do that will be severely  
19 reduced if you allow this market concentration in this  
20 application. There's substantial evidence, and I know  
21 Dr. Hyde has talked about it at length in his testimony,  
22 but that monopolies drive up prices. They do. They just  
23 do. We can't afford 15 percent higher costs.  
24 Individuals can't, businesses can't, and I know the State

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1 can't.

2                   Every time anybody brings up, you know,  
3 we're going to have to pay more for this, we're going to  
4 have to pay more for that at the Capitol, I try to  
5 translate it into how many more Husky parents have to  
6 lose coverage for us to afford whatever it is you want to  
7 do?

8                   I mean I think that's the sort of the  
9 tradeoff we need to think about, is how many people are  
10 going to lose coverage, and how many people aren't going  
11 to be able to afford care and are going to delay it?

12                   And the third piece, Yale-New Haven  
13 mentioned in their media that they are going to invest  
14 \$300 million, some of it in HIT, which sounds like it was  
15 a bad business decision, but they're not going to say  
16 what it's for.

17                   If they want to invest in New London,  
18 their community health needs assessment lays out a really  
19 good roadmap. There are a lot of needs in this  
20 community, and effective solutions are pretty easy to  
21 find. They just need money.

22                   Yale-New Haven must be very clear about  
23 what investments they will be making, how they're going  
24 to make them, who they're going to make them from, and

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1 what they expect, and that should happen now, not later,  
2 behind closed doors, without community input.

3 And taking it from L & M's cash flow is  
4 not a net benefit to this community, and it needs to be  
5 enforceable, and it needs to be accountable to the  
6 community, and it's unfortunate that you're not going to  
7 hear from Maritza Bond about what happened in Windham,  
8 but a lot of promises were made, and they weren't kept,  
9 and that would be a tragic shame, if that happens here.

10 Healthcare costs -- one other piece I  
11 wanted to respond to, the Applicants saying that -- well,  
12 first of all, we heard a lot about clinical  
13 collaborations that are happening now already, before the  
14 acquisition, so I think they need to make a case that  
15 this is really necessary for clinical care.

16 They talked about how it's about value-  
17 based purchasing, and I understand that. That's the  
18 shiny new toy in healthcare right now. We've had a lot  
19 of shiny new toys. It seems every 10 years we get a new  
20 one, but this is the one, and it is driving acquisitions.

21 The problem with this is that it's going  
22 to be extremely difficult to unravel. Unraveling managed  
23 care was hard enough for Husky. Unraveling this I don't  
24 know if we'll be able to, and it is driving -- there's a

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1 lot of pressure to adopt alternative payment models, and  
2 those are about risk sharing, risk going on to provider  
3 networks, large health systems, and this is going to be a  
4 much bigger one, with a lot more members. That's what  
5 this is about.

6 On the other side, acquisition doesn't  
7 guarantee clinical integration. There are plenty of  
8 instances from Connecticut and elsewhere, where there  
9 have been corporate mergers and acquisitions, but, in  
10 fact, healthcare systems still don't talk to each other.  
11 Physicians can't coordinate care any better than they  
12 could before the corporate change. That isn't necessary,  
13 nor is it sufficient, for integration.

14 So I just want you to take a lot of time  
15 and think this through, and maybe this isn't the right  
16 time for this application. Thank you.

17 HEARING OFFICER HANSTED: Thank you.

18 MR. MURRAY: Our last witness is Jason  
19 Pelletier.

20 MR. PELLETIER: My name is Jason  
21 Pelletier. I live in Groton, Connecticut. I'd like to  
22 adopt my pre-filed testimony.

23 Healthcare coverage for me is very  
24 important. I work as a steward. I'm also a cook at

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1 Pfizer. I've been there for about 15 years.

2 Healthcare coverage for us is always about  
3 recurring doctor visits and our prescriptions. We're all  
4 very concerned about having adequate healthcare coverage.  
5 The older people get, the more health issues you get, the  
6 more often you have to go to the hospital, and the more  
7 expensive things get.

8 Currently, we are in contract negotiations  
9 in Local 217. There are also seven other corporate  
10 cafeterias in Connecticut that are operated by Compass,  
11 including our brothers and sisters at Electric Boat.

12 We pay currently 20 percent of our  
13 premiums and are trying to reduce that percentage at the  
14 bargaining table. The cost of employees' shares went up  
15 by about 10 percent last October.

16 That means that everyone who had coverage  
17 had a big bite taken out of the raises that they had  
18 negotiated at the bargaining table.

19 We have a really good healthcare plan and  
20 have fought really hard to keep the costs down, but I  
21 have co-workers, who are uninsured, or they're on State  
22 assistance, they also have children, because they can't  
23 afford the premiums.

24 Before I talk about Yale taking over the

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1 hospital at L & M, I want to tell you how hard our Union  
2 works to keep the costs down of our healthcare plan.

3 Our Unite Here Health is run jointly by  
4 our Union and by our employers in our industries.  
5 Workers in our Union take leave from their jobs for  
6 several weeks to educate our co-workers about keeping  
7 costs down on their own; not going to the emergency room  
8 for colds and things of that nature.

9 As a steward, I'm trained to help my co-  
10 workers use their healthcare the right way and to help  
11 them connect with our healthcare plan if they have any  
12 problems. We have healthcare coordinators that are very,  
13 very helpful in that regard, but that won't matter if  
14 prices for hospitals and doctors go up, because Yale  
15 takes over.

16 Even if we convince our employer to lower  
17 the percentage of the premiums that we do pay, if the  
18 care, itself, gets more expensive, the premiums will go  
19 up, and we'll be paying what we paid before.

20 Please stop this takeover, or, if it is  
21 approved, make Yale-New Haven guarantee in writing that  
22 they won't raise prices.

23 We don't make a lot of money. I make  
24 about \$16.44 an hour, and I'm one of the better paid

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1 people where I work.

2 I'm fortunate to have a full-time hour job  
3 and a steady paycheck, but none of us can afford to pay  
4 more for healthcare. Affordable healthcare insurance has  
5 always been important, but where I'm at in my life now I  
6 can't afford to do without it. Thank you very much for  
7 your time.

8 HEARING OFFICER HANSTED: Thank you.

9 MR. MURRAY: Attorney Hansted, that  
10 concludes our testimony.

11 HEARING OFFICER HANSTED: Okay, thank you.  
12 It's getting late, so, at this point, we are going to  
13 stop the hearing. We'll continue it for a date to be  
14 set, about two weeks out.

15 For those members of the public, we will  
16 post a new date on OHCA's website, and we'll work with  
17 the Applicants and the Intervenors on the new date.

18 Attorney Feldman, did you have something?

19 MS. FELDMAN: Yes. With respect to this  
20 document that was --

21 HEARING OFFICER HANSTED: We're not  
22 accepting it tonight.

23 MS. FELDMAN: Okay, so, if this is going  
24 to be presented at the next hearing date, we'd like to

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1 receive it at least a week before, so that we could  
2 understand what this document is, where it came from,  
3 unless Attorney Murray can tell us now whether you got  
4 that from Comptroller Lembo directly.

5 MR. MURRAY: Well I didn't get it from  
6 Comptroller Lembo, but members of the Intervenors did  
7 receive it directly from --

8 MS. FELDMAN: Without a Freedom of  
9 Information request?

10 MR. MURRAY: I don't know whether it was a  
11 Freedom of Information request or not.

12 MS. FELDMAN: Okay, because my law office  
13 has done several Freedom of Information requests, and we  
14 have not received any documents, whatsoever, so I'm  
15 curious to know how this was obtained.

16 MR. MURRAY: Well I just told you that it  
17 was obtained directly from the Comptroller's office. I  
18 don't know whether it would be responsive to the Freedom  
19 of Information request that you made or not, because I  
20 haven't seen what your Freedom of Information requests  
21 are.

22 MS. FELDMAN: Can you tell me when you  
23 received it, or how current this is?

24 MR. MURRAY: Well it's clearly after that

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1 time period that's there. That particular document, I  
2 don't have it in front of me, but, from memory, it takes  
3 a look at the payments at Yale-New Haven Hospital and  
4 Lawrence & Memorial for inpatient and outpatient  
5 procedures for the one-year period from May 1, 2014 to  
6 April 30, 2015, and then paid through July 31, 2015, so,  
7 clearly, the information was compiled after July 31,  
8 2015.

9 MS. FELDMAN: But we don't know whether  
10 there's any subsequent modifications to the document,  
11 whether the document is accurate or not.

12 HEARING OFFICER HANSTED: Well let's hold  
13 the discussion on this document for the next hearing. At  
14 the next hearing, will you have the individual, who  
15 obtained the information?

16 MR. MURRAY: Yes, I will.

17 HEARING OFFICER HANSTED: Okay, so,  
18 Attorney Feldman, you can examine the individual, who  
19 obtained the document, at that time.

20 MS. FELDMAN: I need to receive this prior  
21 to the hearing, so I can analyze the information and have  
22 an opportunity --

23 HEARING OFFICER HANSTED: This particular  
24 document that you have in your hand?

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1 MS. FELDMAN: Right.

2 HEARING OFFICER HANSTED: Would you like  
3 to keep that copy?

4 MS. FELDMAN: No, no, no, no. I need to  
5 understand the context in which this document was  
6 derived, what data they used, when they got the data. We  
7 can't just look at one piece of paper, based on the  
8 entire State employee population.

9 MR. MURRAY: But this is not the entire  
10 State employee population. That is probably well over a  
11 couple hundred thousand people. This is admittedly a  
12 small sample. This is just --

13 MS. FELDMAN: Exactly.

14 MR. MURRAY: -- State employees. Let me  
15 finish. These are State employees, who have received  
16 those particular services at Yale-New Haven Hospital or  
17 Lawrence & Memorial Hospital in that one year period of  
18 time and for which payment was made by July 31st, so it's  
19 clearly not a sample of every of the several hundred  
20 thousand insured lives that the State of Connecticut  
21 employees that the State pays for that coverage.

22 MS. FELDMAN: Is it a sample of every  
23 State employee that received care at Yale-New Haven  
24 Hospital and every State employee that received care at

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1 Lawrence & Memorial Hospital?

2 Just like the DRGs were cherry picked, I'd  
3 like to know whether these were cherry picked, also.

4 MR. MURRAY: My understanding is that it  
5 is all of the State employees, who received those  
6 particular services at those two hospitals during that  
7 one-year period of time.

8 HEARING OFFICER HANSTED: But, again,  
9 we're not going to know until the individual, who  
10 obtained the information, is here to testify under oath  
11 how he or she obtained the information.

12 MR. MURRAY: And that may not satisfy  
13 Attorney Feldman, because --

14 MS. FELDMAN: Correct.

15 MR. MURRAY: -- it sounds like she wants  
16 to ask the Comptroller to be part of these proceedings.

17 MS. FELDMAN: Well I'd rather not have  
18 this information introduced at this late date anyway. I  
19 mean there was plenty of time to submit pre-filed  
20 testimony. There was rebuttal to our pre-filed  
21 testimony, and it's being introduced now in the abstract,  
22 plucked out of the air.

23 MR. MURRAY: And I provided it. I  
24 received it this morning.

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1 MS. FELDMAN: Yeah, well, I also received  
2 the pre-file.

3 HEARING OFFICER HANSTED: She has --

4 MR. MURRAY: I absolutely understand the  
5 point.

6 HEARING OFFICER HANSTED: Of course,  
7 Attorney Feldman, you understand the position I'm in.

8 MS. FELDMAN: Right.

9 HEARING OFFICER HANSTED: I don't have the  
10 individual here to question, he or she.

11 MS. FELDMAN: Well I'm asking the  
12 intervenors, if they plan on presenting this at the next  
13 hearing, then, prior to that hearing, at least a couple  
14 of days before, they should substantiate, you know, we  
15 should have access to the person that provided the data,  
16 so we could ask questions and appropriately comprehend  
17 the context in which this document is derived.

18 HEARING OFFICER HANSTED: You want access  
19 to the individual outside of the hearing before the next  
20 hearing?

21 MS. FELDMAN: That would be fine. If it's  
22 the Comptroller, yes. Is that what you're saying?

23 MR. MURRAY: No. I think we're saying two  
24 different things. My understanding is that the Hearing

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1 Officer would like the person, who received this document  
2 from the Comptroller, to testify about how they got it  
3 from the Office of the State Comptroller.

4 HEARING OFFICER HANSTED: If it's  
5 admitted, I want it properly admitted.

6 MR. MURRAY: Right. Right. So if they --

7 MS. FELDMAN: But I --

8 MR. MURRAY: Let me finish. If they got a  
9 business record from the Comptroller that was handed to  
10 them and they, in turn, want to proffer it to the  
11 hearing, that establishes the chain of custody and  
12 authenticates that the document was provided to that  
13 individual by the Comptroller.

14 I hear the Applicant saying something  
15 quite different, which they simply want to inquire about  
16 the underlying data. I don't represent the Comptroller.  
17 I can't produce the Comptroller to talk about that.

18 MS. FELDMAN: Well it would also be  
19 helpful if we could have attachment eight, which was not  
20 included in the pre-filed testimony. It was just  
21 referenced tonight by Dr. Hyde.

22 MR. MURRAY: That's actually not accurate.  
23 If you take a look at the pre-filed testimony, the eight,  
24 it was supplied.

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1 MS. FELDMAN: We don't have it.

2 MR. MURRAY: Oh. You do have a nine,  
3 correct?

4 MS. FELDMAN: Yes.

5 MR. MURRAY: Right. Nine is eight.

6 MS. FELDMAN: Oh. Thank you.

7 HEARING OFFICER HANSTED: It's just mis-  
8 numbered.

9 MS. FELDMAN: Okay.

10 HEARING OFFICER HANSTED: So the question  
11 remains what do we do about this document?

12 MS. FELDMAN: Well we're objecting to it  
13 being entered into the record.

14 HEARING OFFICER HANSTED: It hasn't been  
15 entered into the record.

16 MS. FELDMAN: Potentially.

17 HEARING OFFICER HANSTED: Potentially.

18 MS. FELDMAN: So if the person that  
19 received this document comes to the hearing, the next  
20 scheduled hearing, presumably, you're going to admit it  
21 into the record, if all you need to prove is a chain of  
22 custody.

23 HEARING OFFICER HANSTED: If it can be  
24 properly admitted.

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1 MR. MURRAY: I mean, essentially, they're  
2 asking to authenticate the document, so it can be  
3 properly admitted.

4 HEARING OFFICER HANSTED: Correct.

5 MR. MURRAY: If what Attorney Feldman  
6 wishes us to do is to provide, for example, prior to the  
7 hearing an affidavit to both the Hearing Officer and to  
8 the Applicant's counsel from the individual, who got the  
9 document from the Comptroller's office, laying out  
10 exactly what happened, so that it's no mystery, I mean,  
11 obviously, it's not at the hearing, but a sworn affidavit  
12 about how that came, I don't know if that would satisfy  
13 their objection.

14 MS. FELDMAN: We object to this exhibit,  
15 whatever document this is. We don't know whether it  
16 represents more than one payer, whether it represents a  
17 mixture of governmental payers, plus commercial  
18 insurance.

19 There are State employees that have  
20 multiple types of insurance. It's very inaccurate  
21 information.

22 HEARING OFFICER HANSTED: I understand  
23 what you're saying. Where was this extrapolated from?

24 MS. FELDMAN: Right.

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1 HEARING OFFICER HANSTED: Now the  
2 individual, who received this, would they know how this  
3 was extrapolated?

4 MR. MURRAY: I think the only thing that  
5 they can testify to is what they were told by Comptroller  
6 Lembo.

7 MS. FELDMAN: Are you saying that the  
8 Comptroller prepared this document?

9 MR. MURRAY: I don't know who prepared it.  
10 They got it from the Office of the Comptroller.

11 HEARING OFFICER HANSTED: Well here's what  
12 we're going to do. I won't rule on any objection at this  
13 time. The objection will stand. I want the individual,  
14 who received this document, to be present at the next  
15 hearing, and then I'll rule on Attorney Feldman's  
16 objection at that time.

17 MR. MURRAY: Okay.

18 MS. FELDMAN: I mean it would be very  
19 helpful if the person that generated this information or  
20 this document would be in attendance at the hearing,  
21 otherwise, the person that received the document is not  
22 going to be able to respond to any questions we may have  
23 about the accuracy of the data.

24 HEARING OFFICER HANSTED: That's correct,

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1 and that's up to Attorney Murray to make sure he can get  
2 this properly admitted and that it can be Cross-Examined  
3 with respect to how the information was calculated,  
4 because, to me, I agree with Attorney Feldman, that,  
5 looking at this document, I don't know where it's derived  
6 from.

7 MR. MURRAY: I understand that.

8 HEARING OFFICER HANSTED: Aside from you  
9 saying that it came from the Comptroller's Office.  
10 That's fine to know who generated it, but what  
11 information was it generated from, and how was this  
12 information calculated from the original database?

13 MS. FELDMAN: I mean, frankly, I don't  
14 think this should be given any greater weight than public  
15 testimony at this point.

16 HEARING OFFICER HANSTED: And it may not.  
17 Again, I'm not accepting the document at this time. We  
18 will discuss it further at the next hearing, when we  
19 actually have an individual here to question.

20 MS. FELDMAN: Okay, thank you.

21 HEARING OFFICER HANSTED: I don't want to  
22 further question Attorney Murray on this document when  
23 he's not the one who produced it.

24 MS. FELDMAN: Thank you.

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1 HEARING OFFICER HANSTED: Okay. And  
2 before we adjourn, is there anyone here from the members  
3 of the public that would like to give comment on either  
4 of the applications before us? Okay. Hearing and seeing  
5 none, counsel, did you have another comment?

6 MS. FELDMAN: The question really pertains  
7 to the second application. Are we going to be hearing  
8 the second application at the next hearing date or  
9 tonight?

10 HEARING OFFICER HANSTED: I think we  
11 should hear the second application at the next hearing  
12 date, just so we can keep the two separate.

13 MS. FELDMAN: Okay.

14 HEARING OFFICER HANSTED: For our  
15 purposes, because I want to have the Cross-Examination,  
16 whoever has Cross-Examination on this application we  
17 heard tonight, we'll start with that.

18 MS. FELDMAN: Okay.

19 HEARING OFFICER HANSTED: Okay? Then we  
20 will hear the second application, Cross-Examination, and  
21 then OHCA will do its questions after that is completed.

22 MS. FELDMAN: Okay.

23 HEARING OFFICER HANSTED: Okay. Hearing  
24 and seeing no one that wants to give additional public

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1 comment, I will adjourn this hearing until the next  
2 hearing date. Thank you, all.

3 MS. FELDMAN: Thank you.

4 (Whereupon, the hearing adjourned at 8:56  
5 p.m.)

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75:10 75:15	75:15			
84:17				
<b>years</b> [30]	13:22			
14:20 18:5	23:17			
23:20 24:16	26:23			
26:24 27:13	28:9			
30:1 31:12	36:10			
40:11 41:15	42:14			
43:17 47:2	47:8			
58:21 61:16	68:21			
69:2 70:7	70:11			
75:4 75:5	75:15			
77:19 79:1				
<b>yet</b> [1]	58:9			
<b>York</b> [1]	59:19			
<b>young</b> [1]	17:2			
<b>yourself</b> [1]	12:2			
<b>yourselves</b> [3]	4:18			
7:20 8:17				

## CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore 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, this 18th day of July, 2016.



Paul Landman  
President

**Post Reporting Service**  
**1-800-262-4102**

## Olejarz, Barbara

---

**From:** Olejarz, Barbara  
**Sent:** Friday, July 22, 2016 1:29 PM  
**To:** 'hfmurray@lapm.org'; 'Rosenthal, Nancy'; 'jfeldman@goodwin.com'  
**Cc:** Martone, Kim; Lazarus, Steven; Hansted, Kevin; Riggott, Kaila  
**Subject:** information for July 26th hearing  
**Attachments:** 15-32032 & 15-32033 Combined Agenda continuation.doc; 32032 table continuation.doc; 32033 table continuation.doc

<b>Tracking:</b>	<b>Recipient</b>	<b>Delivery</b>	<b>Read</b>
	'hfmurray@lapm.org'		
	'Rosenthal, Nancy'		
	'jfeldman@goodwin.com'		
	Martone, Kim	Delivered: 7/22/2016 1:29 PM	Read: 7/22/2016 2:06 PM
	Lazarus, Steven	Delivered: 7/22/2016 1:29 PM	Read: 7/22/2016 1:51 PM
	Hansted, Kevin	Delivered: 7/22/2016 1:29 PM	
	Riggott, Kaila	Delivered: 7/22/2016 1:29 PM	

7/22/16

Attached is information for next week's continuation hearing.

Barbara K. Olejarz  
Administrative Assistant to Kimberly Martone  
Office of Health Care Access  
Department of Public Health  
Phone: (860) 418-7005  
Email: [Barbara.Olejarz@ct.gov](mailto:Barbara.Olejarz@ct.gov)





**STATE OF CONNECTICUT**  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

**TENTATIVE AGENDA**

**Docket Number: 15-32033- CON - Yale New Haven Health Services Corporation  
L+M Corporation, Acquisition of Lawrence + Memorial Corporation by Yale New Haven  
Health Services Corporation**

**And**

**Docket Number: 15-32032-CON - Northeast Medical Group, Inc. L&M Physician  
Association, Inc., Acquisition of L&M Physician Association, Inc. by Northeast Medical  
Group**

**July 26, 2016 at 3:00 p.m. (continued from July 11, 2016)**

- I. Convening of the Public Hearing**
- II. Docket Number: 15-32033-CON**
  - B. Applicant and Intervenors cross-examination**
- III. Docket Number: 15-32032-CON**
  - A. Applicant and Intervenors Direct Testimony**
  - B. Applicant and Intervenors cross-examination**
- IV. OHCA's questions**
- V. Public Comment**
- VI. Closing Remarks**
- VII. Public Hearing Adjourned**

*An Equal Opportunity Provider*

*(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)*

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308  
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov



**STATE OF CONNECTICUT**  
 DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

**TABLE OF THE RECORD**

**APPLICANT:** Yale New Haven Health Services Corporation  
 Lawrence+Memorial Corporation

**DOCKET NUMBER:** 15-32033-CON

**PUBLIC HEARING:** July 26, 2016 at 3:00 p.m. (continued from July 11, 2016)

**PLACE:** Holiday Inn New London – Mystic Area  
 35 Governor Winthrop Boulevard – Ballroom  
 New London, CT 06320

EXHIBIT	DESCRIPTION
<b>A</b>	Letter from Yale New Haven Health Services Corporation and L+M Corporation (Applicants) dated October 7, 2015 enclosing the Certificate of Need (CON) application for the Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation under Docket Number 15-32033, received by OHCA on October 7, 2015. (602 Pages)
<b>B</b>	Letters of support in the matter of the CON application filed under Docket Number 15-32033, received by OHCA on various dates. (4 pages)
<b>C</b>	OHCA's letter to the Applicants dated November 6, 2015, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 15-32033.(9 Pages)
<b>D</b>	Designation letter dated December 16, 2015 of Hearing Officer in the matter of the CON application under Docket Number 15-32033. (1 page)
<b>E</b>	Applicants responses to OHCA's letter of November 6, 2015, dated January 5, 2016 in the matter of the CON application under Docket Number 15-32033, received by OHCA on January 5, 2016. (262 Pages)
<b>F</b>	Legislative letters in the matter of the CON application filed under Docket Number 15-32033, received by OHCA on January 5 and 8, 2016. (4 pages)
<b>G</b>	Applicants' letter dated January 8, 2016 enclosing additional completeness responses in the matter of the CON application filed under Docket Number 15-32033. Received by OHCA on January 8, 2016. (62 pages)
<b>H</b>	Letter from Senator Looney dated January 6, 2016 in the matter of the CON application filed under Docket Number 15-32033. Received by the Department of Public Health on January 11, 2016. (2 pages)

*An Equal Opportunity Provider*

*(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)*  
 410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308  
 Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

<b>I</b>	The Department of Public Health's response to Senator Looney's letter of January 6, 2016, dated January 14, 2016, in the matter of the CON application filed under Docket Number 15-32033. (2 pages)
<b>J</b>	OHCA's letter to the Applicants dated January 19, 2016 requesting electronic copies of financial worksheets and Applicants response dated January 21, 2016 enclosing requested financial worksheets in the matter of the CON application filed under Docket Number 15-32033. (6 pages)
<b>K</b>	OHCA's letter to the Applicants dated February 4, 2016, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 15-32033.(5 Pages)
<b>L</b>	Legislative letter to DPH and OAG dated January 29, 2016 in the matter of the CON application under Docket Number 15-32033. Received by OHCA on February 3, 2016.(2 Pages)
<b>M</b>	DPH response to January 29, 2016 legislative letter dated February 10, 2016 in the matter of the CON application under Docket Number 15-32033. (2 pages)
<b>N</b>	Letter from the Applicants dated March 3, 2016 informing OHCA that in light of Governor Malloy's Executive Order No. 51, that they plan to proceed, within the applicable statutory and regulatory framework to complete the CON process as it relates to the application in the matter of the CON application under Docket Number 15-32033. Received by OHCA on March 3, 2016. (3 pages)
<b>O</b>	Applicants' letter dated March 16, 2016 to OHCA regarding additional materials requested by OHCA in the matter of the CON application under Docket Number 15-32033. Received by OHCA on March 16, 2016. (262 pages)
<b>P</b>	Applicants's letter to OHCA dated March 30, 2016 enclosing responses to 2 <sup>nd</sup> set of completeness questions in the matter of the CON application under Docket Number 15-32033. Received by OHCA on March 16, 2016. (13 pages)
<b>Q</b>	OHCA's letter to the Applicants dated May 10, 2016 deeming the application complete in the matter of the CON application filed under Docket Number 15-32033. (1 page)

<b>R</b>	OHCA's request for legal notification in <i>The Day</i> of OHCA's Notice to the Applicants of the public hearing scheduled for June 15, 2016, in the matter of the CON application under Docket Number 15-32033, dated May 11, 2016. (4 pages)
<b>S</b>	OHCA's request for legal notification in <i>The Day</i> of OHCA's Notice to the Applicants of the public hearing rescheduled for June 27, 2016, in the matter of the CON application under Docket Number 15-32033, dated June 2, 2016. (4 pages)
<b>T</b>	OHCA's letter to the Applicants dated June 14, 2016 requesting prefile testimony and enclosing issues in the matter of the CON application under Docket Number 15-32033. (4 pages)
<b>U</b>	Coalition Petition for Intervenor Status dated June 17, 2016 in the in the matter of the CON application under Docket Number 15-32033, received by OHCA on June 22, 2016. (2 pages)
<b>V</b>	OHCA's request for legal notification in <i>The Day</i> of OHCA's Notice to the Applicants of the public hearing rescheduled for July 11, 2016, in the matter of the CON application under Docket Number 15-32033, dated June 22, 2016. (4 pages)
<b>W</b>	Applicants letter to OHCA dated June 22, 2016 enclosing Notice of Appearance, Objection to the Coalitions's request for Intervenor status and certification that documents have been provided to Coalition attorney, in the matter of the CON application under Docket Number 15-32033, received by OHCA on June 22, 2016. (5 pages)
<b>X</b>	OHCA's Ruling on the Petition of the Coalition to be granted intervenor status in the matter of the CON application under Docket Number 16-32033, dated June 23, 2016. (3 pages)
<b>Y</b>	OHCA's letter to the Applicants dated June 23, 2016 enclosing ORDER for filing the pre-file testimony in the matter of the CON application under Docket Number 16-32033, dated June 23, 2016. (1 page)
<b>Z</b>	Letter from the Applicants to OHCA enclosing Prefile Testimony and responses to issues dated July 1, 2016 in the matter of the CON application under Docket Number 16-32033, received by OHCA on July 1, 2016. (186 pages)
<b>AA</b>	Letter from the Intervenor to OHCA enclosing Prefile Testimony dated July 1, 2016 in the matter of the CON application under Docket Number 16-32033, received by OHCA on July 1, 2016. (155 pages)
<b>BB</b>	Letter from the Applicants to OHCA dated July 6, 2016 enclosing supplemental prefiled testimony rebutting prefile testimony of Fred Hyde on behalf of the intervenors in the matter of the CON application under Docket Number 16-32033, received by OHCA on July 6, 2016. (15 pages)
<b>CC</b>	Letter from the Intervenor to OHCA dated July 6, 2016 responding to Applicants' prefile in the matter of the CON application under Docket Number 16-32033, received by OHCA on July 6, 2016. (5 pages)
	<b>The following came in after table was completed</b>

<b>DD</b>	Letter from the Applicant to OHCA dated July 8, 2016 noticing the appearance of Jennifer Willcox in the matter of the CON application under Docket Number 15-32033, received by OHCA on July 8, 2016. (2 pages)
<b>EE</b>	Letter from the Intervenor dated July 11, 2016 enclosing prefile testimony of Maritza Bond in the matter of the CON application under Docket Number 15-32033, received by OHCA on July 1, 2016. (4 pages)
<b>FF</b>	Testimony of Universal Health Care foundation of Connecticut dated July 11, 2016 in the matter of the CON application under Docket Number 15-32033, received by OHCA on July 11, 2016. (2 pages)
<b>GG</b>	Letters from the public in the matter of the CON application under Docket Number 15-32033. (6 pages)
<b>HH</b>	Public Testimonies in the matter of the CON application under Docket Number 15-32033. (7 pages)
<b>II</b>	Department of Public Healths responses to Senators Formica and Looney dated July 15, 2016 in the matter of the CON application under Docket Number 15-32033 (2 pages)
<b>JJ</b>	Hearing Transcript from the July 11, 2016 hearing in the matter of the CON application under Docket Number 15-32033. Received by OHCA on July 19, 2016 (109 pages)



**STATE OF CONNECTICUT**  
 DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

**TABLE OF THE RECORD**

**APPLICANT:** Northeast Medical Group, Inc.  
 L&M Physician Association, Inc

**DOCKET NUMBER:** 15-32032-CON

**PUBLIC HEARING:** July 26, 2016 at 3:00 p.m. (continued from July 11, 2016)

**PLACE:** Holiday Inn New London – Mystic Area  
 35 Governor Winthrop Boulevard – Ballroom  
 New London, CT 06320

EXHIBIT	DESCRIPTION
<b>A</b>	Letter from Yale New Haven Health, Northeast Medical Group, Inc. and L& M Physician Association, Inc. (Applicants) dated October 7, 2015 enclosing the Certificate of Need (CON) application for the merger of L&M Physician Association, Inc. with and into Northeast Medical Group, Inc. under Docket Number 15-32032, received by OHCA on October 7, 2015.(211 Pages)
<b>B</b>	Various letters of in the matter of the CON application filed under Docket Number 15-32032, received by OHCA on various dates. (33 pages)
<b>C</b>	OHCA's letter to the Applicants dated November 6, 2015, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 15-32032.(2 Pages)
<b>D</b>	Applicants responses to OHCA's letter of November 6, 2015, dated January 5, 2016 in the matter of the CON application under Docket Number 15-32032, received by OHCA on January 5, 2016. (22 Pages)
<b>E</b>	OHCA's letter to the Applicants dated February 1, 2016, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 15-32032.(2 Pages)
<b>F</b>	Applicants letter to OHCA dated March 2, 2016 informing OHCA of its plans in light of Executive Order No. 51, received by OHCA on March 2, 2016. (3 pages)
<b>G</b>	Applicants responses to OHCA's letter of February 1, 2016, dated March 30, 2016 in the matter of the CON application under Docket Number 15-32032, received by OHCA on March 30, 2016. (26Pages)

<b>H</b>	OHCA's letter to the Applicants dated May 10, 2016 deeming the application complete in the matter of the CON application filed under Docket Number 15-32032. (1 page)
<b>I</b>	OHCA's request for legal notification in <i>The Day</i> of OHCA's Notice to the Applicants of the public hearing scheduled for June 15, 2016, in the matter of the CON application under Docket Number 15-32032, dated May 11, 2016. (4 pages)
<b>J</b>	OHCA's request for legal notification in <i>The Day</i> of OHCA's Notice to the Applicants of the public hearing rescheduled for June 27, 2016, in the matter of the CON application under Docket Number 15-32032, dated June 2, 2016. (4 pages)
<b>K</b>	OHCA's letter to the Applicant dated June 14, 2016 requesting prefile testimony and enclosing issues in the matter of the CON application under Docket Number 15-32032. (43pages)
<b>L</b>	Letter from AFT Connecticut, Connecticut Citizen Action Group, UNITE HERE Connecticut, National Physicians Alliance in Connecticut, Connecticut Health policy Project, United Action Connecticut, and New England Health Care Employees, District 1199, SEIU ("Petitioners") to OHCA dated June 17, 2016 requesting intervenor Status in the matter of the CON application under Docket Number 15-32032, received by OHCA on June 17, 2016. (152 pages)
<b>M</b>	OHCA's request for legal notification in <i>The Day</i> of OHCA's Notice to the Applicants of the public hearing rescheduled for July 11, 2016, in the matter of the CON application under Docket Number 15-32032, dated June 22, 2016. (4 pages)
<b>N</b>	Letter from the Applicants to OHCA dated June 22, 2016 enclosing Notice of Appearance of Shipman & Goodwin, Objection to the Coalitions request for full intervenor status and certification of the documents have been provided to the Coalition's attorney in the matter of the CON application under Docket Number 15-32032, received by OHCA on June 22, 2016. (5pages)
<b>O</b>	OHCA's Ruling on the Petition of the Coalition to be granted intervenor status with full rights in the matter of the CON application under Docket Number 15-32032, dated June 23, 2016. (2 pages)
<b>P</b>	OHCA's letter dated June 23, 2016 to the Applicants enclosing an ORDER regarding filing of Prefile testimony in the matter of the CON application under Docket Number 15-32032. (1 page)
<b>Q</b>	Designation of Hearing Office in the in the matter of the CON application under Docket Number 15-32032, dated June 24, 2016. (1 page)
<b>R</b>	Letter from the Applicants to OHCA dated July 1, 2016 enclosing Prefile Testimony and responses in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 1, 2016. (42pages)

<b>S</b>	Letter from the Intervenor to OHCA dated July 1, 2016 enclosing Prefile Testimony in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 1, 2016. (155 pages)
<b>T</b>	Letter from the Applicants to OHCA dated July 6, 2016 enclosing supplemental prefile testimony rebutting prefile testimony of Fred Hyde on behalf of the Intervenor in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 6, 2016. (15 pages)
<b>U</b>	Letter from the Intervenor to OHCA dated July 6, 2016 enclosing response to the prefile testimony of Dr. Monical Noether in the in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 6, 2016. (6 pages)
	<b>The following came in after table was completed for hearing held on July 11, 2016</b>
<b>V</b>	Letter from the Applicant to OHCA dated July 8, 2016 noticing the appearance of Jennifer Willcox in the in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 8, 2016. (2 pages)
<b>W</b>	Letter from the Intervenor to OHCA dated July 11, 2016 enclosing prefile testimony of Maritza Bond in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 11, 2016. (8 pages)
<b>X</b>	Testimony of Universal Health Care dated July 11, 2016 in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 11, 2016. (2 pages)
<b>Y</b>	Letter from Senator Looney dated July 7, 2016 in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 8, 2016.(1 page)
<b>Z</b>	Letters from the public in the matter of the CON application under Docket Number 15-32032. (6 pages)
<b>AA</b>	Responses to Senators Looney and Formica in the matter of the CON application under Docket Number 15-32032. (2 pages)
<b>BB</b>	Hearing Transcript from the July 11, 2016 hearing in the matter of the CON application under Docket Number 15-32032. Received by OHCA on July 19, 2016 (109 pages)

## Greer, Leslie

---

**From:** Lazarus, Steven  
**Sent:** Thursday, July 28, 2016 3:47 PM  
**To:** hfmurray@lapm.org; Feldman, Joan (JFeldman@goodwin.com); Carannante, Vincenzo (VCarannante@goodwin.com)  
**Cc:** Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Carney, Brian; Ciesones, Ron  
**Subject:** List Of Late Files Requested by OHCA, DNs 15-32033 & 15-32032  
**Attachments:** List Of Late Files Requested by OHCA.docx

Good Afternoon,

Please see the attached document that was created to help clarify the Late Files dues and other hearing related materials in the above referenced dockets. Please feel free to contact Brian, Ron or myself, if you have any questions at 860-418-7001.

Thank you,

Steve

*Steven W. Lazarus*

Associate Health Care Analyst  
Division of Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, CT 06134  
Phone: 860-418-7012  
Fax: 860-418-7053





## Office of Health Care Access

**Public Hearing held on July 11 & 26, 2016**

**Docket Numbers: 15-32032 & 15-32033**

**Late Files Requested by OHCA**

- **Late File # 1:** A list of additional services, specialists and/or sub-specialists added / recruited to the L&M service area (post-merger). [DN- 15-32032]
- **Late File # 2:** A list of L&M /commercial payer contracts and the expiration dates of said contracts. [DN- 15-32033]
- **Late File # 3:** Submit separate forms for year- to-date (YTD) actual results through June 2016 for L+M Health System, Lawrence + Memorial Hospital (*hospital only and consolidated*) and Yale-New Haven Health System. Use the same format as used previously a Financial Attachment A of the original application. [DN- 15-32032 & DN- 15-32033 ]
- **Late File # 4:** Provide separate YTD Financial Measurement Indicators through June 2016 for L+M Health System, Lawrence + Memorial Hospital and Yale-New Haven Health System in the same format as previously submitted on page 602 (and resubmitted on page 863) of the application which includes amounts for the prior year time period (June 2016.) [DN- 15-32033]
- **Late File # 5:** A copy of L+M Hospital's most recent DPH licensing survey (July 13, 2016) and all communication between L+M Hospital and DPH regarding said survey. [DN- 15-32033]

### **Due Dates:**

1. All late files are due no later than August 5, 2016.
2. Applicants Objection in writing to OHCA's taking Administrative Notice of Exhibits KK (Letter from State of Connecticut Comptroller, Kevin Lembo), and Exhibit LL (the Milliman Analysis), due no later than July 29, 2016.
3. Intervenors' response to the Applicants Objection to OHCA taking Administrative Notice of Exhibits KK and LL, due not later than August 5, 2016.

**GENERAL PUBLIC**

(Only persons speaking as general public must put their names on this list)

**PUBLIC HEARING-SIGN UP SHEET**

July 26, 2016 (continued from July 11, 2016)

3:00 p.m.

PRINT NAME	Representing Organization (If applicable) or Self
Peg. Cortin.	Self
USA D'Abrosio ↳ Victoria Lopez ↳ Krista Pears	ATT local 5049
<del>Tom Sweet (duplicate)</del>	CCHG
Daniel Kilborn	Self 2 Benefit of Christina Chapman

General Public: Anyone not associated with the Applicants, Intervenor or Elected/Public Officials



Office of Health Care Access

Public/Elected Officials

(Only elected/appointed officials making a statement)

PUBLIC HEARING-SIGN UP SHEET

July 26, 2016 (continued from July 11, 2016)

3:00 p.m.

Docket Number: 15-32032-CON

Northeast Medical Group, Inc. L&M Physician Association, Inc.

Acquisition of L&M Physician Association, Inc. by Northeast Medical Group

PRINT NAME	Phone	Email	Public/Appointed Office Name
Ernest Hewett	800-460-9768	epartney@acl.com	State Rep.
<del>Barbara Moran</del>	<del>800-460-9768</del>	<del>nmoran@mcg.com</del>	<del>City Council</del>
John Saffi	860-287-0531	jsaffi@osad.com	City Council



*Office of Health Care Access*

**GENERAL PUBLIC**

(Only persons speaking as general public must put their names on this list)

**PUBLIC HEARING-SIGN UP SHEET**

July 26, 2016 (continued from July 11, 2016)

3:00 p.m.

Docket Number: 15-32033-CON Yale New Haven Health Services Corporation L+M Corporation Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation	PRINT NAME
Representing Organization (If applicable) or Self	Ken Rowland
U.A.W. -	Sue Corrice (READ BY MITCH ROSS)
Riverview Children's Center	+ Ken Rowland Ann Pratt (Reading for Susan Goldman)
AFSCME	NEWMAN, MARSHUS
BRIDGEBOROUGH DISTRICT BOARD	? MITCH ROSS (DUPLICATE)
L+M, V.P. AHT Local 5051	

**GENERAL PUBLIC**

(Only persons speaking as general public must put their names on this list)

**PUBLIC HEARING-SIGN UP SHEET**

July 26, 2016 (continued from July 11, 2016)

3:00 p.m.

PRINT NAME	Representing Organization (If applicable) or Self
Hal Levi	Health Care Consumer
Tom Swan	Citizen Action Group
Alfred Fruttschke	Citizen
Bud McAllister	Partners in Healthy Communities
Sue Fraser	Self
Barbara Sadaski	Self
<del>Matthew Moran</del>	
William Schneider	Self
<del>Ken Jordan (DUPUATE)</del>	Self (Citizen Action Group)
Cathy <del>Van</del> Vandergem	HFT local 5051

General Public: Anyone not associated with the Applicants, Intervenor or Elected/Public Officials

## Greer, Leslie

---

**From:** Lazarus, Steven  
**Sent:** Wednesday, August 03, 2016 7:14 AM  
**To:** Greer, Leslie  
**Cc:** Hansted, Kevin  
**Subject:** FW: YNHH/L+M Late Files Docket No.-15-32033 and 15-32032  
**Attachments:** Late Files.PDF

Leslie,

Please add to the record.

Thank you,

Steve

### *Steven W. Lazarus*

Associate Health Care Analyst  
Division of Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, CT 06134  
Phone: 860-418-7012  
Fax: 860-418-7053



---

**From:** Feldman, Joan [<mailto:JFeldman@goodwin.com>]  
**Sent:** Tuesday, August 02, 2016 5:51 PM  
**To:** Hansted, Kevin; Carney, Brian; Lazarus, Steven; Riggott, Kaila  
**Cc:** [hfmurray@lapm.org](mailto:hfmurray@lapm.org); [jennifer.willcox@ynhh.org](mailto:jennifer.willcox@ynhh.org); Aselyne, Bill; [manderson@lmhosp.org](mailto:manderson@lmhosp.org)  
**Subject:** YNHH/L+M Late Files Docket No.-15-32033 and 15-32032

Attorney Hansted:

Attached you will find an electronic version of the requested late files in connection with the above-referenced dockets. We will hand-deliver a hard copy of the late files in the a.m.

Many thanks.

Joan

**Shipman & Goodwin** LLP  
C O U N S E L O R S   A T   L A W

**Joan W. Feldman**  
Partner  
One Constitution Plaza  
Hartford, CT 06103-1919

Tel (860) 251-5104  
Fax (860) 251-5211  
[jfeldman@goodwin.com](mailto:jfeldman@goodwin.com)  
[www.shipmangoodwin.com](http://www.shipmangoodwin.com)

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 please consider the environment before printing this message



**SHIPMAN & GOODWIN** LLP®  
COUNSELORS AT LAW

Joan W. Feldman  
Phone: (860) 251-5104  
Fax: (860) 251-5211  
[jfeldman@goodwin.com](mailto:jfeldman@goodwin.com)

August 2, 2016

**Via E-Mail**

Kevin T. Hansted  
Staff Attorney/Hearing Officer  
Department of Public Health  
Office of Health Care Access  
410 Capitol Ave., MS #13HCA  
P.O. Box 340308  
Hartford, CT 06134  
Phone: 860-418-7044  
[Kevin.Hansted@ct.gov](mailto:Kevin.Hansted@ct.gov)

Re: Late files - Affiliation of Lawrence + Memorial Corporation with Yale-New Haven Health Services Docket No. 15-32033 and Proposal for Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc. Docket No. 15-32032

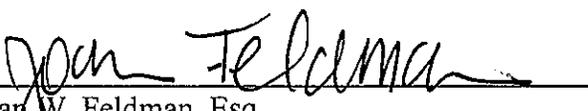
Dear Attorney Hansted:

Attached you will find the late files requested by OHCA in connection with the above-referenced applications. Please let me know if you have any questions.

Respectfully submitted,

Lawrence + Memorial Corporation  
Yale New Haven Health Services Corporation

By

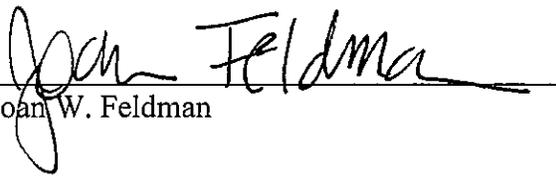
  
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Their Attorneys

CERTIFICATE OF SERVICE

I hereby certify that the foregoing was served by e-mail on August 2, 2016 to the following counsel of record:

Henry F. Murray, Esq.  
Livingston, Adler, Pulda, Meiklejohn & Kelly, P.C.  
557 Prospect Avenue  
Hartford, CT 06105-2922  
(e-mail: [HFMurray@lapm.org](mailto:HFMurray@lapm.org))

  
Joan W. Feldman



## Office of Health Care Access

Public Hearing held on July 11 & 26, 2016

Docket Numbers: 15-32032 & 15-32033

Late Files Requested by OHCA

- **Late File # 1:** A list of additional services, specialists and/or sub-specialists added / recruited to the L&M service area (post-merger). [DN- 15-32032]
- **Late File # 2:** A list of L&M /commercial payer contracts and the expiration dates of said contracts. [DN- 15-32033]
- **Late File # 3:** Submit separate forms for year- to-date (YTD) actual results through June 2016 for L+M Health System, Lawrence + Memorial Hospital (*hospital only and consolidated*) and Yale-New Haven Health System. Use the same format as used previously a Financial Attachment A of the original application. [DN- 15-32032 & DN- 15-32033 ]
- **Late File # 4:** Provide separate YTD Financial Measurement Indicators through June 2016 for L+M Health System, Lawrence + Memorial Hospital and Yale-New Haven Health System in the same format as previously submitted on page 602 (and resubmitted on page 863) of the application which includes amounts for the prior year time period (June 2016.) [DN- 15-32033]
- **Late File # 5:** A copy of L+M Hospital's most recent DPH licensing survey (July 13, 2016) and all communication between L+M Hospital and DPH regarding said survey. [DN- 15-32033]

### Due Dates:

1. All late files are due no later than August 5, 2016.
2. Applicants Objection in writing to OHCA's taking Administrative Notice of Exhibits KK (Letter from State of Connecticut Comptroller, Kevin Lembo), and Exhibit LL (the Milliman Analysis), due no later than July 29, 2016.
3. Intervenors' response to the Applicants Objection to OHCA taking Administrative Notice of Exhibits KK and LL, due not later than August 5, 2016.



**Yale New Haven Health / Lawrence + Memorial Health**  
**Affiliation CON Hearing**  
**Docket Number: 15-32032-CON**

**Late File #1:** A list of additional services, specialists and/or sub-specialists added / recruited to the L&M service area (post-merger). [DN- 15-32032]

Yale New Haven Health System will support the enhancement of clinical services in L+M's service area in the following disciplines subject to community need and the opportunity to provide these services locally at a lower cost over a five-year period:

- Primary care (6)
- Surgical specialties (e.g., cardiovascular, women's and children's, neurosurgery, etc.) (9)
- Medical specialists (e.g., oncology, cardiology, etc.) (10)
- Behavioral health (1)

Late File #2

Lawrence + Memorial Healthcare  
Commercial Payer Contracts as of 07/29/2016

Hospital	Insurer	Latest FPA	Latest Rate Amendment	Next Potential Rate Change	Underlying Contract / LOA Term
L&M	Aetna	1/1/1998	12/1/2001	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	Anthem	10/1/2012	10/1/2015	To be negotiated on 10/1/17	9/30/2017
L&M	Cigna	4/15/1996	3/16/1999	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	Connecticare	9/1/1997	1/1/2014	In negotiations currently	In negotiation
L&M	Harvard Pilgrim	3/1/2015	3/1/2015	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	Healthy CT	1/1/2014	1/1/2014	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	Multipian	3/1/2008	3/1/2008	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	Pequot Plus	3/20/2008	3/20/2008	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	United	10/1/2015	2/1/2016	Rates outlined until 9/30/17 with agreed upon annual inflation neutral to charges on 10/1/2016	Original LOA 03/01/1997;. Current contract expires 9/30/2017 with auto renewals

\*FPA = Facility Participation Agreement

1. Evergreen contracts have no termination dates built into language but minor annual adjustments comparable to inflation increases

Late File #3

LINE	Total Entity: LMC	FY 2016 YTD Thru June 30
	Description	
<b>A. OPERATING REVENUE</b>		
1	Total Gross Patient Revenue	849,188,142.00
2	Less: Allowances	\$505,735,966
3	Less: Charity Care	4,622,724.97
4	Less: Other Deductions	8,225,838.00
	Net Patient Service Revenue:	\$330,603,613
5	Medicare	\$119,815,016
6	Medicaid	\$35,748,799
7	CHAMPUS & TriCare	\$9,249,077
8	Other	(\$8,225,838)
	Total Government:	\$156,587,053
9	Commercial Insurers	\$160,234,793
10	Uninsured	\$0
11	Self Pay	\$7,397,505
12	Workers Compensation	\$6,384,262
13	Other	\$0
	Total Non-Government:	\$174,016,560
	Net Patient Service Revenue (Government+Non-Government)	\$330,603,613
14	Less: Provision for Bad Debts	\$11,223,286
	Net Patient Service Revenue less provision for bad debts	\$319,380,327
15	Other Operating Revenue	\$13,910,987
17	Net Assets Released from Restrictions	\$0
	<b>TOTAL OPERATING REVENUE</b>	<b>\$333,291,314</b>
<b>B. OPERATING EXPENSES</b>		
1	Salaries and Wages	\$164,399,926
2	Fringe Benefits	\$46,210,874
3	Physicians Fees	\$20,689,449
4	Supplies and Drugs	\$55,635,875
5	Depreciation and Amortization	\$21,428,431
6	Provision for Bad Debts-Other <sup>b</sup>	\$2,634,953
7	Interest Expense	\$10,561,456
8	Malpractice Insurance Cost	\$4,520,641
9	Lease Expense	\$21,244,899
10	Other Operating Expenses	\$347,326,504
	<b>TOTAL OPERATING EXPENSES</b>	<b>\$347,326,504</b>
	<b>INCOME/(LOSS) FROM OPERATIONS</b>	<b>(\$14,035,190)</b>
	<b>NON-OPERATING REVENUE</b>	<b>\$1,615,307</b>
	<b>EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES</b>	<b>(\$12,419,883)</b>
	Principal Payments	\$1,325,962
<b>C. PROFITABILITY SUMMARY</b>		
1	Hospital Operating Margin	4.2%
2	Hospital Non Operating Margin	0.5%
3	Hospital Total Margin	3.7%
<b>D. FTEs</b>		
		2,797
<b>E. VOLUME STATISTICS<sup>c</sup></b>		
1	Inpatient Discharges	11,878
2	Outpatient Visits	544,086
	<b>TOTAL VOLUME</b>	<b>555,964</b>

FTE reduction is a transfer to NEMG; see separate CON

LINE	Total Entity:L+M Hospital	FY 2016
	Description	YTD Thru June 30
<b>A. OPERATING REVENUE</b>		
1	Total Gross Patient Revenue	\$639,076,340
2	Less: Allowances	\$378,128,336
3	Less: Charity Care	\$3,961,358
4	Less: Other Deductions	\$8,225,838
	<b>Net Patient Service Revenue</b>	<b>\$248,760,808</b>
5	Medicare	\$87,731,433
6	Medicaid	\$27,790,034
7	CHAMPUS & TriCare	\$8,309,418
8	Other	(\$8,225,838)
	<b>Total Government</b>	<b>\$115,605,047</b>
9	Commercial Insurers	\$123,632,348
10	Uninsured	\$0
11	Self Pay	\$3,905,445
12	Workers Compensation	\$5,617,968
13	Other	\$0
	<b>Total Non-Government</b>	<b>\$133,155,761</b>
	<b>Net Patient Service Revenue<sup>a</sup> (Government+Non-Government)</b>	<b>\$248,760,808</b>
14	Less: Provision for Bad Debts	\$8,431,606
	<b>Net Patient Service Revenue less provision for bad debts</b>	<b>\$240,329,202</b>
15	Other Operating Revenue	24,016,927
17	Net Assets Released from Restrictions	\$0
	<b>TOTAL OPERATING REVENUE</b>	<b>\$264,346,129</b>
<b>B. OPERATING EXPENSES</b>		
1	Salaries and Wages	\$ 106,932,067
2	Fringe Benefits	\$ 41,209,855
3	Physicians Fees	\$ 18,388,808
4	Supplies and Drugs	\$45,975,704
5	Depreciation and Amortization	\$17,266,207
6	Provision for Bad Debts-Other <sup>b</sup>	
7	Interest Expense	\$2,634,617
8	Malpractice Insurance Cost	\$3,608,118
9	Lease Expense	\$2,472,284
10	Other Operating Expenses	\$ 20,847,477
	<b>TOTAL OPERATING EXPENSES</b>	<b>\$259,335,137</b>
	<b>INCOME/(LOSS) FROM OPERATION</b>	<b>\$5,010,992</b>
	<b>NON-OPERATING REVENUE</b>	<b>\$979,682</b>
	<b>EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES</b>	<b>\$5,990,674</b>
	Principal Payments	\$1,325,982
<b>C. PROFITABILITY SUMMARY</b>		
1	Hospital Operating Margin	1.9%
2	Hospital Non Operating Margin	0.4%
3	Hospital Total Margin	2.3%
<b>D. FTEs</b>		
		1,832
<b>E. VOLUME STATISTICS<sup>c</sup></b>		
1	Inpatient Discharges	10,095
2	Outpatient Visits	328,180
	<b>TOTAL VOLUME</b>	<b>336,275</b>

**NON-PROFIT**

Applicant: Yale New Haven Health System  
Financial Worksheet (A)

		(1)
LINE	Total Entity:	FY 2016 YTD June
	Description	Actual
		Results
<b>A. OPERATING REVENUE</b>		
1	Total Gross Patient Revenue	\$9,307,350,000
2	Less: Allowances	\$6,340,612,000
3	Less: Charity Care	\$98,443,000
4	Less: Other Deductions	\$92,233,000
	<b>Net Patient Service Revenue:</b>	<b>\$2,776,062,000</b>
5	Medicare	\$884,333,150
6	Medicald	\$312,433,610
7	CHAMPUS & TriCare	\$9,776,156
8	Other	(\$136,500,000)
	<b>Total Government:</b>	<b>\$1,070,042,916</b>
9	Commercial Insurers	\$1,593,360,493
10	Uninsured	\$0
11	Self Pay	\$98,796,901
12	Workers Compensation	\$13,861,689
13	Other	\$0
	<b>Total Non-Government:</b>	<b>\$1,706,019,084</b>
	<b>Net Patient Service Revenue<sup>a</sup> (Government+Non-Government)</b>	<b>\$2,776,062,000</b>
14	Less: Provision for Bad Debts	\$72,481,000
	<b>Net Patient Service Revenue less provision for bad debts</b>	<b>\$2,703,581,000</b>
15	Other Operating Revenue	\$89,275,000
17	Net Assets Released from Restrictions	\$18,900,000
	<b>TOTAL OPERATING REVENUE</b>	<b>\$2,811,756,000</b>
<b>B. OPERATING EXPENSES</b>		
1	Salaries and Wages	\$1,119,083,000
2	Fringe Benefits	\$298,679,000
3	Physicians Fees	\$451,991,000
4	Supplies and Drugs	\$385,268,000
5	Depreciation and Amortization	\$143,361,000
6	Provision for Bad Debts-Other <sup>b</sup>	\$0
7	Interest Expense	\$20,623,000
8	Malpractice Insurance Cost	\$20,900,000
9	Lease Expense	\$25,828,000
10	Other Operating Expenses	\$243,080,000
	<b>TOTAL OPERATING EXPENSES</b>	<b>\$2,708,813,000</b>
	<b>INCOME/(LOSS) FROM OPERATIONS</b>	<b>\$102,943,000</b>
	<b>NON-OPERATING REVENUE</b>	<b>\$30,600,000</b>
	<b>EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES</b>	<b>\$133,543,000</b>
	Principal Payments	\$0
<b>C. PROFITABILITY SUMMARY</b>		
1	Hospital Operating Margin	3.6%
2	Hospital Non Operating Margin	1.1%
3	Hospital Total Margin	4.7%
<b>D. FTEs</b>		
		16,429
<b>E. VOLUME STATISTICS<sup>c</sup></b>		
1	Inpatient Discharges	84,974
2	Outpatient Visits	1,433,289
	<b>TOTAL VOLUME</b>	<b>1,518,263</b>

<sup>a</sup>Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

<sup>b</sup>Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

<sup>c</sup>Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

**Note to table:**

The updated financial information above reflects the impact of material transactions that are anticipated to be included in the September 30, 2016 year end audited financial statements.

Late File #4

Exhibit File #4 Provide monthly financial reports that include statistics for the current month, and year to date and comparable month from the previous year for the following:  
L+M Corporation (Consolidated)

L+M Hospital

	YTD	YTD	MTD	MTD	YTD	YTD	MTD	MTD	YTD	YTD	MTD	MTD
<b>Monthly Financial Measurements/Indicators</b>												
<b>A. Operating Performance:</b>												
Operating Margin	1.36%	1.63%	13.46%	3.92%	-4.21%	5.65%	1.31%	NA	NA	5.65%	1.31%	NA
Non operating Margin	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total Margin	1.72%	4.82%	14.12%	32.28%	-3.73%	6.31%	21.60%	1.98%	1.98%	6.31%	21.60%	3.97%
Bad Debt as % of Net Revenue	5.73%	6.46%	4.17%	4.00%	5.37%	4.14%	3.97%	5.89%	5.89%	4.14%	3.97%	3.97%
<b>B. Liquidity:</b>												
Current Ratio	2.8	3.5	2.8	3.5	3.4	3.4	4.0	4.0	4.0	3.4	4.0	4.0
Days Cash on Hand	113.8	144.7	113.8	144.7	127.5	127.5	152.7	152.7	152.7	127.5	152.7	152.7
Days in Net Accounts Receivable	41.2	38.5	41.2	38.5	36.9	36.9	37.6	37.6	37.6	36.9	37.6	37.6
Average Payment Period	60.7	56.2	60.7	56.2	57.6	57.6	56.2	56.2	56.2	57.6	56.2	56.2
<b>C. Leverage and Capital Structure:</b>												
Long-term Debt to Equity	89.9%	71.2%	89.9%	71.2%	41.4%	41.4%	37.0%	37.0%	37.0%	41.4%	37.0%	37.0%
Long-term Debt to Capitalization	46.0%	40.4%	46.0%	40.4%	28.2%	28.2%	26.1%	26.1%	26.1%	28.2%	26.1%	26.1%
Unrestricted Cash to Debt	96.9%	118.7%	96.9%	118.7%	144.9%	144.9%	167.8%	167.8%	167.8%	144.9%	167.8%	167.8%
Times Interest Earned Ratio	2.7	5.9	17.5	35.4	-3.7	9.8	3.6	3.6	3.6	9.8	3.6	3.6
Debt Service Coverage Ratio	2.8	3.8	2.8	3.8	1.3	1.3	3.5	3.5	3.5	1.3	3.5	3.5
Equity Financing Ratio	0.36	0.44	0.36	0.44	0.50	0.50	0.55	0.55	0.55	0.50	0.55	0.55
<b>D. Additional Statistics:</b>												
Income from Operation	3,595,629	4,383,117	4,307,722	1,182,420	(14,035,190)	2,419,606	559,877	(4,459,584)	2,419,606	2,419,606	559,877	559,877
Revenue Over/(Under) Expense	4,575,311	12,925,878	4,519,186	9,725,181	(12,419,883)	2,702,080	9,212,158	6,874,703	2,702,080	2,702,080	9,212,158	9,212,158
EBITA	23,496,453	24,317,418	6,493,637	3,380,999	10,028,194	5,188,638	3,227,771	19,344,610	5,188,638	5,188,638	3,227,771	3,227,771
Patient Cash Collected	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cash and Cash Equivalents	5,002,627	5,989,197	5,002,627	5,989,197	15,518,776	15,518,776	16,566,226	16,566,226	15,518,776	15,518,776	16,566,226	16,566,226
Net Working Cash	99,050,177	129,563,076	99,050,177	129,563,076	166,832,875	166,832,875	201,559,545	201,559,545	166,832,875	166,832,875	201,559,545	201,559,545
Unrestricted Assets	90,882,751	127,734,763	90,882,751	127,734,763	217,782,094	217,782,094	259,079,233	259,079,233	217,782,094	217,782,094	259,079,233	259,079,233

Fitch A with Stable  
S&P BBB+ with Developing

Credit Ratings (S&P, Fitch, Moody's)

Yale New Haven Health					
	Jun-16	Jun-15	Jun-16	Jun-15	
	YTD	YTD	MTD	MTD	

**Monthly Financial Measurement/Indicators**

	Jun-16	Jun-15	Jun-16	Jun-15	
	YTD	YTD	MTD	MTD	
<b>1. Operating Performance:</b>					
Operating Margin	3.60%	4.36%	3.13%	6.79%	
Non operating Margin	N/A	N/A	N/A	N/A	
Total Margin	4.74%	5.73%	1.74%	6.99%	
Bad Debt as % of Net Revenue	2.66%	2.50%	2.59%	3.15%	

**3. Liquidity:**

Current Ratio	3.3	3.2	3.3	3.2	
Days Cash on Hand	201.0	191.0	201.0	191.0	
Days in Net Accounts Receivable	41.1	41.8	41.1	41.8	
Average Payment Period	65.2	67.5	65.2	67.5	

**4. Leverage and Capital Structure:**

Long-term Debt to Equity	50.2%	50.0%	50.2%	50.0%	
Long-term Debt to Capitalization	33.4%	33.3%	33.4%	33.3%	
Unrestricted Cash to Debt	160.1%	164.4%	160.1%	164.4%	
Times Interest Earned Ratio	7.5	9.6	3.1	11.2	
Debt Service Coverage Ratio	5.1	6.5	5.1	6.5	
Equity Financing Ratio	0.45	0.46	0.45	0.46	

**5. Additional Statistics:**

Income from Operations	102,943,000	117,683,000	10,352,000	20,406,000	
Revenue Over/(Under) Expense	133,543,000	154,670,000	5,755,000	20,986,000	
EBITA	297,527,000	312,434,000	24,574,000	37,507,000	
Patient Cash Collected	N/A	N/A	N/A	N/A	
Cash and Cash Equivalents	139,260,000	212,913,000	139,260,000	212,913,000	
Net Working Cash	1,416,866,000	1,250,273,000	1,416,866,000	1,250,273,000	
Unrestricted Assets	1,861,952,000	1,801,765,000	1,861,952,000	1,801,765,000	
Credit Ratings (S&P, Fitch, Moody's)					

Fitch AA- with Stable  
 S&P A+ with Positive  
 Moody's Aa3 with Stable

**Note to table:**

The updated financial information above reflects the impact of material transactions that are anticipated to be included in the September 30, 2016 year end audited financial statements.



**CMS**Centers for Medicare & Medicaid Services  
**Office of the Regional Administrator***Boston Region I  
JFK Federal Building, Room 2325  
Boston, MA 02203-0003  
FAX #: 443-380-8871***Confidential Facsimile Transmittal****To: Bruce Cummings, President & CEO**  
Company:  
Fax: 8604444788  
Phone**From: Kathy Mackin**  
Fax: 443-380-5597  
Phone: (617) 565-1211  
E-mail: kathy.mackin@cms.hhs.gov

Date and time: Thursday, July 21, 2016 9:41:58 AM

Number of pages: 43

cc:

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**NOTES:** Advanced copy of notice of findings**CONFIDENTIALITY PROVISION**

**NOTE:** The information following this cover sheet and included in this facsimile transmission is **CONFIDENTIAL**. It is intended for the sole use of the person(s) to whom it is addressed. If the reader of this message is not the named addressee or an employee or agent responsible for delivering this message to the intended recipient(s), please do not read the accompanying information. The dissemination, distribution, or copying of this communication by anyone other than the addressee is strictly prohibited. Anyone receiving this message in error should notify us immediately by telephone and shred the original.

Thank you for your cooperation.

Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
JFK Federal Building, Government Center  
Room 2325  
Boston, MA 02203



**Northwest Division of Survey & Certification**

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July 21, 2016

Mr. Bruce Cummings, President & CEO  
Lawrence & Memorial Hospital  
365 Montauk Avenue  
New London, CT 06320

**Re: CMS Certification Number: 070007  
Survey ID: 7ZQQ11, 07/13/2016**

Dear Mr. Cummings:

Section 1865 of the Social Security Act (the Act) and Centers for Medicare & Medicaid Services (CMS) regulations provide that a provider or supplier accredited by a CMS-approved Medicare accreditation program will be "deemed" to meet all of the Medicare Conditions of Participation (CoPs) for hospitals. In accordance with Section 1864 of the Act, State Survey Agencies may conduct at CMS's direction, surveys of deemed status providers on a selective sampling basis, in response to a substantial allegation of noncompliance, or when CMS determines a full survey is required after a substantial allegation survey identifies substantial noncompliance. CMS uses such surveys as a means of validating the accrediting organization's survey and accreditation process.

A survey conducted by the State of Connecticut Department of Public Health (State Survey Agency) at Lawrence & Memorial Hospital on July 13, 2016 found that the facility was not in substantial compliance with the following Conditions of Participation (CoPs) for hospitals:

- 42 C.F.R. §482.12 - Governing Body**
- 42 C.F.R. §482.13 - Patient's Rights**
- 42 C.F.R. §482.22 - Medical Staff**
- 42 C.F.R. §482.23 - Nursing Services**

As a result, effective July 13, 2016, your facility's deemed status is being removed and survey jurisdiction has been transferred to the State Survey Agency.

A listing of all deficiencies found is enclosed (Form CMS-2567, Statement of Deficiencies and Plan of Correction). You are not required to submit a plan of correction (PoC) for these deficiencies, but you may do so voluntarily. Copies of the Form CMS-2567, including copies containing a facility's PoC, are releasable to the

public in accordance with the provisions of Section 1864(a) of the Act and 42 C.F.R. §401.133(a). As such, if you choose to submit a PoC, it should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names.

The State Survey Agency will conduct an unannounced full survey of your facility to assess compliance with all the applicable Medicare conditions. If that survey indicates your facility is in substantial compliance with all of the applicable conditions, CMS will restore your deemed status and notify you in writing of this. If that survey indicates your facility is not in substantial compliance with one or more of the applicable conditions, then CMS will initiate action to terminate your Medicare agreement and will notify you in writing of this, including your opportunity to make timely correction of deficiencies identified.

In accordance with 42 CFR §498.3(d), this notice of findings is an administrative action, not an initial determination, and therefore formal reconsideration and hearing procedures do not apply.

If you have any questions, please contact Kathy Mackin at (617) 565-1211.

Sincerely,



J. William Roberson  
Associate Regional Administrator  
Northeast Division, Survey & Certification

Enclosure: CMS-2567

cc: CT State Survey Agency  
The Joint Commission (TJC)

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  070007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/13/2016
NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 365 MONTAUK AVE NEW LONDON, CT 06320		
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A 000	INITIAL COMMENTS  An authorized substantial allegation survey commenced on 6/30/16 and concluded on 7/13/16 in response to complaint # CT 20210 at Lawrence and Memorial Hospital 365 Montauk Avenue New London, CT 06320  The following Conditions of Participation were reviewed as they pertain to the complaint 482.12 Governing Body 482.13 Patient Rights 482.21 QAPI 482.22 Medical Staff 482.23 Nursing Staff 482.25 Pharmacy Services  The Conditions of Participation for Governing Body, Patient Rights, Medical Staff, Nursing Staff and were not met.  The census in Lawrence and Memorial Hospital 159  Patient records sampled 12	A 000			
A 043	482.12 GOVERNING BODY  There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...  This CONDITION is not met as evidenced by Based on clinical record reviews, review of facility policies and procedures and interviews	A 043			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 043	Continued From page 1 with facility personnel for one of twelve sampled patients who had a history of suicidal ideation, extensive abdominal surgery, history of chronic pain and receiving analgesia. (Patient #1), the governing body failed to be accountable for the quality of care provided to the patient including emergency treatment/assessments when the patient had expired and/or failed to ensure that the hospitalist's contract was reviewed and implemented to provide ample coverage on the off shifts.	A 043			
A 049	(See A49 and A84) 482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY  [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.  This STANDARD is not met as evidenced by Based on clinical record reviews, review of facility policies and procedures and interviews with facility personnel for one of twelve sampled patients who had a history of suicidal ideation, extensive abdominal surgery history chronic pain and receiving analgesia. (Patient #1), the medical staff failed to be accountable for the quality of care provided to the patient. The findings include.  1. a. Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain and was a Full Code Status. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety	A 049			

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A 049	Continued From page 2 disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus.  Review of the nursing admission assessment dated 6/17/16 failed to identify that an assessment including the patient's risk for suicidal ideation was completed upon admission per the facility's protocol.  Review of the nursing flowsheets dated 6/17/16-6/27/16 identified that Patient #1 had no bowel movement since 6/17/16 (10 days). On 6/27/16, Patient #1 was administered Lactulose 60 milligrams at 10 45 am, Miralax 17 grams at 10 45 am, and Senokol 17.2 milligrams at 10 45 am (laxative medications), in addition, Relistor for narcotic induced constipation was administered at 11.12 am. Although multiple medications were administered to promote bowel activity, an abdominal x-ray was not obtained until 2.47 pm on 6/27/16. The impression of the x-ray identified in part, a nonspecific bowel gas pattern with no obvious small bowel or colonic distension. Further review identified that Patient #1 also received Magnesium Citrate 300 milliliters at 3.52 pm and a soap suds enema at 6 02 pm. Nursing notes dated 6/27/16, 6:02 pm indicated that 1000 cubic centimeters of fluid was infused with the soap suds enema with yellow colored fluid returned. Abdominal assessments were being conducted in accordance with the policy and procedure.	A 049			

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A 049	Continued From page 3  Further review of the nursing flowsheets dated 6/27/16 at 12:10 pm identified that Patient #1's pain level was a 7/10 as acceptable and aching. Patient #1 received Roxycodone 10 mg at 12:04 pm. At 1:00 pm, Patient #1's pain level was a 7/10 as shooting and unbearable. MD #1 was notified at 1:00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2:47 pm, pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patient #1 received another dose of Dilaudid 1.0 mg IV at 6:02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement per the physician. Patient #1 also received Roxycodone 10 mg at 7:20 pm with indications to reassess in one hour. At 7:22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9:00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Although review of the clinical record identified a change in condition, further review failed to identify that the physician was notified regarding the patient's current status.  Interview with Registered Nurse (RN) #1 on 7/6/16 identified that he/she had gone into Patient #1's room after 9:30 pm to obtain his/her blood sugar and noticed the patient was in the bathroom with the water running with the door shut. RN#1 indicated that he/she thought the enema had worked and the patient was in the bathroom having a bowel movement so he/she decided to come back in fifteen minutes. Further interview with RN #1 identified at 9:45 pm, he/she returned to Patient #1's room and the door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the	A 049			

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A 049	Continued From page 4  door and found Patient #1 hanging by a bed sheet tied around a shower rod. RN #1 indicated that he/she had called for help, checked for a pulse while a Code 8 was called at 9 50 pm.  b. Review of the progress notes dated 6/27/16 identified that, although an abdominal assessment was documented by MD #3 at 11:30 am, the clinical record failed to identify any additional assessment conducted by a physician and/or a licensed independent practitioner when the patient had a change in condition including an assessment when the patient coded and expired. Additionally, the medical record lacked documentation to reflect an assessment by MD #2 when the patient coded and expired.  Review of the Discharge Summary dated 7/17/16 identified that Patient #1 started presenting with increasing abdominal pain as well of periods of burping. Further review indicated that abdominal x-ray was done to evaluate for possible complications/obstruction/aspiration however it continued to show the ileus.  Interview with MD #2 on 7/5/16 identified that he/she was first called regarding Patient #1 by responding to the code from the Emergency Department and found Patient #1 hanging from the shower rod. MD #2 indicated that his/her assessment was that Patient #1 had expired "a while ago" so the decision was made based on his/her assessment not to resuscitate the patient and the patient was pronounced at 10 00 pm. Review of the clinical record with MD #2 failed to identify a progress note had been written indicating MD #2's assessment and reason not to proceed with resuscitative efforts, although the	A 049			

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A 049	Continued From page 5  clinical record identified that the patient was a full code. Further interview with MD #2 identified that he/she did not document the assessment in the progress note as he/she was instructed by administration that this was a police matter.  interview with Pastoral Care Representative on 7/5/16 identified that he/she had visited with Patient #1 on 6/27/16 in the afternoon. Further interview identified that Patient #1 was lying on his/her side, scrunched over and groaning so loudly that you could hear him/her throughout the unit. In addition, the Pastoral Care Representative indicated that he/she had not seen anyone struggling and in so much pain.  Interview with Pharmacy Manager on 7/6/16 identified that laxatives are to be discontinued prior to administering Relistor. in addition, use is contraindicated in patients with known or suspected GI obstruction or at increased risk of recurrent obstruction.  Interview with MD #1 on 7/13/16 identified that he/she was aware of Patient #1's suicidal and psychiatric history, however, it was never communicated to the nursing staff and/or had no psychiatric consult was completed. Further interview with MD #1 on 7/13/16 identified that he was aware that MD #2 had not documented in the medical record regarding assessments and code response however he/she was told to wait until DPH finished their investigation.  Interview with MD #6 on 7/13/16 identified that he/she was aware of Patient #1's being on multiple psychiatric meds and previous psychiatric history from reviewing previous admissions however, did not feel the patient	A 049			

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A 049	<p>Continued From page 6</p> <p>needed for a psychiatric consult while in the hospital.</p> <p>Review of hospital policy identified that each patient has an initial assessment by a medical staff member who assesses the physical, psychological and social status of the patient and identifies appropriate care of the need for further assessment. The medical staff member is the leader of the patient care team in the planning and provision of care throughout the continuum.</p> <p>Review of hospital patients' rights policy identified that patients will receive information about pain and symptom management. It further identified that "As healthcare professionals and concerned staff, we are committed to pain prevention and management and want to respond quickly to your reports of pain and related symptoms."</p> <p>Review of hospital policy identified that the Physician-in-Charge/Adult Hospitalist directs the resuscitation efforts from ECG interpretation until final disposition. The I.V. Nurse/Critical Care Nurse/Staff Nurse is in charge of starting I.V.'s, and the Staff Nurse initiates CPR, calls for help, established respiratory support, and prepares equipment for cardiac monitoring and defibrillation. Cardiopulmonary resuscitation is initiated on all patients unless the physician records a DNR order. Resuscitation efforts are only terminated by the decision of the physician-in-charge or the attending physician. The cardiopulmonary resuscitation record is completed and the original becomes part of the patient record.</p> <p>c. Review of the physician orders dated 6/18/16</p>	A 049			

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A 049	Continued From page 7 identified that Patient #1 was to receive Oxycotin 10 mg every twelve hours for pain to be renewed every seven days. On 6/25/16, Patient #1's medication was due to be renewed, however, the hospitalist never renewed the medication. Patient #1 had not received the scheduled Oxycotin for 36 hours. On 6/26/16, the 7-3 nurse noticed the pain medication was not renewed and called the physician for a new order.  Review of hospital policy identified that all Schedule II narcotic ordered will automatically be removed for the Medication Administration Record at 12 midnight on the seventh day if not renewed.  Interview with MD #6 on 7/13/16 identified that he/she was not aware and/or educated of an alert on the computer identifying that a patients narcotics were up for renewal.  Interview with the Pharmacy Manager on 7/1/16 identified that pharmacy staff have no process in place to monitor when narcotics need to be renewed after seven days if the provider fails to renew the order. Further interview identified that the pharmacy relies on the provider to renew the narcotic when a purple tab in the computer that notifies the provider a narcotic needs to be renewed otherwise the narcotic order just drops off.  Review of hospital documentation dated 7/13/16 (16 days later) identified that a memo went out to all providers to remind them of renewing Schedule II Controlled Substances every 7 days per state law.	A 049			
A 084	482.12(e)(1) CONTRACTED SERVICES	A 084			

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A 084	<p>Continued From page 8</p> <p>The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.</p> <p>This STANDARD is not met as evidenced by Based on review of hospital documentation and contracts, the hospital failed to provide hospitalist coverage based on the contract. The findings include</p> <p>Review of hospital documentation and the contracted service for hospitalist coverage identified that from 6/2016-7/2016 indicated that on 11 00 pm-7 00 am one physician, one on-call physician for the intensive care unit and one physician extender were covering the entire hospital. Review of the hospitalist contract identified that on 11 00 pm - 7 00 am shift, the hospital shall be staffed at night with no fewer than one FTE physician assigned to the intensive care unit and one FTE physician assigned to the hospital inpatient units.</p> <p>In addition, review of hospital documentation identified that on 6/25/16-6/27/16 the range of hospital census was from 190-199 and from 5 00 pm -7 00 am, one physician covering the ED, codes and intensive care unit and one Advanced Practice Registered Nurses covering the entire hospital. Further review failed to identify an on-call physician for the intensive care unit. Interview and review of the hospitalist contract with the Chief Hospitalist on 7/13/16 identified that he/she was not aware of what coverage was needed per the contract. Further interview identified that they had one physician who covered the intensive care unit leave and the hospital was providing coverage with one.</p>	A 084			

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A 084	Continued From page 9 physician and a physician extender (APRN) on the overnight shift.	A 084			
A 115	482.13 PATIENT RIGHTS  A hospital must protect and promote each patient's rights.  This CONDITION is not met as evidenced by. Based on review of clinical records, hospital policies and procedures and interviews for one of twelve sampled patients (Patient # 1) with a Full Code status, the hospital failed to ensure that cardiopulmonary resuscitation (CPR) was initiated and/or when a patient presents with a risk for suicidal ideation and/or had an extensive history of abdominal surgeries, chronic pain and receiving analgesia, the facility failed to ensure that the patient received care in a safe setting.	A 115			
A 130	See (A 130, A144) 482.13(b)(1) PATIENT RIGHTS.PARTICIPATION IN CARE PLANNING  The patient has the right to participate in the development and implementation of his or her plan of care.  This STANDARD is not met as evidenced by Based on review of clinical records, hospital policies and procedures and interviews for one of twelve sampled patients (Patient # 1) with a Full code status, the hospital failed to ensure that cardiopulmonary resuscitation (CPR) was initiated when the patient presented without pulse and/or respirations. The findings include.  Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with a chief	A 130			

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A 130	<p>Continued From page 10</p> <p>complaint of abdominal pain and diagnoses that included small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and use of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, and Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus.</p> <p>Physician orders dated 06/17/16 at 6:33 PM identified that the patient's code status was discussed with Patient #1 who requested a Full Code. The Full Code status was consistent with the code status identified on previous hospital/ED admissions.</p> <p>Interview with RN #1 on 7/6/16 identified that, on 06/28/16 at approximately 9:30 PM he/she had gone into Patient #1's room to obtain a fingerstick blood glucose and noticed the patient was in the bathroom with the water running and the door shut. RN#1 indicated that he/she thought that the enema, previously administered, had been effective, and the patient was in the bathroom having a bowel movement. RN #1 decided to return in fifteen minutes. Further interview with RN #1 identified at 9:45 pm, he/she returned to Patient #1's room. The door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging by a bed sheet around the shower curtain rod. RN #1 identified that he/she had called for help, and checked for a pulse while a Code 8 was called.</p>	A 130			

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A 130	Continued From page 11  Interview with RN #7, the intravenous therapy (IV) nurse, on 07/06/16 at 2.45 PM identified that he/she was charting at the nursing station adjacent to the unit when he/she heard screaming and went to the patient's room to investigate. At the same time, RN #10, a nurse from the adjacent unit, was coming out of the room, heading towards the nursing station. RN #7 identified that he/she believed that RN #10 was going to call a Code 8. RN #7 entered the patient room and observed the clinical manager, RN #1, looking into the bathroom. RN #7 then entered the bathroom and observed Patient #1 suspended from the curtain rod. RN #7 checked the patient for movement, palpated the left and right carotid arteries for pulse, checked for respirations, assessed the pupils as fixed and dilated, and observed a dried substance consistent with blood at the right corner of the patient's mouth. RN #7 further identified that a staff member had reported that Patient #1 was a full code and RN #7 responded that the patient had expired and directed the staff not to touch Patient #1, but notify the Assistant Director of Nursing (ADNS), security, and the physician. RN #7 then left the room and observed many staff members coming down the hallway towards the room. RN #7 further identified that, based on his/her professional experience, the patient and his/her environment had become part of a crime scene.  Interview with MD #2 on 07/06/16 identified that he/she had been in the ED when summoned by the Code 8 to Patient #1's room. Patient #1 presented with mottling his/her soles of feet were white and multiple abrasions were visible around his/her neck. The body was already cooled and	A 130			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  070007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/13/2016
NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 365 MONTAUK AVE NEW LONDON, CT 06320		
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A 130	Continued From page 12  The patient appeared to have expired some time ago. Death was pronounced at 10 00 PM. Further interview with MD # 2 on 7/6/16 identified that he/she had been directed by administration not to document at that time and, therefore, failed to document the time of death, circumstances of death, and/or physical assessment in the clinical record. MD #2 returned to the ED.  Interviews with the Director of Patient Care Services (PCS) on 07/06/16 at 10 00 AM and 7/13/16 that on 06/28/16 at approximately 10.00 PM he/she had received a call from the Director on Call, who identified the circumstances of Patient #1's death. The PCS arrived at the hospital by 10.30 PM. The police had arrived and the PCS did not enter the room as it was considered to be a crime scene. According to the PCS, RN #7 had responded to the Code 8 and directed that the situation represented a crime scene and MD #2 agreed with that approach. In a later interview, the PCS identified that he/she had directed the staff to step out of the room so it could be secured as it was a crime scene. Patient #1 was not removed from the hanging position at that time. Interview with the Director of Risk Management on 07/07/16 at 3 00 PM identified that once the police cleared the scene, they removed the patient with assistance of the hospital's public safety staff and the body was removed by a representative of the Medical Examiner's office sometime before 2 00 AM on 06/29/16.  Interview with RN #5 on 07/05/16 identified that the code cart had been brought into the patient's room, however CPR was never initiated.  The hospital policy entitled Cardiopulmonary	A 130			

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A 130	Continued From page 13 Resuscitation identified that CPR is initiated on all patients unless the physician records a "Do Not Resuscitate" order. The Physician-in-Charge/Adult Hospitalist directs the resuscitation efforts from ECG interpretation until final disposition. The I.V. Nurse/Critical Care Nurse/Staff Nurse is in charge of starting I.V.'s, and the Staff Nurse initiates CPR, calls for help, established respiratory support, and prepares equipment for cardiac monitoring and defibrillation. Cardiopulmonary resuscitation is initiated on all patients unless the physician records a DNR order. Resuscitation efforts are only terminated by the decision of the physician-in-charge or the attending physician.	A 130			
A 132	482.13(b)(3) PATIENT RIGHTS, INFORMED DECISION  The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates)  This STANDARD is not met as evidenced by: Based on review of clinical records, hospital policies and procedures and interviews for one of one sampled patient (Patient # 1) with a Full Code, the hospital failed to ensure that cardiopulmonary resuscitation (CPR) was initiated when the patient presented without pulse and/or respirations. The findings include:  Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with a chief complaint of abdominal pain and diagnoses that	A 132			

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A 132	<p>Continued From page 14</p> <p>included small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and use of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, and Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus.</p> <p>Physician orders dated 06/17/16 at 6:33 PM identified that the patient's code status was discussed with Patient #1 who requested Full Code. The Full Code status was consistent with the code status identified on previous hospital/ED admissions.</p> <p>Interview with RN #1 on 7/6/16 identified that, on 06/28/16 at approximately 9:30 PM he/she had gone into Patient #1's room to obtain a fingersick blood glucose and noticed the patient was in the bathroom with the water running and the door shut. RN#1 indicated that he/she thought that the enema, previously administered, had been effective, and the patient was in the bathroom having a bowel movement. RN #1 decided to return in fifteen minutes. Further interview with RN #1 identified at 9:45 pm, he/she returned to Patient #1's room. The door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging from the shower curtain rod. RN #1 identified that he/she had called for help, and checked for a pulse while a Code 8 was called.</p>	A 132			

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A 132	Continued From page 15 Interview with RN #7, the intravenous therapy (IV) nurse, on 07/06/16 at 2:45 PM identified that he/she was charting at the nursing station adjacent to the unit when he/she heard screaming and went to the patient's room to investigate. At the same time, RN #10, a nurse from the adjacent unit, was coming out of the room, heading towards the nursing station. RN #7 identified that he/she believed that RN #10 was going to call a Code 8. RN #7 entered the patient room and observed the clinical manager, RN #1, looking into the bathroom. RN #7 then entered the bathroom and observed Patient #1 suspended from the curtain rod. RN #7 checked the patient for movement, palpated the left and right carotid arteries for pulse, checked for respirations, assessed the pupils as fixed and dilated, and observed a dried substance consistent with blood at the right corner of the patient's mouth. RN #7 further identified that a staff member had reported that Patient #1 was a full code and RN #7 responded that the patient had expired and directed the staff not to touch Patient #1, but notify the Assistant Director of Nursing (ADNS), security, and the physician. RN #7 then left the room and observed many staff members coming down the hallway towards the room. RN #7 further identified that, based on his/her professional experience, the patient and his/her environment had become part of a crime scene.  Interview with MD #2 on 07/06/16 identified that he/she had been in the ED when summoned by the Code 8 to Patient #1's room. Patient #1 presented with mottling. His/her soles were white and multiple abrasions were visible around his/her neck. The body was already cooled and the patient appeared to have expired some time	A 132			

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A 132	<p>Continued From page 16</p> <p>ago. Death was pronounced at 10 00 PM. Further interview with MD # 2 on 7/6/16 identified that he/she had been directed not to document at that time and, therefore, failed to document the time of death, circumstances of death, and/or physical assessment in the clinical record. MD #2 returned to the ED.</p> <p>Interviews with the Director of Patient Care Services (PCS) on 07/06/16 at 10 00 AM and 7/13/16 that on 06/28/16 at approximately 10 00 PM he/she had received a call from the Director on Call, who identified the circumstances of Patient #1's death. The PCS arrived at the hospital by 10:30 PM. The police had arrived and the PCS did not enter the room as it was considered to be a crime scene. According to the PCS, RN #7 had responded to the Code 8 and directed that the situation represented a crime scene and MD #2 agreed with that approach. In a later interview, the PCS identified that he/she had directed the staff to step out of the room so it could be secured as it was a crime scene. Patient #1 was not removed from the hanging position at that time. Interview with the Director of Risk Management on 07/07/16 at 3 00 PM identified that once the police cleared the scene, they removed the patient with assistance of the hospital's public safety staff and the body was removed by a representative of the Medical Examiner's office sometime before 2 00 AM on 06/29/16.</p> <p>Interview with RN #5 on 07/11/16 identified that the code cart had been brought into the patient's room, however CPR was never initiated.</p> <p>The hospital policy entitled Cardiopulmonary Resuscitation identified that the</p>	A 132			

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A 132	Continued From page 17 Physician-in-Charge/Adult Hospitalist directs the resuscitation efforts from ECG interpretation until final disposition. The I.V. Nurse/Critical Care Nurse/Staff Nurse is in charge of starting I.V.'s, and the Staff Nurse initiates CPR, calls for help, established respiratory support, and prepares equipment for cardiac monitoring and defibrillation. Cardiopulmonary resuscitation is initiated on all patients unless the physician records a DNR order. Resuscitation efforts are only terminated by the decision of the physician-in-charge or the attending physician.	A 132			
A 144	482.13(c)(2) PATIENT RIGHTS CARE IN SAFE SETTING  The patient has the right to receive care in a safe setting.  This STANDARD is not met as evidenced by Based on clinical record review, review of policies and procedures and interviews with facility personnel for one of twelve sampled patients (Patient #1) who was at risk for suicidal ideation and/or had an extensive history of abdominal surgeries, chronic pain and was receiving analgesia, the facility failed to ensure that the patient received care in a safe setting. The findings include  Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25	A 144			

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A 144	<p>Continued From page 18</p> <p>micrograms every 72 hours, Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus.</p> <p>Review of the nursing admission assessment dated 6/17/16 failed to identify that an assessment including the patient's risk for suicidal ideation was completed upon admission per the facility's protocol.</p> <p>Review of the nursing flowsheets dated 6/17/16-6/27/16 identified that Patient #1 had no bowel movement since 6/17/16 (10 days). On 6/27/16, Patient #1 was administered Lactulose 60 milligrams at 10:45 am, Miralax 17 grams at 10:45 am, and Senokot 17.2 milligrams at 10:45 am (laxative medications). In addition, Relistor for narcotic induced constipation was administered at 11:12 am. Although multiple medications were administered to promote bowel activity, an abdominal X-ray was not obtained until 2:47 pm on 6/27/16. The impression of the X-ray identified in part, a nonspecific bowel gas pattern with no obvious small bowel or colonic distension. Further review identified that Patient #1 also received Magnesium Citrate 300 milligrams at 3:52 pm and a soap suds enema at 6:02 pm. Nursing notes dated 6/27/16, 6:02 pm indicated that 1000 cubic centimeters of fluid was infused with the soap suds enema with yellow colored fluid returned. Abdominal assessments were being conducted in accordance with the policy and procedure.</p> <p>Further review of the nursing flowsheets dated 6/27/16 at 12:10 pm identified that Patient #1's</p>	A 144		

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A 144	<p>Continued From page 19</p> <p>pain level was a 7/10 as acceptable and aching. Patient #1 received Roxycodone 10 mg at 12.04 pm. At 1.00 pm, Patient #1's pain level was a 7/10 as shooting and unbearable. MD #1 was notified at 1.00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2.47 pm, pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patient #1 received another dose of Dilaudid 1.0 mg IV at 6.02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement. Patient #1 also received Roxycodone 10 mg at 7.20 pm with indications to reassess in one hour. At 7.22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9.00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Although review of the clinical record identified a change in condition, further review failed to identify that the physician was notified regarding the patient's current status.</p> <p>Interview with RN #1 on 7/6/16 identified that he/she had gone into Patient #1's room at 9.30pm to obtain his blood sugar and noticed the patient was in the bathroom with the water running and the door shut. RN#1 indicated that he/she thought the enema had worked and the patient was in the bathroom having a bowel movement so he/she decided to come back in fifteen minutes. Further interview with RN #1 identified at 9.45 pm, he/she returned to Patient #1's room and the door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging from the shower rod. RN #1 indicated that he/she had called for help, checked</p>	A 144			

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A 144	<p>Continued From page 20</p> <p>for a pulse while a Code 8 was called at 9 50 pm. Further review identified that the nursing staff failed to initiate CPR.</p> <p>Interview with MD #2 on 7/5/16 identified that he/she was first called regarding Patient #1 by responding to the code and found Patient #1 hanging from the shower rod. MD #2 indicated that his/her assessment was that Patient #1 had expired "a while ago" so the decision was made based on his/her assessment not to resuscitate the patient and the patient was pronounced at 10 00 pm. Review of the clinical record with MD #2 failed to identify a progress note had been written indicating MD #2's assessment and reason not to proceed with resuscitative efforts, although the clinical record identified that the patient was a Full Code. Further interview with MD #2 identified that she/he did not document the assessment in the progress note as he/she was directed it was a police matter by Administration.</p> <p>Interview with Pastoral Care Representative on 7/5/16 identified that he/she had visited with Patient #1 on 6/27/16 in the afternoon. Interview identified that Patient #1 was lying on his/her side, scrunched over and groaning so loudly that you could hear him/her throughout the unit. In addition, the Pastoral Care Representative indicated that he/she had not seen anyone struggling and in so much pain.</p> <p>Interview with RN #6 on 07/06/16 at 2.00 PM identified that although he/she was not assigned to care for Patient #1 on 06/28/16, he/she had a patient assignment on the same unit and observed RN #1 and RN #5 frequently responding to the patient's needs. Additionally, he/she heard the patient calling out and moaning</p>	A 144			

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A 144	Continued From page 21 loudly throughout the shift.  Interview with Pharmacy Manager on 7/6/16 identified that laxatives are to be discontinued prior to administering Relistor. In addition, use is contraindicated in patients with known or suspected GI obstruction or at increased risk of recurrent obstruction.  Review of hospital patients' rights policy identified that patients will receive information about pain and symptom management. It further identified that "As healthcare professionals and concerned staff, we are committed to pain prevention and management and want to respond quickly to your reports of pain and related symptoms."	A 144			
A 338	482.22 MEDICAL STAFF  The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital. This CONDITION is not met as evidenced by Based on clinical record reviews, review of facility policies and procedures and interviews with facility personnel for one of twelve sampled patients who had a history of suicidal ideation, extensive abdominal surgery history chronic pain and receiving analgesia, (Patient #1), the medical staff failed to be accountable for the quality of care provided to the patient including emergency treatment/assessments when the patient had expired. (See A347)	A 338			
A 347	482.22(b)(1), (2), (3) MEDICAL STAFF ORGANIZATION & ACCOUNTABILITY  The medical staff must be well organized and	A 347			

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A 347	<p>Continued From page 22</p> <p>accountable to the governing body for the quality of the medical care provided to the patients.</p> <p>(1) The medical staff must be organized in a manner approved by the governing body.</p> <p>(2) if the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.</p> <p>(3) The responsibility for organization and conduct of the medical staff must be assigned only to one of the following</p> <p>(i) An individual doctor of medicine or osteopathy.</p> <p>(ii) A doctor of dental surgery or dental medicine, when permitted by State law of the State in which the hospital is located.</p> <p>(iii) A doctor of podiatric medicine, when permitted by State law of the State in which the hospital is located.</p> <p>This STANDARD is not met as evidenced by Based on clinical record reviews, review of facility policies and procedures and interviews with facility personnel for one of twelve sampled patients who had a history of suicidal ideation, extensive abdominal surgery history chronic pain and receiving analgesia, (Patient #1), the medical staff failed to be accountable for the quality of care provided to the patient. The findings include</p> <p>1a. Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous</p>	A 347			

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A 347	<p>Continued From page 23</p> <p>surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus.</p> <p>Review of the nursing admission assessment dated 6/17/16 failed to identify that an assessment including the patient's risk for suicidal ideation was completed upon admission per the facility's protocol.</p> <p>Review of the nursing flowsheets dated 6/17/16-6/27/16 identified that Patient #1 had no bowel movement since 6/17/16 (10 days). On 6/27/16, Patient #1 was administered Lactulose 60 milligrams at 10.45 am, Miralax 17 grams at 10.45 am, and Senokot 17.2 milligrams at 10.45 am (laxative medications). In addition, Reilistor for narcotic induced constipation was administered at 11.12 am. Although multiple medications were administered to promote bowel activity, an abdominal x-ray was not obtained until 2.47 pm on 6/27/16. The impression of the x-ray identified in part, a nonspecific bowel gas pattern with no obvious small bowel or colonic distension. Further review identified that Patient #1 also received Magnesium Citrate 300 milligrams at 3.52 pm and a soap suds enema at 6.02 pm. Nursing notes dated 6/27/16 at 6.02 pm indicated that 1000 cubic centimeters of fluid was infused with the soap suds enema with yellow colored fluid returned. Abdominal assessments were being conducted in accordance with the policy and</p>	A 347			

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NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 365 MONTAUK AVE NEW LONDON, CT 06320		
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A 347	<p>Continued From page 24 procedure.</p> <p>Further review of the nursing flowsheets dated 6/27/16 at 12 10 pm identified that Patient #1's pain level was a 7/10 as acceptable and aching. Patient #1 received Roxicodone 10 mg at 12 04 pm. At 1 00 pm, Patient #1's pain level was a 7/10 as shooting, unbearable. MD #1 was notified at 1.00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2 47 pm, pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patient #1 received another dose of Dilaudid 1.0 mg IV at 6.02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement per the physician. Patient #1 also received Roxicodone 10 mg at 7 20 pm with indications to reassess in one hour. At 7 22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9.00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Although review of the clinical record identified a change in condition, further review failed to identify that the physician was notified regarding the patient's current status.</p> <p>Interview with RN #1 on 7/6/16 identified that he/she had gone into Patient #1's room after 9 30 pm to obtain his blood sugar and noticed the patient was in the bathroom with the water running with the door shut. RN#1 indicated that he/she thought the enema had worked and the patient was in the bathroom having a bowel movement so he/she decided to come back in fifteen minutes. Further interview with RN #1 identified at 9 45 pm, he/she returned to Patient #1's room and the door was still shut so he/she</p>	A 347			

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NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 385 MONTAUK AVE NEW LONDON, CT 06320		
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A 347	<p>Continued From page 25</p> <p>knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging by a bed sheet around the shower rod. RN #1 indicated that he/she had called for help, checked for a pulse while a Code 8 was called at 9:50pm.</p> <p>1b. Review of the progress notes dated 8/27/16 identified that although an abdominal assessment was documented by MD #3 at 11:30 am, the clinical record failed to identify any additional assessment conducted by a physician and/or a licensed independent practitioner when the patient had a change in condition including an assessment when the patient coded and expired. Additionally, the medical record lacked documentation to reflect an assessment by MD #2 when the patient coded and expired.</p> <p>Interview with MD #2 on 7/5/16 identified that he/she was first called regarding Patient #1 by responding to the code from the Emergency Department and found Patient #1 hanging from the shower rod. MD #2 indicated that his/her assessment was that Patient #1 had expired "a while ago" so the decision was made based on his/her assessment not to resuscitate the patient and the patient was pronounced at 10:00 pm. Review of the clinical record with MD #2 failed to identify a progress note had been written indicating MD #2's assessment and reason not to proceed with resuscitative efforts, although the clinical record identified that the patient was a full code. Further interview with MD #2 identified that he/she did not document the assessment in the progress note as he/she was instructed by administration that this was a police matter.</p> <p>Interview with Pastoral Care Representative on</p>	A 347		

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A 347	<p>Continued From page 26</p> <p>7/5/16 identified that he/she had visiled with Patient #1 on 6/27/16 in the afternoon. Further interview identified that Patient #1 was lying on his/her side, scrunched over and groaning so loudly that you could hear him/her throughout the unit. In addition, the Pastoral Care Representative indicated that he/she had not seen anyone struggling and in so much pain.</p> <p>Review of the Discharge Summary dated 7/17/16 identified that Patient #1 started presenting with increasing abdominal pain as well of periods of burping. Further review indicated that abdominal x-ray was done to evaluate for possible complications/obstruction/aspiration however it continued to show the ileus.</p> <p>Interview with Pharmacy Manager on 7/6/16 identified that laxatives are to be discontinued prior to administering Relistor. In addition, use is contraindicated in patients with known or suspected GI obstruction or at increased risk of recurrent obstruction.</p> <p>interview with MD #1 on 7/13/16 identified that he/she was aware of Patient #1's suicidal and psychiatric history, however, it was never communicated to the nursing staff and/or had no psychiatric consult completed. Further interview with MD #1 on 7/13/16 identified that he was aware that MD #2 had not documented in the medical record regarding assessments and code response however he/she was told to wait until DPH finished their investigation.</p> <p>Interview with MD #6 on 7/13/16 identified that he/she was aware of Patient #1's being on multiple psychiatric meds and previous psychiatric history from reviewing previous</p>	A 347			

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NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 365 MONTAUK AVE NEW LONDON, CT 06320
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A 347	<p>Continued From page 27</p> <p>admissions however, did not feel the patient needed for a psychiatric consult while in the hospital.</p> <p>Review of hospital policy identified that each patient has an initial assessment by a medical staff member who assesses the physical, psychological and social status of the patient and identifies appropriate care of the need for further assessment. The medical staff member is the leader of the patient care team in the planning and provision of care throughout the continuum.</p> <p>Review of hospital patients' rights policy identified that patients will receive information about pain and symptom management. It further identified that "As healthcare professionals and concerned staff, we are committed to pain prevention and management and want to respond quickly to your reports of pain and related symptoms."</p> <p>Review of hospital policy identified that CPR is initiated on all patients unless the physician records a "Do Not Resuscitation" order. The Physician-in-Charge/Adult Hospitalist directs the resuscitation efforts from ECG interpretation until final disposition. The I.V. Nurse/Critical Care Nurse/Staff Nurse is in charge of starting I.V.'s, and the Staff Nurse initiates CPR, calls for help, established respiratory support, and prepares equipment for cardiac monitoring and defibrillation. Cardiopulmonary resuscitation is initiated on all patients unless the physician records a DNR order. Resuscitation efforts are only terminated by the decision of the physician-in-charge or the attending physician. The cardiopulmonary resuscitation record is completed and the original becomes part of the patient record.</p>	A 347		
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A 347	Continued From page 28  1c. Review of the physician orders dated 6/18/16 identified that Patient #1 was to receive Oxycontin 10 mg every twelve hours for pain to be renewed every seven days. On 6/25/16, Patient #1's medication was due to be renewed, however, the hospitalist never renewed the medication. Patient #1 had not received the scheduled Oxycontin for 36 hours. On 6/26/16, the 7:00 AM-3:00 PM nurse noticed the pain medication was not renewed and called the physician for a new order.  Review of hospital policy identified that all Schedule I: narcotic ordered will automatically be removed for the medication administration record at 12 midnight on the seventh day if not renewed.  Interview with MD #6 on 7/13/16 identified that he/she was not aware and/or educated of an alert on the computer identifying that a patient's narcotic was up for renewal.  Interview with the Pharmacy Manager on 7/1/16 identified that pharmacy staff have no process in place to monitor when narcotics need to be renewed after seven days if the provider fails to renew the order. Further interview identified that the pharmacy relies on the provider to renew the narcotic when a purple tab in the computer that notifies the provider a narcotic needs to be renewed otherwise the narcotic order just drops off.  Review of hospital documentation dated 7/13/16 (16 days later) identified that a memo went out to all providers to remind them of renewing Schedule I: Controlled Substances every 7 days per state law.	A 347			

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A 385 A 385	Continued From page 29 482.23 NURSING SERVICES  The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.  This CONDITION is not met as evidenced by Based on clinical record review, review of policies and procedures and interviews with facility personnel for one of twelve sampled patients (Patient #1) who was at risk for suicidal ideation and/or had an extensive history of abdominal surgeries, chronic pain and was receiving analgesia, the facility failed to ensure that a nursing admission assessments, comprehensive nursing care plans, pain assessments, physician notification with a change in condition and Cardiopulmonary Resuscitation were conducted per hospital policy. (See A395 and A396)	A 385 A 385		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE  A registered nurse must supervise and evaluate the nursing care for each patient.  This STANDARD is not met as evidenced by Based on review of clinical record, review policies and procedures and interviews with facility personnel, the facility failed to ensure that pain assessments were completed for three of twelve patients ( P#1, #2 and #6) and/or for one of one sampled patients (Patient #1) who was at risk for suicidal ideation and/or had an extensive history of abdominal surgeries, chronic pain and was receiving analgesia, the facility failed to ensure that a nursing admission assessment was	A 395		

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A 395	<p>Continued From page 30</p> <p>conducted when the patient was admitted to the hospital and/or the physician was notified when the patient had a change in condition and/or failed to perform CPR. The findings include</p> <p>1a. Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus. Review of the nursing admission assessment dated 6/17/16 failed to identify that an assessment including the patient's risk for suicidal ideation was completed upon admission per the facility's protocol.</p> <p>Review of the nursing flowsheets dated 6/17/16-6/27/16 identified that Patient #1 had no bowel movement since 6/17/16 (10 days). On 6/27/16, Patient #1 was administered Lactulose 60 milligrams at 10 45 am, Miralax 17 grams at 10 45 am, and Senokot 17.2 milligrams at 10 45 am (laxative medications). In addition, Relistor for narcotic induced constipation was administered at 11 12 am. Although multiple medications were administered to promote bowel activity, an abdominal X-ray was not obtained until 2 47 pm on 6/27/16. The impression of the X-ray identified in part, a nonspecific bowel gas pattern with no obvious small bowel or colonic</p>	A 395			

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NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 365 MONTAUK AVE NEW LONDON, CT 06320		
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A 395	Continued From page 31 distension. Further review identified that Patient #1 also received Magnesium Citrate 300 milliliters at 3:52 pm and a soap suds enema at 6:02 pm. Nursing notes dated 6/27/16, 6:02 pm indicated that 1000 cubic centimeters of fluid was infused with the soap suds enema with yellow colored fluid returned. Abdominal assessments were being conducted in accordance with the policy and procedure.  Review of the nursing flowsheets dated 6/27/16 at 12:10 pm identified that Patient #1's pain level was a 7/10 as acceptable and aching. Patient #1 received Roxicodone 10 mg at 12:04 pm. At 1:00 pm, Patient #1's pain level was a 7/10 as shooting and unbearable. MD #1 was notified at 1:00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2:47 pm, the patient's pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patient #1 received another dose of Dilaudid 1.0 mg IV at 6:02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement. Patient #1 also received Roxicodone 10 mg at 7:20 pm with indications to reassess in one hour. At 7:22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9:00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Although review of the clinical record identified a change in condition, further review failed to identify that the physician was notified regarding the patient's current status.  Interview with RN #1 on 7/6/16 identified that he/she had gone into Patient #1's room at 9:15 pm to obtain his/her blood sugar and noticed the	A 395			

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A 395	<p>Continued From page 32</p> <p>patient was in the bathroom with the water running with the door shut. RN#1 indicated that he/she thought the enema had worked and the patient was in the bathroom having a bowel movement so he/she decided to come back in fifteen minutes. Further interview with RN #1 identified at 9.45 pm, he/she returned to Patient #1's room and the door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging by a bed sheet from the shower rod. RN #1 indicated that he/she had called for help; checked for a pulse while a Code 8 was called. Interview with MD #2 on 7/5/16 identified that he/she was first called regarding Patient #1 by responding to the code and found Patient #1 hanging with a bed sheet around a shower rod. MD #2 indicated that his/her assessment was that Patient #1 had expired "a while ago" so the decision was made based on his/her assessment not to resuscitate the patient and the patient was pronounced at 10 00 pm. Nursing staff failed to initiate CPR when the patient was found hanging from the shower rod.</p> <p>Review of hospital policy identified that at the time of admission, each patient has their needs assessed by a registered nurse and must be completed within eight hours of admission.</p> <p>Interview with Nurse Manager #1 on 7/1/16 identified that the nursing admission assessment was completed by two nurses at the change of shift, however, it was never saved in the computer.</p> <p>1b. Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small</p>	A 395			

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A 395	Continued From page 33  bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxytocin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus.  Review of the nursing flowsheets dated 6/27/16 at 12:10 pm identified that Patient #1's pain level was a 7/10 as acceptable and aching. Patient #1 received Roxycodone 10 mg at 12:04 pm. At 1:00 pm, Patient #1's pain level was a 7/10 as shooting and unbearable. MD #1 was notified at 1:00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2:47 pm, pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patient #1 received another dose of Dilaudid 1.0 mg IV at 6:02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement. Patient #1 also received Roxycodone 10 mg at 7:20 pm with indications to reassess in one hour. At 7:22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9:00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Further review failed to identify that pain reassessments were completed per hospital policy. The clinical record failed to reflect that the patient's pain was reassessed within one hour of the intervention in accordance with hospital policy. Review of the	A 395			

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NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 365 MONTAUK AVE NEW LONDON, CT 06320	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	<p>Continued From page 34</p> <p>pain policy directed that the patient's pain should be reassessed within 30 minutes of receiving an IV medication to determine efficacy of the intervention.</p> <p>2. Patient #2 was admitted to the facility on 6/26/16 with chronic back pain, abdominal pain, nausea and vomiting. Review of a physician's order directed Dilaudid 4 milligrams (mg.) intravenously every four hours as needed for pain. Review of the clinical record dated 7/2/16 at 7:44 PM identified that the patient rated pain as a four (4) on a scale of 1-10 (10 being the worst possible pain). Review of the Medication Administration Record dated 7/2/16 at 9:40 PM identified that Dilaudid 4 mg IV was administered. The clinical record failed to reflect that the patient's pain was reassessed within one hour of the intervention in accordance with hospital policy. The next documented pain assessment was recorded on 7/3/16 at 12:34 AM (2 hours, 54 minutes later). Review of the pain policy directed that the patient's pain should be reassessed within 30 minutes of receiving an IV medication to determine efficacy of the intervention.</p> <p>3. Patient #6 was admitted on 7/1/16 at 8:00 PM with right lower leg cellulitis. Review of the pain assessments for the period of 7/1/16 through 7/3/16 failed to reflect that pain assessments were completed every shift per the policy. Review of the record indicated that the first pain assessment was completed on 7/3/16 at 10:44 AM. Interview with the Clinical Coordinator on 7/3/16 at 10:55 AM stated pain levels should be assessed every shift. Review of the pain policy directed that a baseline pain assessment should be completed every shift with reassessments completed at least every shift.</p>	A 395		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  070067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/13/2016
NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 365 MONTAUK AVE NEW LONDON, CT 06320		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 396	<p>482.23(b)(4) NURSING CARE PLAN</p> <p>The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.</p> <p>This STANDARD is not met as evidenced by Based on clinical record review, review of policies and procedures and interviews with facility personnel for one of one sampled patients (Patient #1) who was at risk for suicidal ideation and/or had an extensive history of abdominal surgeries, chronic pain and was receiving analgesia, the facility failed to ensure that a comprehensive plan of care was completed for the patient on admission to the hospital. The findings include</p> <p>Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus.</p> <p>Review of the nursing admission assessment dated 6/17/16 failed to identify that an assessment including the patient's risk for suicidal ideation was completed upon admission per the facility's protocol. Review of the nursing plan of care failed to indicate the patient's suicidal</p>	A 396			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  070007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/13/2016
NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 365 MONTAUK AVE NEW LONDON, CT 06320		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 396	<p>Continued From page 36</p> <p>risk and/or pain management issues including interventions.</p> <p>Review of the nursing flowsheets dated 6/27/16 at 12:10 pm identified that Patient #1's pain level was a 7/10 as acceptable and aching. Patient #1 received Roxicodone 10 mg at 12:04 pm. At 1:00 pm, Patient #1's pain level was a 7/10 as shooting and unbearable. MD #1 was notified at 1:00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2:47 pm, pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patient #1 received another dose of Dilaudid 1.0 mg IV at 6:02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement. Patient #1 also received Roxicodone 10 mg at 7:20 pm with indications to reassess in one hour. At 7:22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9:00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Although review of the clinical record identified a change in condition, further review failed to identify that the physician was notified regarding the patient's current status.</p> <p>Interview with RN #1 on 7/6/16 identified that he/she had gone into Patient #1's room at 9:30 pm to do his blood sugar and noticed the patient was in the bathroom with the water running with the door shut. RN#1 indicated that he/she thought the enema had worked and the patient was in the bathroom having a bowel movement so he/she decided to come back in fifteen minutes. Further interview with RN #1 identified at 9:45 pm, he/she returned to Patient #1's room</p>	A 396			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  070097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/13/2016
NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 365 MONTAUK AVE NEW LONDON, CT 06320	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 396	Continued From page 37 and the door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging with a bed sheet around a shower rod. RN #1 indicated that he/she had called for help, checked for a pulse while a Code 8 was called at 9 50pm. Interview with MD #2 on 7/5/16 identified that he/she was first called regarding Patient #1 by responding to the code and found Patient #1 hanging from the shower rod. MD #2 indicated that his/her assessment was that Patient #1 had expired "a while ago" so the decision was made based on his/her assessment not to resuscitate the patient and the patient was pronounced at 10 00 pm.  Review of hospital policy identified that the patient plan of care serves as a rapid reference for the active problems, interventions and measurable goals the care team addresses. In addition, the plan of care is reviewed at least every 24 hours and revised as necessary.  Interview with Nurse Manager #1 on 7/1/16 identified that the plan of care did not address the patient's history of suicidal ideation and pain management including narcotic usage concerns.	A 396		
A 494	482.25(a)(3) PHARMACY DRUG RECORDS  Current and accurate records must be kept of the receipt and distribution of all scheduled drugs.  This STANDARD is not met as evidenced by Based on a review of the clinical record, review of hospital policies and procedures and interviews with facility personnel for one of twelve sampled patients (Patient #1), the pharmacy failed to ensure that narcotic renewals were monitored	A 494		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  070007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/13/2016
NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 365 MONTAUK AVE NEW LONDON, CT 06320		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 494	Continued From page 38 and reordered if necessary. The findings include  Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxytocin 10 milligrams every 12 hours prior to admission to the hospital. Review of the physician orders dated 6/18/16 identified that Patient #1 was to receive Fentanyl 25 micrograms every 72 hours and Oxycotin 10mg every 12 hours for pain to be renewed every seven days. On 6/25/16, Patient #1's medication was due to be renewed, however, the hospitalist never renewed the medication. Patient #1 had not received the scheduled Oxycotin for 36 hours. On 6/26/16, the 7:00 am - 3:00 pm nurse noticed the pain medication had not been renewed and called the physician for a new order.  Review of hospital policy identified that all Schedule I narcotic ordered will automatically be removed for the Medication Administration Record at 12:00 am on the seventh day if not renewed.  Interview with MD #6 on 7/13/16 identified that he/she was not aware and/or educated of an alert on the computer identifying that a patient's narcotic medications was up for renewal.  Interview with the Pharmacy Manager on 7/1/16	A 494			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  070007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/13/2016
NAME OF PROVIDER OR SUPPLIER  LAWRENCE & MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 365 MONTAUK AVE NEW LONDON, CT 06320		
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A 494	Continued From page 39 identified that pharmacy staff have no process in place to monitor when narcotics need to be renewed after seven days if the provider fails to renew the order. Further interview identified that the pharmacy relies on the provider to renew the narcotic when a purple tab in the computer that notifies the provider a narcotic needs to be renewed otherwise the narcotic order just drops off.  Review of hospital documentation dated 7/13/16, (16 days later) identified that a memo went out to all providers to remind them of renewing Schedule I: Controlled Substances every 7 days per state law.	A 494			



DEPARTMENT OF PUBLIC HEALTH  
ADVERSE EVENT REPORTING FORM  
HOSPITALS & OUTPATIENT SURGICAL FACILITIES

Sequential Report Number  
**0047 -16 - 08**

**DEMOGRAPHICS – Hospitals Only**

<input checked="" type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Hospital Based <input type="checkbox"/> Off Campus Satellite Site Name: _____  Address _____	<input type="checkbox"/> Outpatient <input type="checkbox"/> Hospital Based <input type="checkbox"/> Off Campus Satellite Site Name: _____  Address _____
<b>LOCATION OF OCCURENCE:</b>  <input type="checkbox"/> Medical Intensive Care <input type="checkbox"/> Neonatal Intensive Care <input type="checkbox"/> Surgical Intensive Care Unit <input checked="" type="checkbox"/> Adult Medical <input checked="" type="checkbox"/> Adult Surgical <input type="checkbox"/> Ambulatory Surgical <input type="checkbox"/> Cardiac Cath Lab <input type="checkbox"/> Cardiac Care <input type="checkbox"/> Dialysis <input type="checkbox"/> Emergency Department	<input type="checkbox"/> Obstetrical /Gynecological <input type="checkbox"/> Operating Room <input type="checkbox"/> Outpatient Services - Specify Type _____  <input type="checkbox"/> Pediatrics <input type="checkbox"/> Psychiatric <input type="checkbox"/> Diagnostic Services – Specify Type: _____  <input type="checkbox"/> Rehabilitative Services – Specify Type: _____  <input type="checkbox"/> Other _____

**NOTIFICATIONS:**

PATIENT AND/OR AUTHORIZED REPRESENTATIVE NOTIFIED OF EVENT: Y  Date notified June 28, 2016 N

DID THE PATIENT EXPIRE? Y  N   
If yes: June 27, 2016

<b>MEDICAL EXAMINER NOTIFIED</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	<b>AUTOPSY PERFORMED (if applicable)</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>
CASE NUMBER (if applicable): 16-70495	LOCATION: Not Applicable

At the time of this report, were any other entities known to have been notified of this event?

Check all that apply:	
<input type="checkbox"/> Centers for Medicare/Medicaid Services <input type="checkbox"/> Department of Children and Families <input type="checkbox"/> Food and Drug Administration <input type="checkbox"/> Joint Commission on the Accreditation of Health Care Organizations	<input checked="" type="checkbox"/> Local/State Police <input type="checkbox"/> Office of Protection and Advocacy for Persons with Disabilities <input type="checkbox"/> State Fire Marshal <input type="checkbox"/> Department of Social Services, Protective Services <input type="checkbox"/> Unknown to reporter at time of report

DEPARTMENT OF PUBLIC HEALTH  
ADVERSE EVENT REPORTING FORM  
HOSPITALS & OUTPATIENT SURGICAL FACILITIES

Sequential Report Number  
0047-16-08

**"CUT & PASTE" DESCRIPTION OF EVENT HERE FROM LIST**

**NQF 3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.**

**Facts of Event and Status of Patient Condition:**

Patient is a 64 year old male with extensive past medical history of chronic abdominal pain, chronic obstructive pulmonary disease, pulmonary embolism, congestive heart failure, coronary artery disease, anxiety, diabetes mellitus, irritable bowel syndrome, traumatic brain injury, pancreatitis, small bowel obstruction, recurrent ileus, appendectomy, cholecystectomy, splenectomy and multiple abdominal surgeries secondary to adhesions and obstruction, who presented to the ED on June 17, 2016 at 1627 with sudden onset diffuse abdominal pain, nausea, and vomiting requesting pain control. CT scan revealed some nondescript gaseous distention of the transverse colon with some gas and fluid in the ascending colon. Patient was admitted under hospitalist service on June 17, 2016 with a plan to keep patient NPO, IV fluids, and pain control. Surgical consult assessment and plan consist of treating conservatively with strict NPO, intravenous fluids, intravenous antibiotics via PICC and rule out ischemia. Patient refused NG tube. Over hospital stay, patient diet advanced to clear liquids and then to full liquids. Patient bowel sounds returned as well as flatus, but negative bowel movement since admission. Patient transitioned from IV pain medication to PO pain medication in anticipation of discharge. On June 26, 2016 patient cleared by surgery for discharge, pending bowel movement and hospitalist service. On June 27, 2016 patient had increased pain, nausea, and vomiting. IV pain medication given as well as soapy suds enema. Last documented assessment at 1902. Patient last visualized at 2115. Patient found asphyxiated at 2145.

**Immediate Plan of Action**

6/27 Immediate call for assistance from other 6.2 nursing staff. CODE 8 called. CODE 8 team responded.

No pulse palpated. MD pronounced. Director and Administrator on call notified. Security notified and contacted NLPD. Scene secured. NLPD responded. Medical Examiner contacted and responded.

6/30 Suicide Education with staff

Crisis debrief

Huddle with unit clinical coordinators regarding audit of patients on unit for nursing admission assessment saved in EMR, risk/safety assessment concerns incorporated into nursing care plan, documentation of last bowel movement, and nursing assessments documentation completed once a shift.

**FOR DPH USE ONLY**

Date Report Received- Emergent	
Date Report Received	
Date Corrective Action Plan Received	

DEPARTMENT OF PUBLIC HEALTH  
ADVERSE EVENT REPORTING FORM  
HOSPITALS & OUTPATIENT SURGICAL FACILITIES

**CORRECTIVE ACTION PLAN (CAP)**

Facility: Lawrence + Memorial Hospital 365 Montauk Avenue New London, CT 06320	Sequential Report Number for which this plan is being submitted:  0047-016-08
Patient Billing Number:	Date CAP Submitted:
Event being addressed:  NQF 3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.	
Findings:	
Corrective Action Plan to prevent reoccurrence:	
Does JCAHO require a root cause analysis for this event? Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Time line for implementation: Not applicable	Completion date for CAP: Not applicable
Identification of staff member, by title, who has been designated the responsibility for monitoring CAP implementation: Not applicable	
Submitted by: Tina Loarte-Rodriguez, MSQAc, BSN, RN, CIC, CPPS	Date:

**Henriques, Jennie**

---

**From:** Henriques, Jennie  
**Sent:** Tuesday, July 19, 2016 9:27 AM  
**To:** Caron, Heidi  
**Subject:** Re: additional documents not received

Hi Heidi - I am out of the office but I have asked someone from my office to get this information to you.

On Jul 19, 2016, at 8:45 AM, Caron, Heidi <[Heidi.Caron@ct.gov](mailto:Heidi.Caron@ct.gov)> wrote:

Hi Jenni,

I am still waiting on the progress notes that were to be completed by the physician on 6/27 and the discharge summary.

Thanks,

Heidi

## Henriques, Jennie

---

**From:** Henriques, Jennie  
**Sent:** Tuesday, July 26, 2016 5:04 PM  
**To:** 'Heidi.Caron@ct.gov'  
**Subject:** RE: additional documents not received

Hi Heidi:

We are working on finalizing our CAP and while reviewing the CMS report, there are a couple of items we need to add to our CAP. It is my understanding that our CAP is due 30 days from date of incident which would be tomorrow. I was wondering if it would be possible to give us until Friday to finalize and submit our CAP?

Jennie C. Henriques, CPHRM  
Director of Risk Management, Patient Safety & Quality Innovation  
Lawrence + Memorial Hospital  
Westerly Hospital  
365 Montauk Avenue, New London, CT 06320  
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707  
EMAIL: [jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)

**From:** Caron, Heidi [<mailto:secureMailer.d-f384194e5e2e4fd682aebccf33dcf758@ct.gov>] **On Behalf Of** Caron, Heidi  
**Sent:** Tuesday, July 19, 2016 11:31 AM  
**To:** Henriques, Jennie  
**Subject:** RE: additional documents not received

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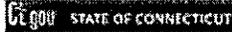
**From:** "Caron, Heidi" <[Heidi.Caron@ct.gov](mailto:Heidi.Caron@ct.gov)>  
**Subject:** RE: additional documents not received

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Message available online until 08/18/2016. Use your password to access the message.

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Original Version

From: Heidi Caron <Heidi.Caron@ct.gov>  
 To: Jennie Henriques <jhenriques@lmhosp.org>  
 Date: 19 July 2016 11:50

Expires in 20 days

RE: additional documents not received

Can we have a copy of the death certificate and the request for autopsy documents that were completed as well.

Thanks,

Heidi

From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]  
 Sent: Tuesday, July 19, 2016 9:27 AM  
 To: Caron, Heidi <Heidi.Caron@ct.gov>  
 Subject: Re: additional documents not received

Hi Heidi - I am out of the office but I have asked someone from my office to get this information to you.

On Jul 19, 2016, at 8:45 AM, Caron, Heidi <Heidi.Caron@ct.gov> wrote:

Hi Jenni,

I am still waiting on the progress notes that were to be completed by the physician on 6/27 and the discharge summary.

Thanks,

Heidi



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Drafts (4)

Fw: Re: RE: Items you Requested

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Fw: Re: RE: Items you Requested

On 11 July 2016, "Jennie Henriques" <jhenriques@lmhosp.org> wrote:  
> Hi Heidi:

: Can you do Wednesday? It looks like we can do all of the provider interviews Wednesday morning and the two nursing supervisors in the early afternoon. Let me know.

: Thanks!

: On 11 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:

: > Hi Jennie,

: I am hopefully that the interviews will all be scheduled for Tuesday. In addition, can you tell me who the nursing supervisor and/or administrator was that night? I will need to interview that person and I will need to speak with Heather the Nurse Manager of CDU.

: Any questions, call me today in the office.

: Heidi

: From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]

: Sent: Friday, July 08, 2016 4:49 PM

: To: Caron, Heidi <Heidi.Caron@ct.gov>

: Subject: RE: Items you Requested

: Hi Heidi:

: I just wanted to follow up and let you know that IPC has retained counsel for Drs. Donovan, Debaets and APRN Luther. They have retained Joyce Lagnese who is Nell Danaher's partner, and she is great to work with.

: Joyce has been provided with your contact information and will reach out to you directly to schedule the interviews. She is aware that you were trying to schedule them for Monday or Tuesday of next week, and thought that Tuesday might work but would need to coordinate that with the providers.

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JULIE MAILBOX

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Drafts (4)

Pw: Re: RE: Items you Requested

Re: RE: Items you Requested

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ndanaher@danaherfagnese.com  
jhenriques@lmhosp.org

Re: RE: Items you Requested

FYI

On 11 July 2016, "Jennie Henriques" <jhenriques@lmhosp.org> wrote:  
> Hi Heidi:

Can you do Wednesday? It looks like we can do all of the provider interviews Wednesday morning and the two nursing supervisors in the early afternoon. Let me know.

Thanks!

On 11 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:

> Hi Jennie,  
I am hopefully that the interviews will all be scheduled for Tuesday. In addition, can you tell me who the nursing supervisor and/or administrator was that night? I will need to interview that person and I will need to speak with Heather the Nurse Manager of CDU.

Any questions, call me today in the office.  
Heidi

From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]  
Sent: Friday, July 08, 2016 4:49 PM  
To: Caron, Heidi <Heidi.Caron@ct.gov>  
Subject: RE: Items you Requested

Hi Heidi:

I just wanted to follow up and let you know that IPC has retained counsel for Drs. Donovan, Debaets and APRN Luther. They have retained Joyce Lagnese who is Neil Danaher's partner, and she is great to work with.

Joyce has been provided with your contact information and will reach out to you directly to schedule the interviews. She is aware that you were trying to schedule them for Monday or Tuesday of next week, and thought that Tuesday might work but

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Inbox (1)

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Original Version

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Drafts (4)

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Hi Jennie,

If you can provide the info that would be greatly appreciated.

Thanks,

Heidi

From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]
Sent: Wednesday, July 06, 2016 7:16 AM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Items you Requested
Importance: High

Hi Heidi:

I wanted to follow up on some of the things you requested yesterday afternoon.

You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted to have legal counsel present and those interviews will need to be coordinated through their legal counsel. I will provide your contact information to their attorney. If you have any questions or concerns, please do not hesitate to call me.



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RE: Items you Requested

Interviews

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Drafts (4)

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Original Version

Hi Jeannie,

Can these interviews with the physicians and APRN be scheduled on Monday or Tuesday next week?

Thanks,

Heidi

From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]
Sent: Wednesday, July 06, 2016 7:16 AM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Items you Requested
Importance: High

Hi Heidi:

I wanted to follow up on some of the things you requested yesterday afternoon.

You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted



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Drafts (4)

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Interviews

RE: Interviews

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Can you add the admin or manager that was on that night and who from admin came in after the event?  
Thanks.  
Heidi

-----Original Message-----

From: Jennie Henriques [mailto:secureMailer.d-23498657249847e2ab65035a8925d09f@ct.gov] On Behalf Of Jennie Henriques  
Sent: Thursday, July 07, 2016 1:40 PM  
To: Caron, Heidi <Heidi.Caron@ct.gov>  
Subject: Re: interviews

Hi Heidi:

I put a call into to check and see if we can make it happen. I am hoping we can, and will reach out to you by tomorrow morning

Have a great day!

On 7 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:  
> Hi Jeannie,  
Can these interviews with the physicians and APRN be scheduled on Monday or Tuesday next week?  
Thanks,  
Heidi

From: Henriques, Jennie [mailto:jhenriques@lmihosp.org]  
Sent: Wednesday, July 06, 2016 7:16 AM  
To: Caron, Heidi <Heidi.Caron@ct.gov>  
Subject: Items you Requested  
Importance: High

Hi Heidi

SECURE MAILBOX

RE: additional documents not received Drafts (4) Fw: Re: RE: Items you Requested Ra: RE: Items you Requested  
Inbox (1) RE: Items you Requested Interviews RE: Interviews RE: Items you Requested

Compose Mail

Inbox (1)  
Sent  
Drafts (4)  
Search  
Manage Folders

Reply Reply to All Forward Delete Move to folder... Move Original Version

Thanks for the update. Hope to be able to coordinate for Tuesday then.  
Heidi

From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]  
Sent: Friday, July 08, 2016 4:49 PM  
To: Caron, Heidi <Heidi.Caron@ct.gov>  
Subject: RE: Items you Requested

Hi Heidi:

I just wanted to follow up and let you know that IPC has retained counsel for Drs. Donovan, Debaets and APRN Luther. They have retained Joyce Lagnese who is Neil Danaher's partner, and she is great to work with.

Joyce has been provided with your contact information and will reach out to you directly to schedule the interviews. She is aware that you were trying to schedule them for Monday or Tuesday of next week, and thought that Tuesday might work but would need to coordinate that with the providers.



- SECURE MAILBOX
- Compose Mail
- Inbox (1)
- Sent
- Drafts (4)
- Search
- Manage Folders

RE: additional documents not received      Drafts (4)      Fw: Re: RE: Items you Requested      Re: RE: Items you Requested

Inbox (1)      RE: Items you Requested      Interviews      RE: Interviews      RE: Items you Requested

RE: RE: RE: RE: Items you Requested

Hi Jenni,  
 Would the Director of Radiology be available to review xrays and CT scans?

-----Original Message-----  
 From: Jennie Henriques [mailto:secureMailer-d-bf7af3cc4d9a414f910eb0efae495ca0@ct.gov] On Behalf Of Jennie Henriques  
 Sent: Monday, July 11, 2016 2:57 PM  
 To: Caron, Heidi <Heidi.Caron@ct.gov>  
 Subject: Re: RE: RE: RE: Items you Requested

Great, see you then!

On 11 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:  
 > By 930am

-----Original Message-----  
 From: Jennie Henriques [mailto:secureMailer-d-7f60da34144f4ca4a6c71a1cb42ccc4f@ct.gov] On Behalf Of Jennie Henriques  
 Sent: Monday, July 11, 2016 1:50 PM  
 To: Caron, Heidi <Heidi.Caron@ct.gov>  
 Subject: Re: RE: RE: Items you Requested

Perfect! What time should I expect you as I want to make sure we fine up the interviews based on your estimated arrival time

See you on Wednesday.

On 11 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:  
 > That would be fine  
 Heidi



- SECURE MAIL BOX
- Compose Mail
- Inbox (1)
- Sent
- Drafts (4)
- Search
- Manage Folders

- RE: additional documents not received
- Drafts (4)
- FW: RE: RE: Items you Requested
- RE: RE: Items you Requested
- Inbox (1)
- RE: Items you Requested
- Interviews
- RE: Interviews
- RE: Items you Requested
- RE: RE: RE: RE: Items you Requested
- additional info not received on Tuesday

Reply  
 Reply to All  
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Hi Jenni,

These are a few pieces of info I did not receive on Tuesday.

1. On Call List for 6/2016 and 7/2016
2. Privileges for Donovan, Wolf, Debaets and Luther.

Please fax asap to 8605097543.

Thanks,

Heidi



- SECURE MAILBOX
- Compose Mail
- Inbox (1)
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- Drafts (4)
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- Manage Folders

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Reply    Reply to All    Forward    Delete    Move to folder    Move

Can you email it to me?

-----Original Message-----

From: Jennie Henriques [mailto:secureMailbox-d-72b309d3b1b1422ea0d0e6bd7e057dd8@ct.gov] On Behalf Of Jennie Henriques  
 Sent: Friday, July 15, 2016 3:10 PM  
 To: Caron, Heidi <Heidi.Caron@ct.gov>  
 Subject: Re: additional info not received on Tuesday

Hi Heidi-

We have tried to fax over the documents several times but it keeps telling us no answer. Can you confirm the fax machine is working. It is a large document 62 pages total

Thanks

Jennie

On 15 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote.

> Hi Jenni,

These are a few pieces of info I did not receive on Tuesday.

1 On Call List for 6/2016 and 7/2016

2 Privileges for Donovan, Wolf, Debaets and Luther.

Please fax asap to 8605097543

Thanks,

Heidi



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RE: RE: additional info not received on Tuesday

Reply   Reply to All   Forward   Delete   Move to folder   Move

I have received it  
Thanks,  
Heidi

-----Original Message-----

From: Jennie Henriques [mailto:secureMailer-d-3e68c3031bca47cd99f753652406c1e6@ct.gov] On Behalf Of Jennie Henriques  
Sent: Monday, July 18, 2016 10:39 AM  
To: Caron, Heidi <Heidi.Caron@ct.gov>  
Subject: Re: RE: additional info not received on Tuesday

Hi Heidi.

We were able to fax it over this morning. Can you please confirm that you received it?

On 18 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote  
> Can you email it to me?

-----Original Message-----

From: Jennie Henriques [mailto:secureMailer-d-72b309d3b1b1422ca0d0c6bd7c057dd8@ct.gov] On Behalf Of Jennie Henriques  
Sent: Friday, July 15, 2016 3:10 PM  
To: Caron, Heidi <Heidi.Caron@ct.gov>  
Subject: Re: additional info not received on Tuesday

Hi Heidi

We have tried to fax over the documents several times but it keeps telling us no answer. Can you confirm the fax machine is working. It is a large document 62 pages total.



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RE: RE: additional info not received on Tuesday

↩Reply    ↩Reply to All    ↗Forward    🗑Delete    📁Move to folder...    ➦Move    Original Version

Can we have a copy of the death certificate and the request for autopsy documents that were completed as well.

Thanks,  
Heidi

**From:** Henriques, Jennie [mailto:jhenriques@lmhosp.org]  
**Sent:** Tuesday, July 19, 2016 9:27 AM  
**To:** Caron, Heidi <Heidi.Caron@ct.gov>  
**Subject:** Re: additional documents not received

Hi Heidi - I am out of the office but I have asked someone from my office to get this information to you.

On Jul 19, 2016, at 8:45 AM, Caron, Heidi <Heidi.Caron@ct.gov> wrote:

Hi Jenni,  
  
I am still waiting on the progress notes that were to be completed by the physician on 6/27 and the discharge summary.  
  
Thanks.



- SECURE MAILBOX
- Compose Mail
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RE: additional documents not received      Sent      Re: RE: additional info not received on Tuesday

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Hi Heidi:

We were able to fax it over this morning. Can you please confirm that you received it?

On 18 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:  
> Can you email it to me?

-----Original Message-----

From: Jennie Henriques [mailto:secureMailer.d-72b309d3b1b1422ca0d0e6bd7e057dd8@ct.gov] On Behalf Of Jennie Henriques  
 Sent: Friday, July 15, 2016 3:10 PM  
 To: Caron, Heidi <Heidi.Caron@ct.gov>  
 Subject: Re: additional info not received on Tuesday

Hi Heidi,

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Thanks

Jennie

On 15 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:  
> Hi Jenni,  
> These are a few pieces of info I did not receive on Tuesday

1. On Call List for 6/2016 and 7/2016
2. Privileges for Donovan, Wolf, Debaets and Luther.

Please fax asap to 8605097543.  
Thanks,



- SECURE MAILBOX
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Jennie

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Please fax asap to 8605097543  
Thanks,  
Heidi



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RE: additional documents not received

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Re: additional info not received on Tuesday

Re: additional info not received on Tuesday

Reply Reply to All Forward Delete Recall Move to folder Move

Hi Heidi:

It is being faxed right now. Please let me know that you have received it

Thanks!

On 15 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote

> Hi Jenni,

These are a few pieces of info I did not receive on Tuesday.

- 1. On Call List for 6/2016 and 7/2016
- 2 Privileges for Donovan, Wolf, Dehaets and Luther

Please fax asap to 8605097543

Thanks,

Heidi

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RE: additional documents not received Sent Re: RE: additional info not received on Tuesday

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Hi Heidi

I just wanted to let you know that I believe I have all the interviews you requested scheduled for tomorrow. See you in the morning.

On 12 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:

> Hi Jenni,  
Would the Director of Radiology be available to review xrays and CT scans?

-----Original Message-----

From: Jennie Henriques [mailto:secureMailer.d-bf7af8cc4d9a414f910eb0efae495ca0@ct.gov] On Behalf Of Jennie Henriques

Sent: Monday, July 11, 2016 2:57 PM

To: Caron, Heidi <Heidi.Caron@ct.gov>

Subject: Re: RE: RE: RE: Items you Requested

Great, see you then!

On 11 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote.  
> By 9:30am

-----Original Message-----

From: Jennie Henriques [mailto:secureMailer.d-7f60da34144f4ca4a6e71a1eb42ecc4f@ct.gov] On Behalf Of Jennie Henriques

Sent: Monday, July 11, 2016 1:50 PM

To: Caron, Heidi <Heidi.Caron@ct.gov>

Subject: Re: RE: RE: Items you Requested

Perfect! What time should I expect you as I want to make sure we line up the interviews based on your estimated arrival time.

**Henriques, Jennie**

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**From:** Henriques, Jennie  
**Sent:** Wednesday, July 13, 2016 4:05 PM  
**To:** 'Heidi.Caron@ct.gov'  
**Subject:** RE: RE: RE: RE: Items you Requested  
**Attachments:** DPC Prescriber Education 7-16.doc

Hi Heidi:

Attached please find the communication that is going out to providers. Please let me know if you have any questions.

Jennie C. Henriques, CPHRM  
Director of Risk Management, Patient Safety & Quality Innovation  
Lawrence + Memorial Hospital  
Westerly Hospital  
365 Montauk Avenue, New London, CT 06320  
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707  
EMAIL: [jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)

**From:** Caron, Heidi [<mailto:secureMailer.d-f6bae7ca55f64e8d9afb88f75b34f223@ct.gov>] **On Behalf Of** Caron, Heidi  
**Sent:** Tuesday, July 12, 2016 11:38 AM  
**To:** Henriques, Jennie  
**Subject:** RE: RE: RE: RE: Items you Requested



**Secure Message Delivery**

**From:** "Caron, Heidi" <[Heidi.Caron@ct.gov](mailto:Heidi.Caron@ct.gov)>  
**Subject:** RE: RE: RE: RE: Items you Requested

[View Message](#)

Message available online until 08/11/2016. Use your password to access the message.

TO: All Providers

FROM: Daniel Rissi, MD, VP/Chief Medical & Clinical Operations Officer  
Kenneth Donovan, MD, Chair, Department of Medicine  
Robert Lincer, MD, Chari, Department of Surgery

DATE: July 13, 2016

This memo is to serve as a reminder of the CT state law mandates Schedule II Controlled Substance orders for inpatients expire after 7 days, and to increase awareness of the fact that these orders must be renewed or they will fall off the patient's profile.

Please see the below screenshots which are found on the orders tab of Mckesson HEO CPOE system. Once in the orders screen, you will see the fourth tab from the left on the bottom screen called "Renew". In the event that there is an order that needs to be renewed, this tab will be colored bright pink. To renew the expiring order(s), simply click on the tab and renew the orders.

While renewing orders is primarily a provider responsibility, both nursing and pharmacy staff will take measures to remind providers of orders soon to expire. The following methods will be utilized:

1. Nursing will incorporate review of expiring Schedule II orders with notification to prescriber as part of nightly chart check.
2. Pharmacy will incorporate this review as part of interdisciplinary rounds on all units pharmacy currently rounds on, which has been expanded to include CDU.
3. Once the Epic system is implemented in October 2016, a custom report will be available and run daily that lists all expiring controlled substance orders. The pharmacy will plan on running this report daily and communicating with prescribers regarding expiring orders.

Please contact the pharmacy at extension 2513 if there are any questions.

Patient with 2 narcotics about to expire within the next 24 hrs (2:59 am 7/14 to be exact):

- LUKAZEPAM tablet [ AMBIEN ] 0.5 mg oral every 4 hr prn x30 days for anxiety »Jul 07 03:00... Aug 0 02:59
- morphINE Inj 2 mg iv every 4 hr prn x7 days for severe pain scale 8-10 »Jul 07 03:00... Jul 14 02:59
- oxyCODONE 5 mg - acetaminophen 325 mg [ PERCOCET ] 1 tablet oral every 6 hr prn x7 days for pain scale 4-7 may repeat x 1 within 1 hr xcomment 2 ngth constant). »Jul 07 03:00... Jul 14 02:59
- sodium chloride 0.9% flush 5 ml iv as directed »Jul 07 23:00...
- sodium chloride 0.9% flush 10 ml iv as directed »Jul 07 23:00...
- zolpidem tablet [ AMBIEN ] 5 mg oral at bedtime prn x30 days for sleep »Jul 07 03:00...Aug 6 02:59

V fluids -

IPN orders

Other interventions

- WOUND CONSULT wound wound type/location toe »Jul 07 01:57...

aboratory tests -

print <F1>	display <F2>	Del		outline <F4>
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## Henriques, Jennie

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**From:** Henriques, Jennie  
**Sent:** Friday, July 08, 2016 4:49 PM  
**To:** 'Heidi.Caron@ct.gov'  
**Subject:** RE: Items you Requested

Hi Heidi:

I just wanted to follow up and let you know that IPC has retained counsel for Drs. Donovan, Debaets and APRN Luther. They have retained Joyce Lagnese who is Neil Danaher's partner, and she is great to work with.

Joyce has been provided with your contact information and will reach out to you directly to schedule the interviews. She is aware that you were trying to schedule them for Monday or Tuesday of next week, and thought that Tuesday might work but would need to coordinate that with the providers.

In the meantime, if you have any questions, concerns, or if you need anything else, please do not hesitate to call or email me.

Sincerely,

Jennie C. Henriques, CPHRM  
Director of Risk Management, Patient Safety & Quality Innovation  
Lawrence + Memorial Hospital  
Westerly Hospital  
365 Montauk Avenue, New London, CT 06320  
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707  
EMAIL: [jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)

**From:** Henriques, Jennie  
**Sent:** Wednesday, July 06, 2016 7:16 AM  
**To:** 'Heidi.Caron@ct.gov'  
**Subject:** Items you Requested  
**Importance:** High

Hi Heidi:

I wanted to follow up on some of the things you requested yesterday afternoon.

You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted to have legal counsel present and those interviews will need to be coordinated through their legal counsel. I will provide your contact information to their attorney. If you have any questions or concerns, please do not hesitate to call me.

Sincerely,

Jennie C. Henriques, CPHRM  
Director of Risk Management, Patient Safety & Quality Innovation  
Lawrence + Memorial Hospital  
Westerly Hospital

365 Montauk Avenue, New London, CT 06320  
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707  
EMAIL: [jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)

## Henriques, Jennie

---

**From:** Henriques, Jennie  
**Sent:** Wednesday, July 06, 2016 7:16 AM  
**To:** 'Heidi.Caron@ct.gov'  
**Subject:** Items you Requested  
  
**Importance:** High

Hi Heidi:

I wanted to follow up on some of the things you requested yesterday afternoon.

You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted to have legal counsel present and those interviews will need to be coordinated through their legal counsel. I will provide your contact information to their attorney. If you have any questions or concerns, please do not hesitate to call me.

Sincerely,

Jennie C. Henriques, CPHRM  
Director of Risk Management, Patient Safety & Quality Innovation  
Lawrence + Memorial Hospital  
Westerly Hospital  
365 Montauk Avenue, New London, CT 06320  
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707  
EMAIL: [jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)

**Henriques, Jennie**

---

**From:** Henriques, Jennie  
**Sent:** Tuesday, July 19, 2016 9:27 AM  
**To:** Caron, Heidi  
**Subject:** Re: additional documents not received

Hi Heidi - I am out of the office but I have asked someone from my office to get this information to you.

On Jul 19, 2016, at 8:45 AM, Caron, Heidi <[Heidi.Caron@ct.gov](mailto:Heidi.Caron@ct.gov)> wrote:

Hi Jenni,  
I am still waiting on the progress notes that were to be completed by the physician on 6/27 and the discharge summary.  
Thanks,  
Heidi

## Goodson, Marcia

---

**From:** Henriques, Jennie <jhenriques@lmhosp.org>  
**Sent:** Friday, July 29, 2016 4:30 PM  
**To:** 'Susan.Newton@ct.gov'  
**Subject:** secure FINAL DPH CAP 7 30 16 Site Survey June 30 through July 1 2016 (Incident date June 27 2016)  
**Attachments:** FINAL DPH CAP 7 30 16 Site Survey June 30 through July 1 2016 (Incident date June 27 2016).docx

**Hi Sue:**

Attached please find our CAP for Adverse Event dated June 27, 2016, Sequential Report Number 0047-16-08/DPH Survey. As we discussed, you had agreed to an extension until today, July 29, 2016. Please confirm that you have received this email.

If you have any questions or concerns, please do not hesitate to call or email me.

Jennie C. Henriques, CPHRM, CHPC  
Director of Risk Management, Patient Safety & Quality Innovation  
Interim Compliance + Privacy Officer  
Lawrence + Memorial Hospital  
Westerly Hospital  
365 Montauk Avenue, New London, CT 06320  
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707  
EMAIL: [jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)

Lawrence & Memorial Hospital  
 Date of Submission: July 29, 2016  
 DPH Corrective Action Plan

Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016  
 Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
1	Compliance with completing Nursing Admission Assessment for inpatients.	Associate Chief Nursing Officer	a.	<u>Review</u> policies titled “Documentation, Patient” and “Assessment & Reassessment of Patients” to ensure compliance with current evidence based practice.	June 30, 2016	Policies will be reviewed every three years or when changes are needed to reflect evidence based practice.	June 30, 2016	P3 Committee (Policy, Procedure, Protocol)  Patient Care Services
		CDU Nurse Manager	b.	<u>Educate</u> nursing staff on compliance with policies titled “The Document, Patient” and “Assessment & Reassessment of Patients” on <u>CDU</u> .	June 30, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety  Quality Council
		CDU Manager	c.	<u>AUDIT:</u> Compliance with completing nursing Admission Assessment to include suicide risk assessment questions on all <u>CDU</u> patients.	July 1, 2016	<u>AUDITS:</u> Four (4) consecutive months with 100% compliance.  100% of charts will be audited	November 8, 2016	Patient Safety  Quality Council
		Associate Chief Nursing Officer	d.	<u>Educate</u> nursing staff on compliance with policies titled “Documentation, Patient” and “Assessment &	July 8, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and	August 5, 2016	Patient Safety  Quality

Lawrence & Memorial Hospital  
 Date of Submission: July 29, 2016  
 DPH Corrective Action Plan

Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016  
 Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				Reassessment of Patients” on <u>all adult inpatient units excluding NICU and Perioperative Services.</u>	July 8, 2016	signoff on education.		Council
		Associate Chief Nursing Officer	e.	<b>AUDIT</b> Compliance with nursing admission assessment audit on <u>all adult inpatient units excluding NICU and Perioperative Services.</u>	July 8, 2016	<b>AUDITS:</b> Four (4) consecutive months with 90% or greater compliance.  5 charts per inpatient unit per week.	November 8, 2016	Patient Safety  Quality Council
		ED Nurse Managers  ED Crisis Manager	f.	<b>Educate</b> ED nursing & ED Crisis staff on policy titled “Delivery of Care for ED Patients” and “Management of Behavior Patient” at main ED and PEQ ED.	July 8, 2016	<b>Monitoring:</b> 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety  Quality Council
		ED Crisis Manager	g.	<b>Educate</b> Inpatient Psychiatric Unit staff on policy titled “Levels of Observation, Inpatient Psych”.	August 15, 2016	<b>Monitoring:</b> 100% of nursing staff will be educated and signoff on	September 15, 2016	Patient Safety  Quality Council

Lawrence & Memorial Hospital  
 Date of Submission: July 29, 2016  
 DPH Corrective Action Plan

Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016  
 Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						education.		
		ED Nurse Managers ED Crisis Manager	h.	<u>Audit</u> compliance with Emergency Dept. Room record (includes ED Crisis) for suicide screening documentation.	July 8, 2016	<u>AUDITS:</u> Four (4) consecutive months with 90% or greater compliance.  Five (5) ED records each at Main ED and PEQ per week  <u>ED Crisis:</u> 100% of patients charts will be audited.	November 8, 2016	Patient Safety Quality Council
<b>2</b>	<b>Compliance with completing assessment and reassessment of pain</b>	Associate Chief Nursing Officer	a.	<u>Review and revise</u> policy titled "Pain Management" to ensure policy reflects current practice.	July 30, 2016	Policy will be reviewed every three years <u>or</u> when changes are needed to reflect	August 15, 2016	Patient Safety Quality Council

Lawrence & Memorial Hospital  
 Date of Submission: July 29, 2016  
 DPH Corrective Action Plan

Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016  
 Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						evidence based practice.		
		CDU Manager	b.	<u>Educate</u> nursing staff on compliance with policy titled "Pain Management" on <u>CDU</u> . Education will reinforce assessment and reassessment of pain before and after interventions.	August 10, 2016	<u>Monitoring:</u> 100% of CDU nursing staff will be educated and signoff on education.	September 10, 2016	Patient Safety Quality Council
		CDU Manager	c.	<u>AUDIT</u> Compliance with completing nursing assessment and reassessment of pain before and after interventions on <u>CDU</u> .	September 10, 2016	<u>AUDITS:</u> Four (4) consecutive months with 100% compliance.  <u>CDU:</u> 100% of charts will be audited.	January 10, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	<u>Educate</u> nursing staff on compliance with policy titled "Pain Management" on <u>all adult inpatient units, emergency room and crisis ED. (excluding NICU and Perioperative Services)</u> . Education will reinforce	August 10, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.	September 10, 2016	Patient Safety Quality Council

Lawrence & Memorial Hospital  
 Date of Submission: July 29, 2016  
 DPH Corrective Action Plan

Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016  
 Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				assessment and reassessment of pain before and after interventions.				
		Associate Chief Nursing Officer	e.	<u>AUDIT</u> compliance with completing nursing assessment and reassessment of pain before and after interventions on <u>all adult inpatient units and emergency rooms (Includes Main and PEQ; excludes NICU and Perioperative Services)</u>	September 10, 2016	<u>AUDITS:</u> Four (4) consecutive months with 90% or greater compliance.  Five (5) ED records each at Main ED and PEQ per week.  <u>ED Crisis:</u> 100% of patients charts will be audited.	January 10, 2016	Patient Safety  Quality Council
3	Compliance with completing psychosocial assessment on inpatient nursing	CDU Nurse Manager	a.	<u>Educate</u> nursing staff on compliance with policies titled “The Document, Patient” and “Assessment & Reassessment of Patients” on <u>CDU</u> .	June 30, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety  Quality Council

Lawrence & Memorial Hospital  
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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
	flowsheet(s).	CDU Manager	b.	<p><u>AUDIT</u> Compliance with completion of psychosocial documentation on nursing flowsheet for <u>CDU</u>.</p> <ul style="list-style-type: none"> <li>If change in psychosocial is identified, has the Care Plan been personalized to reflect intervention(s).</li> </ul>	July 8, 2016	<p><u>AUDITS:</u> Four (4) consecutive months with 100% compliance.</p>	November 8, 2016	<p>Patient Safety</p> <p>Quality Council</p>
		Associate Chief Nursing Officer	c.	<p><u>Educate</u> nursing staff on compliance with policies titled “The Document, Patient” and “Assessment &amp; Reassessment of Patients” on <u>all adult inpatient units</u>.</p>	July 8, 2016	<p><u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.</p>	August 5, 2016	<p>Patient Safety</p> <p>Quality Council</p>
		Associate Chief Nursing Officer	d.	<p><u>AUDIT</u> Compliance with completion of psychosocial documentation on nursing flowsheet for <u>all inpatient units</u>.</p> <ul style="list-style-type: none"> <li>If change in psychosocial is identified, has the Care Plan been personalized to reflect intervention(s).</li> </ul>	July 8, 2016	<p><u>AUDITS:</u> Four (4) consecutive months with 90% or greater compliance.</p> <p>Five (5) charts per inpatient unit per week.</p>	November 8, 2016	<p>Patient Safety</p> <p>Quality Council</p>

Lawrence & Memorial Hospital  
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 Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
4	Compliance with completing Personalized Care Plan	Associate Chief Nursing Officer	a.	<u>Review</u> policies titled “The Document, Patient” and “Assessment & Reassessment of Patients” to ensure compliance with current evidence based practice.	June 30, 2016	Policies will be reviewed every <u>or</u> three years when changes are needed to reflect evidence based practice.	June 30, 2016	Patient Safety Quality Council
		CDU Manager	b.	<u>Educate</u> nursing staff on compliance with policies titled “The Document, Patient” and “Assessment & Reassessment of Patients” on <u>CDU</u> .	June 30, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		CDU Manager	c.	<u>AUDIT</u> compliance with completing Nursing personalized care plan based on patient assessment on all <u>CDU</u> patients.	July 1, 2016	<u>AUDITS:</u> Four (4) consecutive months with 100% compliance. 100% of charts will be audited.	November 8, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	<u>Educate</u> nursing staff on compliance with policies titled “The Document,	July 8, 2016	<u>Monitoring:</u> 100% of nursing	August 5, 2016	Patient Safety

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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				Patient” and “Assessment & Reassessment of Patients” on <u>all adult inpatient units (excludes ED &amp; Perioperative)</u>	July 8, 2016	staff will be educated and signoff on education.		Quality Council
			e.	<u>AUDIT</u> compliance with nursing personalized care plan audit on <u>all adult inpatient units, inpatient psychiatry (excludes ED, ED Crisis &amp; Perioperative)</u> .	July 8, 2016	<u>AUDITS: Four (4)</u> consecutive months with 90% or greater compliance.  Five (5) charts per inpatient unit per week.	November 8, 2016	Patient Safety  Quality Council
5	Compliance with Schedule Class II narcotic medication order.	Director of Pharmacy	a.	<u>Review and revise</u> “Controlled Substance” Policy to ensure compliance with current evidence based practice and current state regulations.	July 30, 2016	Policies will be reviewed every three years <u>or</u> when changes are needed to reflect evidence based practice.	August 5, 2016	Pharmacy and Therapeutics
			b.	<u>Educate</u> nursing staff on compliance with policy “Controlled Substance” on <u>all adult inpatient units</u> .	August 10, 2016	<u>Monitoring:</u> 100% of nursing staff will be	September 10, 2016.	Patient Safety

Lawrence & Memorial Hospital  
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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						educated and signoff on education.		Quality Council
		Director of Pharmacy & Chief of Medicine	c.	<u>Educate</u> medical staff regarding current electronic medical record renewal process of Schedule Class II narcotic orders and renewal alert via email communication.	July 13, 2016	<u>Monitoring:</u> Ongoing	July 13, 2016	Quality Council
		Director of Pharmacy	d.	<u>Process:</u> Pharmacy will review daily report of medication profiles for CDU, specifically Schedule Class II narcotic order(s) and renewal(s) to ensure compliance with policy.	July 6, 2016	Ongoing	Ongoing	Patient Safety Quality Council
		CDU Nurse Manager / Clinical Coordinator Director of Pharmacy	e.	<u>Implement</u> nursing daily chart review for Schedule Class II narcotics scheduled to automatically discontinue with notification to licensed independent practitioners.	July 8, 2016	Ongoing <u>or</u> until a report can be created to transition monitoring to pharmacy department.	Ongoing <u>or</u> until a report can be created to transition monitoring to pharmacy department.	Patient Safety Quality Council
6	Review of CDU Scope of	Associate Chief Nursing Office	a.	<u>Review of:</u> a. CDU Staffing model, staffing	July 1, 2016	<u>Monitoring:</u> On-going	On-going	Nursing Leadership

**Lawrence & Memorial Hospital**  
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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
	Services.			<p>orientation and competency,</p> <p>b. leadership expertise and competency</p> <p>to reflect current evidence based practice.</p> <p>No changes to current structure needed at this time.</p>				Meeting
7	Governing Board minutes	Special Project Coordinator & Executive Assistant	a.	Governing Board minutes to include actions taken by the board as follows: review of Quality Council Minutes, Patient Safety Minutes, and Board agreement and/or identify opportunities with Quality & Patient Safety activities.	August 1, 2016	Ongoing	Ongoing	N/A
8	Quality Council Minutes	Director of Risk Management, Patient Safety & Quality	a.	Quality Council minutes to include actions taken by the council as follows: review of Patient Safety Minutes, and identify opportunities with Quality & Patient Safety activities that are reviewed and discussed at	August 1, 2016	Ongoing	Ongoing	Governing Board

Lawrence & Memorial Hospital  
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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
9	Physician Documentation related to patient change in condition	Director of Risk Management, Patient Safety & Quality	a.	<u>Continuing Education</u> for medical staff regarding medical record documentation standards and best practices.	October 31, 2016	Ongoing	November 15, 2016	Quality Council
		Director of Risk Management, Patient Safety & Quality	b.	<u>Audit</u> compliance of medical records to ensure completeness of medical record. Identified opportunities for improvement will be reported to physician leaders.	August 15, 2015	<b>AUDITS:</b> four (4) consecutive months with 90% or greater compliance.  Five (5) charts per inpatient unit per week.	December 15, 2016	Quality Council
10	Provide emergency treatment/assessment	Associate Chief of Nursing	a.	<u>Review and revise</u> Cardiopulmonary Resuscitation policy.	August 15, 2016	Policies will be reviewed every three years <u>or</u> when changes are needed to reflect evidence based practice.	September 15, 2015	Patient Safety  Quality Council

Lawrence & Memorial Hospital  
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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
		Associate Chief of Nursing	b.	<u>Educate</u> on Cardiopulmonary Resuscitation policy.	September 20, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	October 15, 2016	Patient Safety Quality Council
		Associate Chief of Nursing Critical Care Committee	c.	<u>Audit</u> all Code 8s will be reviewed for compliance with Cardiopulmonary Resuscitation policy.	October 15, 2016	100% of Code 8 with 90% or greater compliance to policy.	February 15, 2016	Patient Safety Quality Council
11	Patient Rights: Care in a safe setting	Chief Medical Officer Associate Chief of Nursing	a.	<u>Educate</u> medical and nursing staff on updating patient problem list to reflect patients with a known history of suicide ideation.	August 15, 2016	<u>AUDITS:</u> four (4) consecutive months with 90% or greater compliance. Five (5) charts per inpatient unit per week.	December 15, 2016	Patient Safety Quality Council
			b.	<u>Audit</u> Patients identified with history of suicide ideation will have history listed on problem list.	August 15, 2016	<u>AUDITS:</u> four (4) consecutive months with 90% or greater	December 15, 2016	Patient Safety Quality Council

Lawrence & Memorial Hospital  
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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
12	Hospitalist Coverage	Chief Medical Officer	a.	<u>Audit</u> Compliance with Hospitalist coverage pursuant to contract.	August 1, 2016	<u>AUDITS</u> : four (4) consecutive months with 90% or greater compliance.  Five (5) charts per inpatient unit per week.  compliance.	December 1, 2016	Governing Board  Council

## Goodson, Marcia

---

**From:** Henriques, Jennie <jhenriques@lmhosp.org>  
**Sent:** Wednesday, July 06, 2016 7:16 AM  
**To:** Heidi.Caron@ct.gov  
**Subject:** Items you Requested

**Importance:** High

Hi Heidi:

I wanted to follow up on some of the things you requested yesterday afternoon.

You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted to have legal counsel present and those interviews will need to be coordinated through their legal counsel. I will provide your contact information to their attorney. If you have any questions or concerns, please do not hesitate to call me.

Sincerely,

Jennie C. Henriques, CPHRM  
Director of Risk Management, Patient Safety & Quality Innovation  
Lawrence + Memorial Hospital  
Westerly Hospital  
365 Montauk Avenue, New London, CT 06320  
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707  
EMAIL: [jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)

## Goodson, Marcia

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**From:** Henriques, Jennie <jhenriques@lmhosp.org>  
**Sent:** Friday, July 08, 2016 4:49 PM  
**To:** Heidi.Caron@ct.gov  
**Subject:** RE: Items you Requested

Hi Heidi:

I just wanted to follow up and let you know that IPC has retained counsel for Drs. Donovan, Debaets and APRN Luther. They have retained Joyce Lagnese who is Neil Danaher's partner, and she is great to work with.

Joyce has been provided with your contact information and will reach out to you directly to schedule the interviews. She is aware that you were trying to schedule them for Monday or Tuesday of next week, and thought that Tuesday might work but would need to coordinate that with the providers.

In the meantime, if you have any questions, concerns, or if you need anything else, please do not hesitate to call or email me.

Sincerely,

Jennie C. Henriques, CPHRM  
Director of Risk Management, Patient Safety & Quality Innovation  
Lawrence + Memorial Hospital  
Westerly Hospital  
365 Montauk Avenue, New London, CT 06320  
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707  
EMAIL: [jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)

---

**From:** Henriques, Jennie  
**Sent:** Wednesday, July 06, 2016 7:16 AM  
**To:** 'Heidi.Caron@ct.gov'  
**Subject:** Items you Requested  
**Importance:** High

Hi Heidi:

I wanted to follow up on some of the things you requested yesterday afternoon.

You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted to have legal counsel present and those interviews will need to be coordinated through their legal counsel. I will provide your contact information to their attorney. If you have any questions or concerns, please do not hesitate to call me.

Sincerely,

Jennie C. Henriques, CPHRM  
Director of Risk Management, Patient Safety & Quality Innovation  
Lawrence + Memorial Hospital  
Westerly Hospital  
365 Montauk Avenue, New London, CT 06320

Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707  
EMAIL: [jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)

## Goodson, Marcia

---

**From:** Henriques, Jennie <jhenriques@lmhosp.org>  
**Sent:** Friday, July 01, 2016 11:01 PM  
**To:** Cass, Barbara  
**Cc:** Newton, Susan  
**Subject:** Re: [not-secure]

We will be doing audits daily.

Sent from my iPhone

> On Jul 1, 2016, at 9:26 PM, Cass, Barbara <[Barbara.Cass@ct.gov](mailto:Barbara.Cass@ct.gov)> wrote:

>

> Hello Jenny

> Thank you, what is the frequency of the audits for completion of assessments?

>

> Sent from my iPhone

>

> On Jul 1, 2016, at 9:14 PM, Henriques, Jennie <[jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)<<mailto:jhenriques@lmhosp.org>>> wrote:

>

> Hi Barbara:

>

> Attached please find our Corrective Action Plan. I am heading home but will be available by cell. Please do not hesitate to call me at 401-595-9707 with any questions.

>

> Jennie C. Henriques, CPHRM

> Director of Risk Management, Patient Safety & Quality Innovation

> Interim Compliance + Privacy Officer Lawrence + Memorial Hospital

> Westerly Hospital

> 365 Montauk Avenue, New London, CT 06320 Direct 860.442.0711 EXT. 2161

> | Fax 860.444.4788 | Cell 401.595-9707

> EMAIL: [jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)<<mailto:dthomas@westerlyhospital.org>>

>

>

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> <CAP Site Survey June 30, 2016 through July 1, 2016 (incident dated

> June 27, 2016).docx>

**Goodson, Marcia**

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**From:** Henriques, Jennie <jhenriques@lmhosp.org>  
**Sent:** Friday, July 01, 2016 9:15 PM  
**To:** barbara.cass@ct.gov  
**Cc:** susan.newton@CT.gov  
**Subject:** Corrective Action Plan  
**Attachments:** CAP Site Survey June 30, 2016 through July 1, 2016 (incident dated June 27, 2016).docx

Hi Barbara:

Attached please find our Corrective Action Plan. I am heading home but will be available by cell. Please do not hesitate to call me at 401-595-9707 with any questions.

Jennie C. Henriques, CPHRM  
Director of Risk Management, Patient Safety & Quality Innovation  
Interim Compliance + Privacy Officer  
Lawrence + Memorial Hospital  
Westerly Hospital  
365 Montauk Avenue, New London, CT 06320  
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EMAIL: [jhenriques@lmhosp.org](mailto:jhenriques@lmhosp.org)

**Lawrence & Memorial Hospital**  
**Date of Submission: July 1, 2016**

**Site Survey: June 30, 2016 -- July 1, 2016**  
**Corrective Action Plan**

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
1	Admission assessment for inpatient was not completed on Clinical Design Unit (CDU).	Associate Chief Nursing Officer	<ol style="list-style-type: none"> <li>1. Policies titled "The Document, Patient" and "Assessment &amp; Reassessment of Patients" reviewed to ensure compliance with current evidence based practice.</li> <li>2. Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment &amp; Reassessment of Patients" at safety huddles and change of shift on CDU.  Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment &amp; Reassessment of Patients" at safety huddles and change of emergency room.</li> <li>3. <u>AUDIT:</u> Implement nursing admission assessment audit of all patients on Clinical Design Unit (CDU).</li> <li>4. <u>AUDIT:</u> Implement nursing admission</li> </ol>	<p>June 30, 2016</p> <p>June 30, 2016</p> <p>July 8, 2016</p> <p>July 1, 2016</p> <p>July 8, 2016</p>	<p><b>AUDITS:</b> Four (4) consecutive months with 100% compliance</p>	<p>Patient Safety Committee</p> <p>Quality Council</p>

**Lawrence & Memorial Hospital**  
**Date of Submission: July 1, 2016**

**Site Survey: June 30, 2016 – July 1, 2016**  
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#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
			assessment audit on all adult inpatient units emergency room.			

**Lawrence & Memorial Hospital**  
**Date of Submission: July 1, 2016**

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**Corrective Action Plan**

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
2	Incomplete assessment and reassessment of patients with a history of suicide ideation and pain management on the Clinical Design Unit (CDU).	Associate Chief Nursing Officer	<ol style="list-style-type: none"> <li>1. Policies titled "The Document, Patient" and "Assessment &amp; Reassessment of Patients" reviewed to ensure compliance with current evidence based practice.</li> <li>2. Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment &amp; Reassessment of Patients" at safety huddles and change of shift on CDU.</li> <li>3. Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment &amp; Reassessment of Patients" at safety huddles and change of emergency room.</li> <li>4. <u>AUDIT:</u> Implement nursing admission assessment audit of all patients on Clinical Design Unit (CDU).</li> <li>5. <u>AUDIT:</u> Implement nursing admission</li> </ol>	<p>June 30, 2016</p> <p>June 30, 2016</p> <p>July 8, 2016</p> <p>July 1, 2016</p> <p>July 8, 2016</p>	<p><b>AUDITS:</b> Four (4) consecutive months with 100% compliance</p>	<p>Patient Safety Committee</p> <p>Quality Council</p>

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#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
			assessment audit on all adult inpatient units and emergency room.			

**Lawrence & Memorial Hospital**  
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#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
3	Nursing care plan not updated to reflect change in patient condition on CDU.	Associate Chief Nursing Officer	<ol style="list-style-type: none"> <li>1. Policies titled "The Document, Patient" and "Assessment &amp; Reassessment of Patients" reviewed to ensure compliance with current evidence based practice.</li> <li>2. Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment &amp; Reassessment of Patients" at safety huddles and change of shift on CDU.</li> <li>3. Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment &amp; Reassessment of Patients" at safety huddles and change of emergency room.</li> <li>4. <u>AUDIT:</u> Implement nursing care plan audit of all patients on Clinical Design Unit (CDU).</li> <li>5. <u>AUDIT:</u> Implement nursing care plan</li> </ol>	<p>June 30, 2016</p> <p>June 30, 2016</p> <p>July 8, 2016</p> <p>July 1, 2016</p> <p>July 8, 2016</p>	<p><u>AUDITS:</u> Four (4) consecutive months with 100% compliance</p>	<p>Patient Safety Committee</p> <p>Quality Council</p>

**Lawrence & Memorial Hospital  
Date of Submission: July 1, 2016**

**Site Survey: June 30, 2016 – July 1, 2016  
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#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
			assessment on all adult inpatient units and emergency room.			

**Lawrence & Memorial Hospital**  
**Date of Submission: July 1, 2016**

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#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
4	Overview of unit to determine appropriateness of staffing composition and oversight to ensure both clinical needs and patient care needs are met.	Associate Chief Nursing Office	Staffing model, staffing orientation and competency, leadership expertise and competency, patient mix and ratios all reviewed to reflect current evidence based practice. No changes to current structure needed at this time.	July 1, 2016	N/A	N/A

**Lawrence & Memorial Hospital**  
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#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
5	Order management of narcotic medication	Chief of Medicine Chief of Surgery Director of Pharmacy Associate Chief Nursing Officer Director of Risk Management, Patient Safety & Quality	<ol style="list-style-type: none"> <li>1. Review of Controlled Substance Policy to ensure compliance with current evidence based practice and current state regulations.</li> <li>2. Provide education to licensed independent practitioners regarding electronic medical record renewal process of narcotic medication orders and renewal alert.</li> <li>3. Weekday interdisciplinary Team Rounds to commence on CDU to include review of narcotic pain medication order(s) and renewal(s). An order to discontinue narcotic medications will be written when a renewal is not indicated.</li> <li>4. Review and revise "Controlled Substance" policy.</li> <li>5. <u>AUDIT</u>: Compliance of review of narcotic pain medication order(s) and renewal(s)</li> </ol>	July 8, 2016  July 8, 2016  July 6, 2016  July 30, 2016  July 5, 2016	<u>AUDITS</u> : Four (4) consecutive months with 100% compliance	Patient Safety Committee  Quality Council

**Lawrence & Memorial Hospital**  
**Date of Submission: July 1, 2016**

**Site Survey: June 30, 2016 – July 1, 2016**  
**Corrective Action Plan**

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
			<p>at weekday Interdisciplinary Team Rounds.</p> <p>6. Implement nursing daily chart review for controlled substances scheduled to automatically discontinue with notification to licensed independent practitioners.</p> <p>7. <u>AUDIT</u>: Implement audit of nursing daily chart review for completeness.</p>	<p>July 8, 2016</p> <p>July 8, 2016</p>		

**Lawrence & Memorial Hospital  
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Lawrence & Memorial Hospital  
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 DPH Corrective Action Plan  
 Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016  
 Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
1	Compliance with completing Nursing Admission Assessment for inpatients.	Associate Chief Nursing Officer	a.	<u>Review</u> policies titled “Documentation, Patient” and “Assessment & Reassessment of Patients” to ensure compliance with current evidence based practice.	June 30, 2016	Policies will be reviewed every three years <u>or</u> when changes are needed to reflect evidence based practice.	June 30, 2016	P3 Committee (Policy, Procedure, Protocol)  Patient Care Services
		CDU Nurse Manager	b.	<u>Educate</u> nursing staff on compliance with policies titled “The Document, Patient” and “Assessment & Reassessment of Patients” on <u>CDU</u> .	June 30, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety  Quality Council
		CDU Manager	c.	<u>AUDIT:</u> Compliance with completing nursing Admission Assessment to include suicide risk assessment questions on all <u>CDU</u> patients.	July 1, 2016	<u>AUDITS:</u> Four (4) consecutive months with 100% compliance.  100% of charts will be audited	November 8, 2016	Patient Safety  Quality Council
		Associate Chief Nursing Officer	d.	<u>Educate</u> nursing staff on compliance with policies titled “Documentation, Patient” and “Assessment &	July 8, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and	August 5, 2016	Patient Safety  Quality

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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				Reassessment of Patients" on all <u>adult inpatient units excluding NICU and Perioperative Services.</u>	July 8, 2016	<u>AUDITS:</u> Four (4) consecutive months with 90% or greater compliance. 5 charts per inpatient unit per week.	November 8, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	e.	<u>AUDIT</u> Compliance with nursing admission assessment audit on <u>all adult inpatient units excluding NICU and Perioperative Services.</u>	July 8, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		ED Nurse Managers ED Crisis Manager	f.	<u>Educate</u> ED nursing & ED Crisis staff on policy titled "Delivery of Care for ED Patients" and "Management of Behavior Patient" at main ED and PEQ ED.	July 8, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		ED Crisis Manager	g.	<u>Educate</u> Inpatient Psychiatric Unit staff on policy titled "Levels of Observation, Inpatient Psych".	August 15, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and signoff on	September 15, 2016	Patient Safety Quality Council

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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						education.		
		ED Nurse Managers ED Crisis Manager	h.	<u>Audit</u> compliance with Emergency Dept. Room record (includes ED Crisis) for suicide screening documentation.	July 8, 2016	<u>AUDITS:</u> Four (4) consecutive months with 90% or greater compliance.  Five (5) ED records each at Main ED and PEQ per week  <u>ED Crisis:</u> 100% of patients charts will be audited.	November 8, 2016	Patient Safety Quality Council
2	Compliance with completing assessment and reassessment of pain	Associate Chief Nursing Officer	a.	<u>Review and revise</u> policy titled "Pain Management" to ensure policy reflects current practice.	July 30, 2016	Policy will be reviewed every three years <u>or</u> when changes are needed to reflect	August 15, 2016	Patient Safety Quality Council

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		CDU Manager	b.	<u>Educate</u> nursing staff on compliance with policy titled "Pain Management" on <u>CDU</u> . Education will reinforce assessment and reassessment of pain before and after interventions.	August 10, 2016	evidence based practice. <u>Monitoring:</u> 100% of CDU nursing staff will be educated and signoff on education.	September 10, 2016	Patient Safety Quality Council
		CDU Manager	c.	<u>AUDIT</u> Compliance with completing nursing assessment and reassessment of pain before and after interventions on <u>CDU</u> .	September 10, 2016	<u>AUDITS:</u> Four (4) consecutive months with 100% compliance. <u>CDU:</u> 100% of charts will be audited.	January 10, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	<u>Educate</u> nursing staff on compliance with policy titled "Pain Management" on all <u>adult inpatient units, emergency room and crisis ED, (excluding NICU and Perioperative Services)</u> . Education will reinforce	August 10, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.	September 10, 2016	Patient Safety Quality Council

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				assessment and reassessment of pain before and after interventions.				
		Associate Chief Nursing Officer	e.	<u>AUDIT</u> compliance with completing nursing assessment and reassessment of pain before and after interventions on <u>all adult inpatient units and emergency rooms (includes Main and PEQ; excludes NICU and Perioperative Services)</u>	September 10, 2016	<u>AUDITS:</u> Four (4) consecutive months with 90% or greater compliance.  Five (5) ED records each at Main ED and PEQ per week.  <u>ED Crisis:</u> 100% of patients charts will be audited.	January 10, 2016	Patient Safety  Quality Council
3	Compliance with completing psychosocial assessment on inpatient nursing	CDU Nurse Manager	a.	<u>Educate</u> nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" on <u>CDU</u> .	June 30, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety  Quality Council

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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
	flowsheet(s).							
		CDU Manager	b.	<p><u>AUDIT</u> Compliance with completion of psychosocial documentation on nursing flowsheet for <u>CDU</u>.</p> <ul style="list-style-type: none"> <li>If change in psychosocial is identified, has the Care Plan been personalized to reflect intervention(s).</li> </ul>	July 8, 2016	<p><u>AUDITS:</u> Four (4) consecutive months with 100% compliance.</p>	November 8, 2016	<p>Patient Safety Quality Council</p>
		Associate Chief Nursing Officer	c.	<p><u>Educate</u> nursing staff on compliance with policies titled “The Document, Patient” and “Assessment &amp; Reassessment of Patients” on <u>all adult inpatient units</u>.</p>	July 8, 2016	<p><u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.</p>	August 5, 2016	<p>Patient Safety Quality Council</p>
		Associate Chief Nursing Officer	d.	<p><u>AUDIT</u> Compliance with completion of psychosocial documentation on nursing flowsheet for <u>all inpatient units</u>.</p> <ul style="list-style-type: none"> <li>If change in psychosocial is identified, has the Care Plan been personalized to reflect intervention(s).</li> </ul>	July 8, 2016	<p><u>AUDITS:</u> Four (4) consecutive months with 90% or greater compliance. Five (5) charts per inpatient unit per week.</p>	November 8, 2016	<p>Patient Safety Quality Council</p>

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4	Compliance with completing Personalized Care Plan	Associate Chief Nursing Officer	a.	<u>Review</u> policies titled “The Document, Patient” and “Assessment & Reassessment of Patients” to ensure compliance with current evidence based practice.	June 30, 2016	Policies will be reviewed every three years or when changes are needed to reflect evidence based practice.	June 30, 2016	Patient Safety Quality Council
		CDU Manager	b.	<u>Educate</u> nursing staff on compliance with policies titled “The Document, Patient” and “Assessment & Reassessment of Patients” on <u>CDU</u> .	June 30, 2016	<u>Monitoring:</u> 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		CDU Manager	c.	<u>AUDIT</u> compliance with completing Nursing personalized care plan based on patient assessment on all <u>CDU</u> patients.	July 1, 2016	<u>AUDITS:</u> Four (4) consecutive months with 100% compliance. 100% of charts will be audited.	November 8, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	<u>Educate</u> nursing staff on compliance with policies titled “The Document,	July 8, 2016	<u>Monitoring:</u> 100% of nursing	August 5, 2016	Patient Safety

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				Patient” and “Assessment & Reassessment of Patients” on <u>all adult inpatient units (excludes ED &amp; Perioperative)</u>		staff will be educated and signoff on education.		Quality Council
			e.	<u>AUDIT</u> compliance with nursing personalized care plan audit on <u>all adult inpatient units, inpatient psychiatry (excludes ED, ED Crisis &amp; Perioperative).</u>	July 8, 2016	<u>AUDITS: Four (4)</u> consecutive months with 90% or greater compliance.  Five (5) charts per inpatient unit per week.	November 8, 2016	Patient Safety  Quality Council
5	Compliance with Schedule Class II narcotic medication order.	Director of Pharmacy	a.	<u>Review and revise</u> “Controlled Substance” Policy to ensure compliance with current evidence based practice and current state regulations.	July 30, 2016	Policies will be reviewed every three years <u>or</u> when changes are needed to reflect evidence based practice.	August 5, 2016	Pharmacy and Therapeutics
			b.	<u>Educate</u> nursing staff on compliance with policy “Controlled Substance” on <u>all adult inpatient units.</u>	August 10, 2016	<u>Monitoring:</u> 100% of nursing staff will be	September 10, 2016.	Patient Safety

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						educated and signoff on education.		Quality Council
		Director of Pharmacy & Chief of Medicine	c.	<u>Educate</u> medical staff regarding current electronic medical record renewal process of Schedule Class II narcotic orders and renewal alert via email communication.	July 13, 2016	<u>Monitoring:</u> Ongoing	July 13, 2016	Quality Council
		Director of Pharmacy	d.	<u>Process:</u> Pharmacy will review daily report of medication profiles for CDU, specifically Schedule Class II narcotic order(s) and renewal(s) to ensure compliance with policy.	July 6, 2016	Ongoing	Ongoing	Patient Safety Quality Council
		CDU Nurse Manager / Clinical Coordinator Director of Pharmacy	e.	<u>Implement</u> nursing daily chart review for Schedule Class II narcotics scheduled to automatically discontinue with notification to licensed independent practitioners.	July 8, 2016	Ongoing <u>or</u> until a report can be created to transition monitoring to pharmacy department.	Ongoing <u>or</u> until a report can be created to transition monitoring to pharmacy department.	Patient Safety Quality Council
6	Review of CDU Scope of	Associate Chief Nursing Office	a.	<u>Review of:</u> a. CDU Staffing model, staffing	July 1, 2016	<u>Monitoring:</u> On-going	On-going	Nursing Leadership

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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
	Services.			orientation and competency, b. leadership expertise and competency  to reflect current evidence based practice.  No changes to current structure needed at this time.				Meeting
7	Governing Board minutes	Special Project Coordinator & Executive Assistant	a.	Governing Board minutes to include actions taken by the board as follows: review of Quality Council Minutes, Patient Safety Minutes, and Board agreement and/or identify opportunities with Quality & Patient Safety activities.	August 1, 2016	Ongoing	Ongoing	N/A
8	Quality Council Minutes	Director of Risk Management, Patient Safety & Quality	a.	Quality Council minutes to include actions taken by the council as follows: review of Patient Safety Minutes, and identify opportunities with Quality & Patient Safety activities that are reviewed and discussed at	August 1, 2016	Ongoing	Ongoing	Governing Board

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9	Physician Documentation related to patient change in condition	Director of Risk Management, Patient Safety & Quality	a.	<u>Continuing Education</u> for medical staff regarding medical record documentation standards and best practices.	October 31, 2016	Ongoing	November 15, 2016	Quality Council
		Director of Risk Management, Patient Safety & Quality	b.	<u>Audit</u> compliance of medical records to ensure completeness of medical record. Identified opportunities for improvement will be reported to physician leaders.	August 15, 2015	<b>AUDITS:</b> four (4) consecutive months with 90% or greater compliance.  Five (5) charts per inpatient unit per week.	December 15, 2016	Quality Council
10	Provide emergency treatment/assessment	Associate Chief of Nursing	a.	<u>Review and revise</u> Cardiopulmonary Resuscitation policy.	August 15, 2016	Policies will be reviewed every three years <u>or</u> when changes are needed to reflect evidence based practice.	September 15, 2015	Patient Safety  Quality Council

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		Associate Chief of Nursing	b.	<u>Educate</u> on Cardiopulmonary Resuscitation policy.	September 20, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	October 15, 2016	Patient Safety Quality Council
		Associate Chief of Nursing Critical Care Committee	c.	<u>Audit</u> all Code 8s will be reviewed for compliance with Cardiopulmonary Resuscitation policy.	October 15, 2016	100% of Code 8 with 90% or greater compliance to policy.	February 15, 2016	Patient Safety Quality Council
11	<b>Patient Rights: Care in a safe setting</b>	Chief Medical Officer Associate Chief of Nursing	a.	<u>Educate</u> medical and nursing staff on updating patient problem list to reflect patients with a known history of suicide ideation.	August 15, 2016	<b>AUDITS:</b> four (4) consecutive months with 90% or greater compliance.  Five (5) charts per inpatient unit per week.	December 15, 2016	Patient Safety Quality Council
			b.	<u>Audit</u> Patients identified with history of suicide ideation will have history listed on problem list.	August 15, 2016	<b>AUDITS:</b> four (4) consecutive months with 90% or greater	December 15, 2016	Patient Safety Quality Council

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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						compliance. Five (5) charts per inpatient unit per week.		Council
12	Hospitalist Coverage	Chief Medical Officer	a.	<u>Audit</u> Compliance with Hospitalist coverage pursuant to contract.	August 1, 2016	<u>AUDITS:</u> four (4) consecutive months with 90% or greater compliance.	December 1, 2016	Governing Board

ORIGINAL

1

STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS



YALE-NEW HAVEN HEALTH SERVICES CORPORATION  
L & M CORPORATION

ACQUISITION OF LAWRENCE & MEMORIAL CORPORATION  
BY YALE-NEW HAVEN HEALTH SERVICES CORPORATION

DOCKET NO. 15-32033-CON

AND

NORTHEAST MEDICAL GROUP, INC.  
L & M PHYSICIAN ASSOCIATION, INC.

ACQUISITION OF L & M PHYSICIAN  
ASSOCIATION, INC. BY  
NORTHEAST MEDICAL GROUP

DOCKET NO. 15-32032-CON

JULY 26, 2016

3:00 P.M.

HOLIDAY INN  
35 GOVERNOR WINTHROP BOULEVARD  
NEW LONDON, CONNECTICUT

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

HEARING RE: YALE-NEW HAVEN & NORTHEAST MEDICAL GROUP  
JULY 26, 2016

1 . . .Continued verbatim proceedings of a  
2 hearing before the State of Connecticut, Department of  
3 Public Health, Office of Health Care Access, in the  
4 matter of Yale-New Haven Health Services Corporation, L &  
5 M Corporation, Acquisition of Lawrence & Memorial  
6 Corporation by Yale-New Haven Health Services Corporation  
7 and Northeast Medical Group, Inc., L & M Physician  
8 Association, Inc., Acquisition of L & M Physician  
9 Association, Inc. by Northeast Medical Group, held at the  
10 Holiday Inn, 35 Governor Winthrop Boulevard, New London,  
11 Connecticut, on July 26, 2016 at 3:00 p.m. . . .

12  
13  
14

15 HEARING OFFICER KEVIN HANSTED: Good  
16 afternoon, everyone. Welcome back. This is the second  
17 half of a hearing that we started on July 11, 2016 to  
18 consider two applications, one under Docket No. 15-32032-  
19 CON and the other under 15-32033-CON.

20 I would remind everyone that took the oath  
21 at the first hearing that you are still under oath, and I  
22 believe we completed Cross-Examination last time. I'm  
23 sorry. Direct Examination last time. If that's  
24 incorrect, please let me know.

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1 MR. HENRY MURRAY: I believe it -- is this  
2 on? I think it is, isn't it? Okay. I believe it was,  
3 Mr. Hansted, but we had two individuals, who had  
4 submitted pre-filed testimony, Maritza Bond and Dr.  
5 Steven Smith, who were unable to be here, because of the  
6 length of the public testimony last time, and I just  
7 thought we would like them to be able to testify on  
8 Direct, also, to provide -- make them available,  
9 obviously, for the Applicants to Cross-Examine them,  
10 also.

11 HEARING OFFICER HANSTED: Okay, is this on  
12 15-32033?

13 MR. MURRAY: Yes, it is.

14 HEARING OFFICER HANSTED: Okay. Okay.  
15 I'm going to allow that.

16 MS. JOAN FELDMAN: I'm going to have to  
17 object.

18 HEARING OFFICER HANSTED: Okay. Based  
19 upon what?

20 MS. FELDMAN: Well there are rules that I  
21 would expect to be adhered to. I understand that one of  
22 the witnesses was here and chose to leave, so --

23 HEARING OFFICER HANSTED: Okay. I'm going  
24 to allow them to testify. I'll also allow you to Cross-

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1 Examine those folks.

2 But just before we get started with the  
3 hearing again, for those folks that weren't here last  
4 time, we had an opportunity for the public and elected  
5 officials to give comment on both applications at the  
6 beginning of the hearing last time.

7 This time, I will allow for public comment  
8 again. It will be at the end of today's hearing, so  
9 after we finish Direct Examination, complete Cross-  
10 Examination, any Redirect we might have, and after OHCA's  
11 questions, then we will go to the public comment portion  
12 of the hearing.

13 MS. FELDMAN: Attorney Hansted, before we  
14 begin, we do have three additional folks that might be  
15 able to provide some answers to any questions that we  
16 would like to have sworn in.

17 HEARING OFFICER HANSTED: Okay, that's  
18 fine. Attorney Murray, do you have any additional  
19 individuals that need to be sworn in?

20 MR. MURRAY: No, not for the Intervenors.  
21 Well, yes. I believe, Maritza, you took the oath last  
22 time. Okay, so, Dr. Smith is the only one that hasn't  
23 been sworn in.

24 HEARING OFFICER HANSTED: Okay. If I

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1 could have those folks please stand and raise your right  
2 hand and be sworn in by the court reporter?

3 (Whereupon, Dr. Steven Smith, Christopher  
4 O'Connor, Lisa Stump, Laurel Holmes and Pat McCabe were  
5 duly sworn in.)

6 HEARING OFFICER HANSTED: Okay, thank you,  
7 all. And, just for the record, would you please identify  
8 yourselves one at a time into a microphone, those, who  
9 just took the oath?

10 DR. STEVEN SMITH: Dr. Steven Smith.

11 HEARING OFFICER HANSTED: Thank you.

12 MR. CHRISTOPHER O'CONNOR: Christopher  
13 O'Connor.

14 MS. LISA STUMP: Lisa Stump.

15 HEARING OFFICER HANSTED: Okay, thank you,  
16 all.

17 MS. LAUREL HOLMES: Laurel Holmes.

18 MR. PAT McCABE: Pat McCabe.

19 HEARING OFFICER HANSTED: Thank you. Did  
20 you get that, court reporter? Thank you. Okay, Attorney  
21 Murray, if you want to have the two individuals that you  
22 referenced earlier provide their testimony, I'll take  
23 that now.

24 MR. MURRAY: Okay, thank you very much,

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1 Mr. Hansted.

2 HEARING OFFICER HANSTED: Hold on.

3 MS. FELDMAN: Hold on. During the  
4 interval since the last hearing and today, there were  
5 several documents that were given administrative notice.  
6 I would like to know whether or not you're going to  
7 discuss that before we begin the testimony, or are we  
8 just going to plan on proceeding from this point?

9 HEARING OFFICER HANSTED: I won't  
10 specifically be discussing it, but if you want to comment  
11 on it, I'll take comment on it.

12 MS. FELDMAN: Before I comment, I would  
13 like some clarification, in terms of the weight that the  
14 e-mail from Comptroller Lembo and the Milliman Study,  
15 which we objected to at the last hearing, will be given  
16 with respect to the record.

17 HEARING OFFICER HANSTED: I really can't  
18 make that determination at this point until I look at the  
19 entire record as a whole. I can't tell you what  
20 percentage I would give it, as to weight.

21 MS. FELDMAN: Okay, well, for the record,  
22 just looking at Connecticut General Statute, Section 4-  
23 178, which refers to evidence in contested cases, it lays  
24 out the criteria for introducing these documents into

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1 evidence and having greater weight than perhaps the  
2 public testimony, and I point your attention to items one  
3 and six.

4 Item one says that, if the information is  
5 irrelevant, immaterial, or unduly repetitious evidence,  
6 it should not be introduced, or item six, notice may be  
7 taken of judicially cognizable facts and of generally  
8 recognized technical or scientific facts within the  
9 agency's specialized knowledge.

10 With respect to the Milliman report, I  
11 believe at the last hearing I objected on the basis that  
12 I thought that the document, itself, was completely  
13 unreliable, irrelevant.

14 And if you look at the first two pages  
15 that were not present on July 11th, but that were part of  
16 the e-mail that Comptroller Lembo sent, even Milliman,  
17 itself, states that on page two of three that any third  
18 party recipient of Milliman's work product, who desires  
19 professional guidance, should not rely upon Milliman's  
20 work product, but should engage qualified professionals  
21 for advice appropriate to specific needs.

22 There's also other disclaimers in the  
23 first two pages of the document. In fact, I think  
24 there's a typo, because they said they relied on

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1 Milliman's health cost guideline grouping mythologies.

2 In addition, we don't think the data is  
3 relevant, in that it does not take into effect the acuity  
4 of the patient or the other factors that they,  
5 themselves, identified, in terms of various cost,  
6 geographic areas, catastrophic claims, and quality of  
7 care.

8 So we don't know whether this is complete  
9 data, we don't think it's reliable data, and, for those  
10 reasons, we object to it being introduced as evidence  
11 that would have any weight, other than public testimony,  
12 beyond that of public testimony.

13 HEARING OFFICER HANSTED: Okay. I would  
14 ask that you put your objection in writing, and I'll rule  
15 on it in writing.

16 MS. FELDMAN: Okay. Can I also object to  
17 Comptroller Lembo's letter? I would have assumed that  
18 this letter would have been similar to any other letters  
19 that OHCA would receive, and that this, too, would not be  
20 given any additional weight beyond that of public  
21 testimony.

22 There is, interestingly, an e-mail that  
23 accompanies the Milliman data, which seems to be at odds  
24 with the position that the Comptroller took in this

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1 letter.

2 He seems to be comfortable with the fact  
3 that, in the e-mail, he states that he understands now  
4 that this is not a merger that this application  
5 describes, but that it is an affiliation, so I think a  
6 lot of what he says in his letter is irrelevant.

7 HEARING OFFICER HANSTED: Okay, thank you.

8 MR. MURRAY: Mr. Hansted?

9 HEARING OFFICER HANSTED: Yes.

10 MR. MURRAY: If Attorney Feldman is going  
11 to put her objection in writing, would we be given an  
12 opportunity to weigh in on that, or would you like our  
13 comments now?

14 HEARING OFFICER HANSTED: No, I'll allow  
15 you an opportunity to weigh in in writing.

16 MR. MURRAY: Okay.

17 HEARING OFFICER HANSTED: So, Attorney  
18 Feldman, I would ask that your objection be filed by --  
19 let's see. Today is Tuesday. By Friday. Does that give  
20 you enough time?

21 MS. FELDMAN: Sure.

22 HEARING OFFICER HANSTED: By Friday. And,  
23 Attorney Murray, a response by you by the following  
24 Friday.

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1 MR. MURRAY: That's fine. Thank you.

2 HEARING OFFICER HANSTED: Okay.

3 MR. MURRAY: Mr. Hansted, just before we  
4 move on, just for the record, when the comment that -- I  
5 think, if one carefully reads the Milliman report, you'll  
6 see that page two is often what we would refer to as risk  
7 analysis of language, in the sense that I believe it's  
8 probably for Milliman's protection, so that they're not  
9 quoted.

10 It has nothing to do with the reliability  
11 of the information, but I'll put that in writing.

12 HEARING OFFICER HANSTED: Thank you.  
13 Counsel, anything further?

14 MS. FELDMAN: No.

15 HEARING OFFICER HANSTED: Okay. Attorney  
16 Murray, if you want to have your two witnesses present  
17 their evidence?

18 MR. MURRAY: Yeah. The Intervenors would  
19 call Maritza Bond.

20 MS. MARITZA BOND: Good afternoon.

21 HEARING OFFICER HANSTED: Good afternoon.

22 MS. BOND: My name is Maritza Bond. I am  
23 the Executive Director for Eastern Area Health Education  
24 Center, and I adopt my pre-filed testimony.

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1 HEARING OFFICER HANSTED: Thank you.

2 MS. BOND: Our local non-profit  
3 organization, which implements services within Windham  
4 and New London County, our mission is to ensure that  
5 access to quality healthcare services are delivered in a  
6 culturally and linguistic manner. This includes  
7 equitable distribution of the healthcare workforce. I am  
8 also a coalition member of both Windham and New London.

9 Today, I am here in the interest of  
10 underserved communities, whose voices are not able to be  
11 heard, and to share what I am witnessing in the Windham  
12 community upon the Hartford HealthCare merger.

13 In Windham, we are already experiencing  
14 the impact of what can occur when hospital services are  
15 reduced following a merger.

16 This past year, a woman in her early  
17 fifties with limited English proficiency suffered a  
18 stroke. When transported to Windham Hospital, the family  
19 was told they could not provide the care she needed,  
20 because they did not have a neurologist on site.

21 Instead, the woman was put in a Life Star  
22 helicopter and transported to Hartford Hospital. This  
23 was detrimental to both the patient and the family  
24 members, who were left to drive over 30 minutes to be by

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1 her side.

2 There were no language services provided  
3 or offered, and there was no way to effectively  
4 communicate with this patient. Thankfully, this woman's  
5 story did not end tragically.

6 During the Hartford HealthCare merger,  
7 promises were made that services were not going to be  
8 reduced, nor eliminated.

9 Nonetheless, this is not the case. With  
10 the CCU now being closed, patients are traveling long  
11 distances by ambulance, private car, or even helicopter  
12 for urgently-needed care that used to be available at  
13 Windham. At the end, Hartford's original CON was filled  
14 with broken promises.

15 If this acquisition is a necessity for  
16 improving efficiency, then I would request that the CON  
17 application have clear provisions in place that will  
18 protect the community of New London and surrounding  
19 areas.

20 We must ensure that access to healthcare  
21 would not be reduced, outsourced, or eliminated, services  
22 will be affordable to all patients from all social  
23 economic backgrounds and cultural background, and to  
24 ensure that local healthcare workforce are not eliminated

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1 or replaced, due to this new regionalization of  
2 healthcare phenomenon that is happening in the state and  
3 across the country.

4 It is my hope that this acquisition truly  
5 leads to improving health outcomes of this community and  
6 not just the bottom line of improving the financial  
7 status of an organization.

8 Thank you for the opportunity to provide  
9 testimony before you today.

10 HEARING OFFICER HANSTED: Thank you.

11 MR. MURRAY: The Intervenors would like to  
12 call for testimony of Dr. Steven Smith.

13 DR. SMITH: Thank you. Good afternoon,  
14 Attorney Hansted and OHCA staff.

15 HEARING OFFICER HANSTED: Good afternoon.

16 DR. SMITH: I'd like to adopt my pre-filed  
17 testimony as my own.

18 My name is Steven Smith. I'm a family  
19 physician, and I practice at the Community Health Center  
20 here in New London. I'm also Professor Emeritus of  
21 family medicine at the Warren Alpert Medical School at  
22 Brown University, and I served as Associate Dean of  
23 Medicine at Brown University for 25 years.

24 I also taught an undergraduate health

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1 policy course during that time, and after scouring and  
2 critically reviewing the literature, one lesson is very  
3 clear.

4 By and large, hospital mergers are not  
5 good for the public. Most of the time, prices end up  
6 rising. Most of the time, quality does not improve, and  
7 safety does not improve.

8 The often mentioned efficiencies often  
9 never materialize, and, worst of all, as Ms. Bond has  
10 just testified, local access to vital services sometimes  
11 are terminated. The other thing is that, when hospitals  
12 acquire physician practices, productivity plummets.

13 This article, which is in our Exhibit 2,  
14 just came out a few weeks ago, June 16th, in New England  
15 Journal, by McWilliams, et al, and it's the first report  
16 of early performance of Accountable Care Organizations in  
17 Medicare.

18 And the article states that savings are  
19 achieved only by independent physician primary care  
20 practices, not by hospital-owned practices.

21 One wonders whether the dire call for more  
22 capital by the Applicants might, in fact, just be used to  
23 acquire more physician practices and increase the  
24 hegemony over physician services here in Southeastern

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1 Connecticut.

2 In my opinion, hospital mergers can only  
3 be justified if there are no other available options to  
4 save a financially-distressed hospital, and we know from  
5 publicly-available documents that L & M operates in the  
6 black and is not financially-threatened.

7 If any other benefits are being suggested  
8 as a justification for a merger or whatever you want to  
9 call it, but these benefits can be achieved by some other  
10 way, then a merger should not really be considered.

11 Just such a claim is being made by the  
12 Applicants, in terms of close clinical coordination.  
13 What I want to testify is that, in fact, close clinical  
14 coordination can be achieved without legal acquisition,  
15 merger affiliation, whatever you want to call it.

16 As a physician at the Community Health  
17 Center in New London, I have instant access to the  
18 records at L & M through a portal, so I can get x-ray  
19 reports, I can get laboratory reports, I get hospital  
20 admissions and discharge summaries only at the touch of a  
21 key.

22 Emergency room physicians, if they're  
23 seeing some of our patients in the hospital through a  
24 procedure that we've established with the hospital, can

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1 guarantee that those patients are seen within 24 hours,  
2 and our Community Health Center and L & M are completely  
3 separate, independent institutions.

4 In terms of ER, I mean my relationships  
5 with physicians at Yale, they're excellent. In fact,  
6 recently, with the patient with the severe pulmonary  
7 disease, another patient with vascular problems, I'm on  
8 the phone with the specialists in New Haven, and they can  
9 ask me to see the patients, order tests in between,  
10 without any need for formal merger between the two.

11 The neonatal intensive care unit at L & M  
12 is, in fact, manned, staffed by neonatologists, who are  
13 employees at Yale-New Haven, without the need for any  
14 kind of merger.

15 Again, babies, who are discharged from the  
16 NICU can be seen in my clinic within 24 hours with  
17 arrangements we've made with them.

18 Community hospitals like L & M should  
19 maintain close clinical coordination with a tertiary care  
20 hospital like Yale, and they've managed to do so, without  
21 the need for a formal affiliation.

22 I believe they should continue to do what  
23 they've done for years and adopt those kinds of close  
24 cooperations, without the need for formal merger. That

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1 will benefit our patients here in Southeastern  
2 Connecticut and maintain our independent community  
3 hospital. Thank you very much.

4 HEARING OFFICER HANSTED: Thank you,  
5 Doctor.

6 MR. MURRAY: Attorney Hansted, that  
7 concludes the testimony for the Intervenors.

8 HEARING OFFICER HANSTED: Okay, thank you,  
9 Attorney Murray. Attorney Feldman, do you have any  
10 Cross-Examination?

11 MS. FELDMAN: I do.

12 HEARING OFFICER HANSTED: Okay.

13 MS. FELDMAN: I would like to Cross Mr.  
14 Hyde. Mr. Hyde, are you referred to as Dr. Hyde, or  
15 Attorney Hyde, or Mr. Hyde? I want to make sure I refer  
16 to you properly.

17 DR. FRED HYDE: Dr. Hyde will do.

18 MS. FELDMAN: Dr. Hyde? And are you a  
19 doctor of economics?

20 DR. HYDE: No, no. My degree in medicine  
21 is an MD from Yale.

22 MS. FELDMAN: Okay, very good. Mr. Hyde,  
23 is it true, is it not, that since 1981 you have been  
24 engaged as a consultant with respect to the management of

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1 healthcare facilities?

2 DR. HYDE: Yes.

3 MS. FELDMAN: Okay. As part of your  
4 consultancy, you served as CEO of various hospitals,  
5 including Windham and Winsted?

6 DR. HYDE: Two hospitals, Windham and, in  
7 Western Pennsylvania, Aliquippa. When I was Chief  
8 Executive of the Winsted Health Center Foundation, it had  
9 closed as a hospital and reopened as a community health  
10 center.

11 MS. FELDMAN: Okay, thank you. Is it also  
12 true that, while you were serving as CEO of Windham  
13 Hospital, that Attorney General Blumenthal initiated an  
14 investigation of the misuse of endowment funds while you  
15 were CEO, and, as a result of that investigation, there  
16 was a settlement agreement, which was reached between the  
17 AG's office and Windham Hospital, which required you to  
18 refund or reinvest \$1.8 million back into the endowment?

19 DR. HYDE: Yes.

20 HEARING OFFICER HANSTED: And just for the  
21 benefit of the public, the AG's office is the Attorney  
22 General's office.

23 MS. FELDMAN: And, as part of your  
24 consultancy, is it fair to say that you've been engaged

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1 by and testified on behalf of community hospitals in  
2 opposition to their acquisition by a larger hospital  
3 system?

4 DR. HYDE: I believe that's true, but if  
5 you ask me about a specific, I could be more accurate.

6 MS. FELDMAN: Okay, well, let me ask you  
7 this question. Have you ever, at any time, testified in  
8 favor of the acquisition of a small community hospital by  
9 a larger health system or hospital?

10 DR. HYDE: I don't believe so.

11 MS. FELDMAN: Okay, so, to date, it seems  
12 as if your position has been pretty much negative with  
13 respect to such acquisitions, and, so, I want to bring  
14 your attention to an article written in the Hartford  
15 Courant, an editorial written by you on January 11, 2009,  
16 where you criticize the -- the title of it is This Merger  
17 is Malpractice, Bad Deal, In Perils, UConn Facilities  
18 Mission. Did you write that editorial?

19 DR. HYDE: I'd have to take a look at it.  
20 It's been seven years from the date you cite.

21 MR. MURRAY: I'd like an opportunity to  
22 look at that.

23 HEARING OFFICER HANSTED: Sure.

24 DR. HYDE: Yes, that's correct.

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1 MS. FELDMAN: Is it fair to say that the  
2 list of horrors that you describe in that article  
3 cannot be generalized to all affiliations?

4 DR. HYDE: Could you repeat your question,  
5 please?

6 MS. FELDMAN: Well, in your testimony in  
7 this proceeding and your pre-filed testimony and your  
8 response to Dr. Noether's pre-filed testimony, you take a  
9 rather negative stance with respect to this proposed  
10 application, and you do the same in that editorial you  
11 submitted to the Hartford Courant regarding Hartford  
12 HealthCare and its affiliation with UConn Health Center.

13 Is it accurate to say that the horrors  
14 that you describe cannot be generalized with respect to  
15 every affiliation by a large system and a small community  
16 hospital?

17 DR. HYDE: I think it would be accurate to  
18 say at least three things from a review of this article.  
19 First, that my views haven't changed. My clients find  
20 me, because of my views. I don't alter them to fit my  
21 clients.

22 Secondly, that the John Dempsey Hospital,  
23 which continues today as an independent institution,  
24 would, in all likelihood, not continue, not have

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1 continued, but for the effort of the Unions that  
2 represented employees and the faculty to oppose a  
3 Hartford takeover.

4 Third, that fundamental in the examination  
5 of the takeover were specifics concerning prices. I  
6 recall, for example, members of the legislature asking  
7 officials from the University of Connecticut Health  
8 Center specific questions, as opposed to generalities,  
9 about budgets and prices.

10 So those three things I think would be my  
11 summary, quickly reviewing this. My views haven't  
12 changed. I believe that the medical faculty and the  
13 Unions, who opposed a takeover of Dempsey by Hartford at  
14 the time, were correct, and that many of the issues  
15 discussed by the executive leadership were discussions  
16 that were taking place in the absence of close  
17 examination of the facts.

18 MS. FELDMAN: Would it be fair to say that  
19 you would object to any acquisition by a large healthcare  
20 system of a small community hospital?

21 DR. HYDE: It would be fair to say that we  
22 have, as a nation and what I attempted in 14 years of  
23 teaching to pass along to students, extraordinary  
24 problems with access, that we've gone from 60, 200

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1 independent hospitals in modern times before the DRG  
2 revolution to 4,900 hospitals, that, as a consequence and  
3 with another 500 or so in periled and rural areas, that,  
4 as a consequence, access to small hospital services,  
5 which might be either guaranteed by their assumption by  
6 large hospitals or by strengthening their independence,  
7 I've always believed in the latter.

8 MS. FELDMAN: When you were CEO of Windham  
9 Hospital, was Windham Hospital a sole community hospital  
10 not affiliated with Hartford HealthCare?

11 DR. HYDE: No. At the time, it was not.

12 MS. FELDMAN: Okay and when you left  
13 Windham Hospital, is it true that Windham Hospital was  
14 financially \$6 million in the red?

15 DR. HYDE: Windham was actually in  
16 reasonably good position in comparison to other  
17 Connecticut hospitals. We had rebuilt the hospital  
18 entirely.

19 My successor, Mr. Brvenik, did an even  
20 better job in operations and used the new facilities to  
21 restore complete financial health.

22 In fact, for the three years prior to  
23 2008, when Hartford first became involved, Windham was  
24 doing fine.

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1 MS. FELDMAN: In your pre-filed testimony,  
2 I believe this was attached as an exhibit. It's Hospital  
3 Market Concentration in Connecticut, the Impact of Yale-  
4 New Haven Health Systems Expansion. I just have a simple  
5 question.

6 DR. HYDE: You're referring to Exhibit 4  
7 or Attachment 4, and which page, if any, would you like  
8 me to address?

9 MS. FELDMAN: Just generally, did you --  
10 could you tell me who prepared this, who wrote this?

11 DR. HYDE: I had no role in writing this,  
12 but I have relied on this document for a statement I made  
13 in my testimony.

14 MS. FELDMAN: Okay, thank you.

15 DR. HYDE: If I may complete my answer,  
16 Mr. Hansted?

17 HEARING OFFICER HANSTED: Go ahead.

18 DR. HYDE: I stated that Yale-New Haven  
19 and Lawrence & Memorial were important competitors, a  
20 statement contested by Dr. Noether.

21 In fact, a reference to a bond issue  
22 footnote in this document confirms that 80 percent of  
23 Yale-New Haven's work is as a community hospital from its  
24 primary service area.

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1 Fifteen percent is from its so-called  
2 referral service area, which, of course, includes the  
3 entirety of Lawrence & Memorial service area. Five  
4 percent is beyond that.

5 I don't say that to diminish the role of  
6 Yale-New Haven in providing primary and secondary care to  
7 its community, but, rather, to emphasize that the markets  
8 that are perceived by Yale-New Haven to be part of its  
9 primary responsibility overlap with those of Lawrence &  
10 Memorial.

11 MS. FELDMAN: No further questions for Mr.  
12 Hyde.

13 HEARING OFFICER HANSTED: Attorney Murray,  
14 do you have any Redirect?

15 MR. MURRAY: Just give me a second. No  
16 Redirect.

17 HEARING OFFICER HANSTED: Okay. Attorney  
18 Feldman, did you have Cross for any of his other  
19 witnesses?

20 MS. FELDMAN: No, I don't.

21 HEARING OFFICER HANSTED: Okay. Attorney  
22 Murray, do you have any --

23 MR. MURRAY: I just wanted to make a  
24 comment on the last round of questioning that Attorney

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1 Feldman did, in terms of the report that she was  
2 referring to.

3 If OHCA would like that, the Intervenors -  
4 - that report was written by someone, an analyst. She  
5 was an employee of one of the Intervenors. We can  
6 certainly provide, if OHCA wants it, all of the data  
7 files, in which that report was based.

8 HEARING OFFICER HANSTED: No. Thank you,  
9 Attorney Murray. That will be fine.

10 MR. MURRAY: Okay.

11 HEARING OFFICER HANSTED: Do you have any  
12 Cross-Examination?

13 MR. MURRAY: Yes, I do, of a couple of the  
14 Applicant's witnesses. Let me just get my notes here.

15 Yes, I have questions for Dr. Sanfilippo.  
16 Good afternoon, Doctor.

17 DR. LOUIS SANFILIPPO: Good afternoon.

18 MR. MURRAY: You're a member of the  
19 Lawrence & Memorial Board of Directors, correct?

20 DR. SANFILIPPO: Yes.

21 MR. MURRAY: Okay and in both your pre-  
22 filed testimony and the testimony here on July 11th you  
23 stated that the L & M Board of Directors made sure that,  
24 as a result of the acquisition by Yale-New Haven Health

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1 System, L & M Board would remain in place and continue to  
2 govern locally, is that correct?

3 DR. SANFILIPPO: That is correct.

4 MR. MURRAY: Okay. You even asserted that  
5 the acquisition by Yale-New Haven Health System was in  
6 stark contrast, and I'm quoting that, that was in your  
7 testimony, to how other systems in the State govern  
8 locally, is that correct?

9 DR. SANFILIPPO: That is correct.

10 MR. MURRAY: Okay and, in fact, you even  
11 drew a distinction between this acquisition and Hartford  
12 Hospital, Hartford HealthCare's acquisition of Windham  
13 Hospital, correct?

14 DR. SANFILIPPO: Yes.

15 MR. MURRAY: Okay and, finally, I believe  
16 in your testimony you asserted that the Board of L & M  
17 made sure, and, again, that's in quotes, that's in your  
18 testimony, that there wouldn't be a loss of local  
19 control, is that correct?

20 DR. SANFILIPPO: That's correct.

21 MR. MURRAY: Okay, now, as part of the  
22 application, you and the L & M Board have final proposed  
23 amended corporate bylaws that will govern the future  
24 operation of L & M, correct?

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1 DR. SANFILIPPO: Yes.

2 MR. MURRAY: Okay and, as part of the due  
3 diligence as a Board member and in your words from your  
4 July 11th testimony as fiduciary to the community, when  
5 you and the other Board members reviewed the changes in  
6 the corporate governance, did you understand that Yale-  
7 New Haven Health System would become the sole member of  
8 the L & M Corporation?

9 DR. SANFILIPPO: Yes.

10 MR. MURRAY: Okay and under the proposed  
11 new bylaws for the L & M Corporation, there are two  
12 classes of trustees on the Board, correct, elected  
13 trustees and ex officio trustees?

14 DR. SANFILIPPO: Yes.

15 MR. MURRAY: And the ex officio trustees  
16 consist of the President/CEO of L & M and the Board  
17 Chairs for each of its affiliates, correct? L & M  
18 Hospital, Westerly Hospital and the VNA?

19 DR. SANFILIPPO: Yes.

20 MR. MURRAY: Okay and, also, the  
21 President/CEO of the sole corporate member, Yale-New  
22 Haven Health System, correct?

23 DR. SANFILIPPO: And I believe the  
24 President of the medical staff, as well.

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1 MR. MURRAY: Okay. I may have missed that  
2 in reading. Okay and, as the sole corporate member of  
3 the L & M Corporation, you're aware, aren't you, that,  
4 under Section 3.2 of the proposed bylaws --

5 MS. FELDMAN: I think he's going to need  
6 to look at the bylaws.

7 MR. MURRAY: I'll give you the citation.  
8 It's page 186 of the Certificate of Need application.

9 DR. SANFILIPPO: Okay, go ahead with your  
10 question.

11 MR. MURRAY: Okay. Let me repeat the  
12 question. As the sole corporate member of the L & M  
13 Corporation, you're aware, aren't you, that, under  
14 Section 3.2 of the proposed bylaws, that Yale-New Haven  
15 has the sole authority to select or elect, depending on  
16 the word that's used in the bylaws, the elected trustees  
17 to the L & M Corporation Board?

18 DR. SANFILIPPO: Yes.

19 MR. MURRAY: Okay and you're aware, aren't  
20 you, that under the proposed post-acquisition bylaws,  
21 that Yale-New Haven Health System, as the sole corporate  
22 member, has the power to reject nominees proposed by the  
23 trustees of the L & M Corporation Board? That's Section  
24 3.4 of the proposed bylaws.

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1 DR. SANFILIPPO: Yes. We were also  
2 advised by Bridgeport and Greenwich Hospitals on how the  
3 operation would take place.

4 MR. MURRAY: Okay, so, if I understand it,  
5 you were advised that this is the same corporate  
6 governance model that both Bridgeport and Greenwich have,  
7 is that correct?

8 DR. SANFILIPPO: It is comparable, yes.

9 MR. MURRAY: Okay, but my question was  
10 simply that you were aware that if Yale-New Haven Health  
11 System, as a sole corporate member, did not like the  
12 candidates being proposed by the L & M Board, that it had  
13 the sole power to reject those and elect whoever it chose  
14 fit to be on the Board?

15 DR. SANFILIPPO: Yes.

16 MR. MURRAY: Okay, now --

17 DR. SANFILIPPO: We were also  
18 parenthetically advised that both Bridgeport and  
19 Greenwich had never had any of their Board selections  
20 rejected.

21 MR. MURRAY: Okay, but we're talking about  
22 L & M, aren't we?

23 DR. SANFILIPPO: Yes, we are.

24 MR. MURRAY: Okay and you're also aware,

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1 aren't you, that under the proposed post-acquisition  
2 bylaws, that the L & M Board would no longer have the  
3 power to appoint the President and CEO?

4 DR. SANFILIPPO: Yes.

5 MR. MURRAY: But that power would reside  
6 solely in the sole corporate member?

7 DR. SANFILIPPO: Yes, we were aware of  
8 that.

9 MR. MURRAY: Okay and it's true, isn't it,  
10 that under that bylaw provision, the bylaws state  
11 explicitly that the President and CEO of Lawrence &  
12 Memorial Corporation serves at the pleasure of the member  
13 and not at the pleasure of the L & M Board?

14 DR. SANFILIPPO: Yes.

15 MR. MURRAY: Okay, now, I want to ask you  
16 a couple of questions. We just talked about the elected  
17 Board members, and I just have a couple of questions to  
18 ask you about the ex officio members of the Board.

19 Now the remaining three ex officio members  
20 of the Board, which are the L & M Hospital, Westerly  
21 Hospital and the VNA, those Boards are all selected by  
22 the sole corporate member now of the L & M Corporation,  
23 which is the L & M Board, correct?

24 DR. SANFILIPPO: Yes, and there's no plans

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1 to change that.

2 MR. MURRAY: Okay, but, as the sole  
3 corporate member, Yale-New Haven Hospital would be in a  
4 position to change the composition of those particular  
5 Boards if it chose to, couldn't it?

6 DR. SANFILIPPO: Yes.

7 MR. MURRAY: Okay, now, Dr. Sanfilippo, as  
8 a Board member, did you read the proposed L & M post-  
9 acquisition bylaws, including Exhibit A and Exhibit B to  
10 those bylaws, which can be found on pages 197 to 198 of  
11 the application?

12 MS. FELDMAN: Say those pages again?

13 MR. MURRAY: 195 to 198.

14 MS. FELDMAN: Just one second.

15 DR. SANFILIPPO: Yes, we reviewed this.

16 MR. MURRAY: Okay and you would agree with  
17 me, wouldn't you, that, if you read Exhibit A, it sets  
18 out, doesn't it, that virtually every management action  
19 by the L & M Board can only be taken with the approval of  
20 the sole corporate member?

21 DR. SANFILIPPO: We realize that this  
22 would all be -- first of all, this document was mutually  
23 agreed upon, and, second of all, we do agree that these  
24 would be joint decisions.

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1 MR. MURRAY: I'm sorry. I couldn't hear  
2 what you said.

3 DR. SANFILIPPO: These would be joint  
4 decisions.

5 MR. MURRAY: Well I understand that. That  
6 may have been the assurances, and that may have been what  
7 you said. I'm simply asking you isn't it true that  
8 Exhibit A provides for the fact that every major decision  
9 must have the approval of the sole corporate member?

10 DR. SANFILIPPO: Those decisions cannot be  
11 made without the approval of the local Board.

12 MR. MURRAY: Okay and Exhibit B in the  
13 bylaws gives the sole corporate member the --

14 MS. FELDMAN: Just one second.

15 MR. MURRAY: I'm sorry.

16 DR. SANFILIPPO: Go ahead with your  
17 question.

18 MR. MURRAY: Yeah. Exhibit B gives the  
19 sole corporate member, Yale-New Haven Health System, the  
20 retained authority to set budget targets, incur debt on  
21 behalf of L & M, and control the liquid assets, appoint  
22 auditors, and, if it chooses, designate any activity a  
23 major activity requiring its approval before L & M or any  
24 of its affiliates can take action?

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1 DR. SANFILIPPO: Yes.

2 MR. MURRAY: Okay.

3 DR. SANFILIPPO: This is what we  
4 understand is how a system would work, since we already  
5 are a system. We're just going by how we've done things,  
6 and this is how the system would work.

7 MR. MURRAY: Right, so, in other words,  
8 the way the system operates, in terms of Lawrence &  
9 Memorial Corporation, the Lawrence & Memorial  
10 Corporation, is that you have lots of retained authority  
11 as the sole member for all the other affiliates, L & M  
12 Hospital, the Physicians' Association and the VNA,  
13 correct?

14 DR. SANFILIPPO: And Westerly Hospital.

15 MR. MURRAY: Excuse me. And Westerly  
16 Hospital. And what would change under these bylaws is  
17 that that power that the L & M Corporation currently has  
18 would now be retained and exercised by the sole corporate  
19 member, which is the Yale-New Haven Health System,  
20 correct?

21 MS. FELDMAN: Can you restate the  
22 question, please?

23 MR. MURRAY: Okay. It's a long question.  
24 As it is right now, Lawrence & Memorial Corporation

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1 retains certain authority with respect, as the sole  
2 corporate member, retains authority with respect to your  
3 other affiliates, L & M Hospital, Westerly Hospital and  
4 the VNA, correct?

5 DR. SANFILIPPO: At a high level, yes.

6 MR. MURRAY: Okay and when Yale-New Haven  
7 Health System becomes the sole corporate member of the L  
8 & M Corporation, it will retain the authority that L & M  
9 currently exercises now, correct?

10 DR. SANFILIPPO: Somewhat, yes.

11 MR. MURRAY: Well somewhat. The powers  
12 retained by the sole corporate member in Exhibit A and  
13 Exhibit B are pretty clear, aren't they, Dr. DeFilippo?  
14 Sanfilippo. Pardon me.

15 DR. SANFILIPPO: No, I would disagree with  
16 that. Exhibit A and B reflect joint governance.

17 MR. MURRAY: Joint governance. Joint  
18 governance is a situation, where someone can make --  
19 would you agree with me that situations of joint  
20 governance is where one party can't take an action,  
21 unless it has the approval of the other party?

22 DR. SANFILIPPO: Yes.

23 MR. MURRAY: Okay and nothing in the  
24 proposed bylaws does it indicate that Lawrence & Memorial

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1 Board of Directors can take an action without the  
2 approval of the sole corporate member or that the  
3 Lawrence & Memorial Board can veto any of the actions  
4 taken by the sole corporate member?

5 MS. FELDMAN: Can you restate the  
6 question?

7 DR. SANFILIPPO: I don't understand the  
8 question.

9 MR. MURRAY: Okay. I prefaced it by  
10 saying that joint governance is a situation, and you  
11 agreed with me, where one party can't act without the  
12 approval of another party, correct?

13 DR. SANFILIPPO: With respect to the  
14 specifics in Exhibit A, yes, I would agree.

15 MR. MURRAY: Okay, but, in Exhibit A and  
16 Exhibit B and elsewhere in the proposed bylaws it's  
17 pretty clear that Yale-New Haven Health System, as a sole  
18 corporate member post-acquisition of the L & M Board,  
19 retains the authority to take actions without the  
20 approval of the L & M Board and, conversely, that the L &  
21 M Board can't take any actions without Yale-New Haven  
22 Health System's approval, isn't that true?

23 DR. SANFILIPPO: I would say no.

24 MR. MURRAY: Okay.

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1 DR. SANFILIPPO: That's incorrect.

2 MR. MURRAY: Okay. Can you point to where  
3 in any of the proposed bylaws post-acquisition the  
4 Lawrence & Memorial corporate trustees retain the power  
5 to act against the expressed consent of the sole  
6 corporate member?

7 DR. SANFILIPPO: We retain the power for  
8 local day-to-day operations, clearly, in this.

9 MR. MURRAY: So local day-to-day  
10 operations. Would you agree with me, then, that major  
11 decisions, major financial, clinical, strategic decisions  
12 are ones, which the sole corporate member retains the  
13 authority on?

14 DR. SANFILIPPO: No.

15 MR. MURRAY: And, again, can you point  
16 anywhere in the bylaws that it indicates that governance  
17 is joint governance, as opposed to governance by a sole  
18 member?

19 MS. FELDMAN: I'm going to object. These  
20 questions are very broad in scope and confusing. With  
21 respect to the last question regarding control over  
22 clinical, I don't even know what that means, and I think  
23 he's leading my witness.

24 HEARING OFFICER HANSTED: Counsel?

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1 MR. MURRAY: I'm simply -- you know, the  
2 Applicants put in quite a thick number of volumes,  
3 including the proposed bylaws of the corporation.

4 The bylaws are very clear on what a sole  
5 corporate member's powers are. The literature, you know,  
6 the law review literature about what it is to be apparent  
7 as the sole corporate member is very voluminous, and  
8 we're happy to submit them, but I don't think we need to.

9 All I'm simply saying is that these are  
10 their documents. I think we have a right to ask  
11 questions.

12 MS. FELDMAN: We don't need to look at law  
13 review articles to understand corporate governance. And  
14 I agree with Attorney Murray, that this document is  
15 crystal clear. I'm afraid that he doesn't understand the  
16 document and how it's intended to work, and he keeps  
17 restating the same question in a way that's trying to put  
18 words in my witness's mouth.

19 MR. MURRAY: I'm not going to take umbrage  
20 with saying that I don't understand the document. That's  
21 okay. I'm not the witness. I don't need to understand  
22 the document.

23 MS. FELDMAN: Well you do if you're going  
24 to ask questions that are meaningful.

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1 MR. MURRAY: Well, Attorney Feldman, I  
2 think you just betrayed the issue that we have here, and  
3 I'm going to say something.

4 You said the intent of the documents. I'm  
5 talking about the black and white words of the document,  
6 and that's why I intended to ask the question of the  
7 witness.

8 The documents are crystal clear about the  
9 power and the retained power of the sole corporate  
10 member. Whether the Lawrence & Memorial Board of  
11 Trustees was told something different in a sotto voce  
12 conversation, I don't know, but the documents are pretty  
13 clear.

14 MS. FELDMAN: I think I would agree that  
15 the documents are very clear, and I think that Exhibit A  
16 articulates those types of decisions that need to be made  
17 jointly by L & M Corporation and Yale-New Haven Health  
18 System.

19 I don't think we need to belabor them.  
20 They're very clear, and they're very limited, so I don't  
21 understand the questioning.

22 HEARING OFFICER HANSTED: Attorney Murray,  
23 I'm going to sustain the objection. I think the document  
24 speaks for itself.

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1 MR. MURRAY: I was about to end my  
2 questioning of Dr. Sanfilippo.

3 HEARING OFFICER HANSTED: Thank you.  
4 We'll move on from this line of questioning.

5 MR. MURRAY: Okay. I have no other  
6 questions, Doctor. We have some questions for Marna  
7 Borgstrom. Good afternoon.

8 MS. MARNA BORGSTROM: Good afternoon.

9 MR. MURRAY: Ms. Borgstrom, during the  
10 application process, OHCA repeatedly asked for price  
11 information related to Yale-New Haven's contracts with  
12 commercial insurers for common diagnoses and procedures.

13 The Applicants have refused to provide  
14 this information, citing both the confidential and  
15 proprietary nature of the data sought.

16 On January 1st of 2017, all of this  
17 information related to the actual prices received from  
18 such commercial insurers or other third party payers will  
19 become public.

20 In light of this development and the  
21 inevitable disclosure of this information within the next  
22 six months, the Applicant's arguments to prevent the  
23 release of information now seems to be out of step with  
24 this movement towards transparency.

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1                   Given these facts, why won't the  
2 Applicants release the price information requested by  
3 OHCA?

4                   MS. FELDMAN: I have to object, because I  
5 believe that he misstated the request of OHCA. OHCA  
6 requested risk adjusted data, and the Applicants  
7 responded by stating that that data is in the hands of  
8 the payers and was not available to us, nor did we have  
9 the capability, just like any other hospital system in  
10 the state or presumably nationally, have the capability  
11 of producing that data, and that is not the same data  
12 that was produced in the Milliman exhibit that was  
13 introduced by the Intervenors.

14                   HEARING OFFICER HANSTED: Attorney Murray,  
15 response?

16                   MR. MURRAY: I guess I'm going to go to  
17 the January 1, 2017 disclosures. Ms. Borgstrom, you  
18 would agree with me that the data, in terms of the prices  
19 actually paid by providers, will be available on January  
20 1st, correct?

21                   MS. FELDMAN: We're unaware. I'm not sure  
22 what he's referring to.

23                   MR. MURRAY: Through the Health Exchange.

24                   MS. FELDMAN: The Health Exchange? Okay.

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1 I don't know if this is appropriate for me to say. I  
2 think you mean the All-Payer Claims Database?

3 MR. MURRAY: That's correct.

4 MS. FELDMAN: I happen to be counsel for  
5 the All-Payer Claims Database, and that is not  
6 information that's available and will not be available as  
7 of January 1, 2017.

8 MR. MURRAY: In objecting to my question  
9 before, Attorney Feldman said that the Applicants claim  
10 that this data, that data was in the hands of the payers.  
11 Can you point to specifically where the Applicants make  
12 that claim?

13 MS. FELDMAN: Well what data are we  
14 talking about here, because it's unclear to me?

15 MR. MURRAY: The data that OHCA requested.

16 MS. FELDMAN: That's risk adjusted data?

17 MR. MURRAY: Yeah.

18 MS. FELDMAN: I would like to have our  
19 expert, Dr. Noether, explain why that information cannot  
20 be readily produced. Is that possible, for me to have  
21 that done?

22 HEARING OFFICER HANSTED: Is that okay  
23 with you, Attorney Murray.

24 MR. MURRAY: That would be fine.

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1 HEARING OFFICER HANSTED: It sounds like  
2 he might be the best witness.

3 MR. MURRAY: She.

4 MS. FELDMAN: Dr. Noether, yes.

5 HEARING OFFICER HANSTED: I'm sorry, she.

6 DR. MONICA NOETHER: So there are data  
7 available that insurers would have that include what they  
8 pay for particular services inpatient or outpatient,  
9 however, even those data do not completely reflect  
10 variation in patient severity or complexity and,  
11 therefore, the underlying cost of treating patients.

12 Therefore, it's not surprising that  
13 different hospitals are paid different amounts for  
14 patients, who are classified into the same DRG, or the  
15 same CPT code, or the same APC code, or whatever  
16 particular acronym you want to apply to a particular  
17 claim.

18 In order to accurately adjust, in terms of  
19 adjusting for risk, as it's often called, or patient  
20 severity, would be another way of doing it, that's a  
21 methodology that is still I don't want to say in its  
22 infancy, but still in the process of being developed.

23 There are a lot of people doing research  
24 on trying to figure out good ways to do severity

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1 adjustment, but I don't think anybody has developed the  
2 Gold Standard. There is no standard methodology for  
3 doing that, so, for that reason, I think it's difficult  
4 when you are comparing prices for anything, but really  
5 routine commodity services to be able to know that you  
6 are, in fact, comparing apples-to-apples, as opposed to  
7 apples-to-watermelons.

8 MR. MURRAY: Just give me one minute.

9 HEARING OFFICER HANSTED: Sure.

10 MR. MURRAY: OHCA has put into the record  
11 a document, which I know the Applicants are going to  
12 object to, which is I'll call it the Milliman report.  
13 Have you seen that report, Ms. Borgstrom?

14 MS. FELDMAN: Just a second.

15 MS. BORGSTROM: I have seen it, yes.

16 MR. MURRAY: Okay and, in that report, the  
17 consultant compares a series of inpatient and outpatient  
18 charges in a one-year period for a universe of patients  
19 in the State Employee Healthcare System that were seen at  
20 both L & M and at Yale-New Haven Hospital, isn't that  
21 correct?

22 MS. FELDMAN: Just give her a second.

23 MS. BORGSTROM: I believe that's correct.

24 MR. MURRAY: Okay and the report.

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1 chronicles the fact that the payment for several  
2 inpatient or outpatient settings, depending on what the  
3 procedure was, was higher at Yale-New Haven Hospital than  
4 at L & M, is that correct?

5 MS. FELDMAN: I'm going to have to object  
6 again, because this is beyond the scope. She didn't  
7 testify about this. We objected to its introduction into  
8 evidence. We don't think it's relevant. We don't think  
9 it's accurate. We don't even know the source of the  
10 data. We don't know whether it's complete, so I don't  
11 understand why she's being Crossed if she hasn't provided  
12 Direct testimony on this.

13 MR. MURRAY: My question is not on  
14 necessarily the report.

15 MS. FELDMAN: Oh, I thought it was.

16 MR. MURRAY: The report is a foundation.  
17 My question is, and I'll ask the question, and, if you  
18 want to object to it, go ahead, are the prices reported  
19 in this report for procedures, inpatient and outpatient  
20 procedures, at Yale-New Haven Hospital, and this report  
21 represents that these are the actual prices paid by the  
22 State Employee Health System, are these comparable to the  
23 prices paid by commercial insurers for these services at  
24 Yale-New Haven Hospital?

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1 MS. BORGSTROM: I would have no way of  
2 knowing that.

3 MR. MURRAY: Okay. Ms. Borgstrom, in the  
4 application and the responses provided to OHCA, the  
5 Applicants have been reluctant to specify exactly where  
6 the \$216 million of the alleged \$300 million investment  
7 in L & M will come from.

8 In the application and the completeness  
9 responses, the claim is that the amount will come from  
10 synergies and efficiencies achieved at L & M post-  
11 acquisition and from L & M's cash flow.

12 In response to OHCA, the Applicant said  
13 that the \$300 million is not a cash commitment. Is that  
14 correct?

15 MS. BORGSTROM: The \$300 million is a  
16 commitment over a period of time to enhance services,  
17 infrastructure operations at Lawrence & Memorial.

18 A portion of that will come in the future,  
19 based on the improved operational performance at Lawrence  
20 & Memorial Hospital, but a significant amount of this are  
21 committed investments in things like a new information  
22 technology service, investment in population health  
23 infrastructure to better allow these communities to  
24 prepare for and manage value-based payment, as well as

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1 investments in recruiting and building out certain  
2 clinical areas that were determined by the Lawrence &  
3 Memorial and Westerly communities to be under-supported  
4 right now, such as primary care, surgery, behavioral  
5 health, women and children's services, emergency critical  
6 care services, so the first \$85 million of this are hard  
7 investments made by the Yale-New Haven Health System.

8 MR. MURRAY: Okay, but the subsequent -- I  
9 was asking about the \$216 or \$215 million that is  
10 supposed to happen after the initial investments.

11 In the completeness answers and  
12 application, the Applicants say that --

13 MS. FELDMAN: Can we have a page  
14 reference?

15 MR. MURRAY: -- the amount is dependent  
16 upon the performance of both Yale-New Haven Health System  
17 and L & M and business and strategic plans that achieve,  
18 and this is the quote from the application, "A positive  
19 return on investment."

20 So I guess my question is, based on these  
21 representations, would you agree with me that \$216  
22 million number isn't really a hard number?

23 HEARING OFFICER HANSTED: Attorney Murray,  
24 just for purposes of the record, what pages are you

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1       referencing?

2                   MR. MURRAY: Well, on page 224, there's a  
3       reference to the \$300 million commitment will come out of  
4       L & M's base operating cash flow.

5                   MS. FELDMAN: Just one second. We have to  
6       find it. I'm sorry. Can you repeat the page?

7                   HEARING OFFICER HANSTED: 224.

8                   MR. MURRAY: 624.

9                   HEARING OFFICER HANSTED: 624.

10                  MS. FELDMAN: Oh, 624. Okay, hold on.  
11       And just give us a second, so she could review it.

12                  HEARING OFFICER HANSTED: Absolutely.

13                  MS. BORGSTROM: Okay, thank you. I had a  
14       chance to take a look at this.

15                  MR. MURRAY: Okay. My question was a more  
16       general question, which is that the total dollar amount  
17       being talked about in the application of a \$300 million  
18       investment is not a completely hard number, is it?

19                  MS. BORGSTROM: Well it depends on the  
20       definition of what a hard number is, but we have made a  
21       hard commitment of the first \$85 million of this and have  
22       identified funding sources.

23                  The funding sources for the remaining \$215  
24       million will come as a result of improved business

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1 operations and business plans for identified needed  
2 services that I couldn't define or articulate right now.

3 MR. MURRAY: All right and, for example,  
4 in answer to some of OHCA's questions, and it was on that  
5 page 624, the Applicants say that \$163 million of the  
6 \$300 million commitment will come out of L & M's base  
7 operating cash flow, isn't that correct?

8 MS. BORGSTROM: Yes.

9 MR. MURRAY: Okay and this amount, this is  
10 in addition to the incremental cash flow from  
11 efficiencies and synergies that the Applicants estimate  
12 will be about \$68 million, is that correct?

13 MS. BORGSTROM: Yes.

14 MR. MURRAY: Okay, now, in answer to  
15 another OHCA question, the Applicants detailed a five-  
16 year table for what it called capital investments in  
17 equipment and facilities, correct? That's on page 625?

18 MS. BORGSTROM: Pardon?

19 MR. MURRAY: On page 625, the Applicants  
20 detailed and actually put a table out, talking about what  
21 it called the capital investment in equipment and  
22 facilities?

23 MS. BORGSTROM: Um-hum.

24 MR. MURRAY: Over a five-year period of

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1 time? Isn't that correct?

2 MS. BORGSTROM: Yes.

3 MR. MURRAY: Okay and if you sum up that  
4 five-year expenditure, as set forth in this table for  
5 capital improvement, that comes to \$163 million, doesn't  
6 it?

7 MS. BORGSTROM: You know, I will confess  
8 I'm not intimately familiar with these numbers and  
9 tables, and if we want to pursue this, I would like to  
10 ask that our senior finance representative here come and  
11 respond to those questions. I don't feel that I can do  
12 that reliably.

13 MR. MURRAY: All right. I understand  
14 you're obviously given the opportunity. I'm just really  
15 asking a simple mathematical equivalent.

16 If that table, if you sum up the amount  
17 put forth for capital improvement over five years, it  
18 comes up to \$163 million, and, earlier on that page in  
19 the response to OHCA, the Applicants say that \$163  
20 million will come from the cash flow of L & M over the  
21 five years.

22 I guess my question is does that mean that  
23 L & M's cash flow is actually funding the capital  
24 improvements over those five years?

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1 MS. FELDMAN: Do we want the truth, or, if  
2 we want accurate and helpful information to explain it  
3 and respond to your question, I think Ms. Borgstrom  
4 indicated that she doesn't feel like she is the best  
5 person to answer the question. We'd be happy to answer  
6 it and elucidate on it and respond to your question.

7 HEARING OFFICER HANSTED: That's an  
8 interesting way to put it, Attorney Feldman. Do we want  
9 the truth? I've never heard an attorney say that.

10 (Laughter)

11 I will say, unequivocally, yes, we want  
12 the truth.

13 MS. FELDMAN: Okay, great.

14 MR. MURRAY: It's in the job description.

15 HEARING OFFICER HANSTED: And I think,  
16 also, to be fair, Ms. Borgstrom already stated that she's  
17 not intimately familiar with that. It's a fair  
18 statement.

19 If she didn't present or if she didn't  
20 prepare the table, let's hear from the person, who  
21 prepared the table, so we can get down to more specifics  
22 about the table.

23 MR. MURRAY: That's fine with me.

24 HEARING OFFICER HANSTED: Okay.

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1 MS. FELDMAN: Keith, you want to come here  
2 and look at the -- do you have the application? Take a  
3 second. Do you need to review it?

4 MR. KEITH TANDLER: Okay.

5 MS. FELDMAN: Can we restate the question?

6 MR. MURRAY: Okay. My question was,  
7 taking a look at the capital investments in that table on  
8 page 625, over a five-year period of time, the capital  
9 infrastructure expenditures amount to \$163 million,  
10 correct?

11 MR. TANDLER: Correct.

12 MR. MURRAY: And, earlier, in one of the  
13 responses to OHCA in the previous page, the Applicants  
14 indicated that \$163 million of the estimated \$215 million  
15 investment was going to happen over a five-year period of  
16 time from the operating cash flow of Lawrence & Memorial  
17 Hospital, isn't that correct?

18 MR. TANDLER: That's correct.

19 MR. MURRAY: Okay and that amount, that  
20 \$163 million from the operating cash flow at L & M is the  
21 equivalent of what the Applicant's estimate is going to  
22 be spent on capital improvements, correct?

23 MR. TANDLER: Yes, that appears correct.

24 MR. MURRAY: Okay. I guess my question

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1 was does that mean that, as this is structured, the  
2 operating cash flow at L & M is going to finance the  
3 capital improvements, infrastructure improvements over  
4 that five-year period of time?

5 MR. TANDLER: So what we described in the  
6 application is the first \$85 million is a hard  
7 commitment. Following the first \$85 million, there are  
8 ongoing investments that will be based on the success of  
9 those synergies, those operating improvements as the  
10 business, as the organization is reorganized.

11 We'll be able to accomplish synergies and  
12 back office operations. Like we described, population  
13 health, bringing access to the community, physician  
14 recruitment. All those investments we do anticipate will  
15 bring a positive ROI.

16 Now we did use the term ROI broadly. It's  
17 not strictly a financial return that we're looking at.  
18 Yes, we do have to bring the business to financial  
19 stability. That's one element of our entire portfolio of  
20 strategic pillars that we manage at the health system,  
21 but there are other forms of ROI.

22 Those include improvements in quality.  
23 Those include improvements in patient satisfaction. And  
24 as we continue to navigate the shift from volume to

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1 value, we'll be measuring those metrics not only from a  
2 financial standpoint, but, also, in our program service  
3 accomplishments.

4 MR. MURRAY: Let me ask you about that, if  
5 you're the correct person to ask this question to, about  
6 that initial investment of \$85 million.

7 Forty-four million of that is targeted to  
8 support clinical programs than physician recruitment, is  
9 that correct?

10 MR. TANDLER: All of the details of the  
11 \$85 million I don't have in front of me, but physician  
12 recruitment is a substantial component of it, yes.

13 MR. MURRAY: Okay and, in fact, at some  
14 point, in response to OHCA, the Applicants made a  
15 statement that, of the \$44 million, half of that \$44  
16 million was targeted for physician recruitment. Do you  
17 recall that?

18 MR. TANDLER: I believe it was responded  
19 30.

20 MS. FELDMAN: What page?

21 MR. TANDLER: On page 628.

22 MS. FELDMAN: I'd like to point out for  
23 OHCA that there was another set of completeness  
24 questions, as you know, that elaborated and clarified

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1 some of the earlier similar questions, and those are on  
2 page 871.

3 MR. MURRAY: Did you see that answer,  
4 where it says launch funding for new position recruits,  
5 50 percent. Others, such as staff augmentation and  
6 clinical support, 50 percent, and it was in response to  
7 the \$44 million?

8 MR. TANDLER: You're referring to page  
9 628?

10 MR. MURRAY: 628, in response to question  
11 30.

12 MR. TANDLER: I do see that, yes.

13 MR. MURRAY: Okay, so, the Applicant's  
14 response said that half of the \$44 million is targeted  
15 for new position recruit.

16 My question is a very simple one. Is the  
17 money targeted for new physician recruit for actually  
18 bringing new physicians to the New London area to work at  
19 L & M or the L & M affiliates, or is this targeted for  
20 the acquisition of community physician practices?

21 MS. BORGSTROM: That is to bring new  
22 physicians to the Lawrence & Memorial and Westerly  
23 communities.

24 MR. MURRAY: So just so it's clear, so

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1 that money is not to be used for the acquisition of  
2 community physician practices?

3 MS. BORGSTROM: I don't believe that  
4 that's ever been the intention of those resources.

5 MR. MURRAY: Could those resources be  
6 allocated, could be earmarked for that, if it needed to?

7 MS. BORGSTROM: You're asking a  
8 hypothetical. I don't know the community. I don't know  
9 the needs. I can tell you what the intent was, is that  
10 there have been expressions of interest and concern in  
11 getting more primary care physicians recruited to the New  
12 London and Westerly communities, more support for  
13 maternal and child health, and then there are some  
14 surgical subspecialties, where the volume and the demand  
15 in these communities would not allow an individual  
16 hospital to recruit physicians and appropriate on-call  
17 and backup.

18 It wouldn't be economically feasible, and,  
19 so, this is to recruit physicians, who can meet those  
20 needs in the community that are not being met now.  
21 They're new providers.

22 MR. MURRAY: And the other part of the  
23 initial \$85 million is \$41 million earmarked for the  
24 support of, at least the Applicants indicate in its

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1 filings, it's about 13 or 14 potential clinical programs  
2 for support. Do you recall that?

3 MS. BORGSTROM: Yes.

4 MR. MURRAY: Okay. Is there any guarantee  
5 given to L & M about which programs that that money will  
6 be spent on, or is that something that's only going to be  
7 decided on after the acquisition with a strategic  
8 planning process?

9 MS. BORGSTROM: You know, I'll give you an  
10 example of how this will be done, based on what we've  
11 actually done in the past with Bridgeport and Greenwich  
12 and continue to do to this day, is they are looking to  
13 develop more clinical services in those communities, and  
14 it's a very fluid process, because it's based on needs,  
15 it's based on, in many cases, unanticipated retirements,  
16 or the departure of certain physicians, but this is  
17 something that's a collaborative process.

18 There's no way that we at the health  
19 system would have the ability to go in and define what's  
20 going to be most appropriate and the greatest need in the  
21 Lawrence & Memorial and Westerly communities.

22 That is something that our planning and  
23 clinical leaders will do in collaboration with their  
24 colleagues in Lawrence & Memorial and Westerly.

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1 MR. MURRAY: And why wasn't, as part of  
2 the process of this acquisition, why wasn't that planning  
3 process done prior to the actual completion of the  
4 acquisition, so that the community could know where those  
5 dollars were going to be spent by Yale?

6 MR. TANDLER: Like Marna just indicated,  
7 we did not want to get too far ahead of the process.  
8 This is a true collaboration. Many of the ideas have  
9 been generated locally.

10 For us to come in and just run a script or  
11 a playbook of all the answers to all the financial and  
12 other operational issues would be, in our mind, gun  
13 jumping, getting ahead of the process.

14 MR. MURRAY: Perhaps my question was  
15 unclear, and I apologize for that. I wasn't suggesting  
16 that you come in and prescribe which clinical programs  
17 get the \$41 million and which don't.

18 The question I asked was why didn't the  
19 joint collaborative planning take place prior to the  
20 application process, so that the community and OHCA would  
21 know exactly what clinical programs were going to receive  
22 the infusion of cash and which weren't?

23 MS. BORGSTROM: You know, this is a fluid  
24 dynamic process. We're trying to be in this for the long

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1 term. This is not all based on data you can collect  
2 right now and come up with the answer. This is going to  
3 evolve, as it has over, you know, 18 and 20 years with  
4 Greenwich and Bridgeport.

5 We are committed for the long term to the  
6 success of these communities and the success of these  
7 organizations, and, you know, frankly, you know, to get  
8 in there and begin to engage people in a detailed  
9 planning process for right now, when, you know, we've got  
10 a lot of things in front of us to get this approval,  
11 wouldn't have made sense and could have appeared to be  
12 heavy-handed.

13 This is going to be an iterative process.  
14 It's going to take time, but I think that you could talk  
15 to the leaders, clinical and otherwise, and the other  
16 communities in which our system operates, and they would  
17 describe a process that's ongoing, that's collaborative,  
18 and that's based on demonstrated need.

19 MR. TANDLER: I would just add that we are  
20 honoring certain regulatory parameters that guide what we  
21 can and cannot do.

22 MR. MURRAY: The regulatory parameters, is  
23 that because you were concerned about the competitive  
24 nature of the affiliation?

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1 MS. FELDMAN: Can you rephrase the  
2 question? I don't know what the question is.

3 MR. MURRAY: Is one of the parameters that  
4 you were concerned about was anti-trust concerns?

5 MS. FELDMAN: Correct. This is -- I don't  
6 think it's fair to ask the witnesses legal questions.  
7 They've been advised by counsel throughout the process.

8 MR. MURRAY: Just I guess one last  
9 question, Ms. Borgstrom. You're aware, aren't you, that  
10 there's a community health needs assessment going on in  
11 New London right now?

12 MS. BORGSTROM: I'm aware that all of the  
13 acute care hospitals perform community health needs  
14 assessments.

15 MR. MURRAY: Okay and is there any reason  
16 why the Applicants couldn't have waited for the  
17 completion of the community health needs assessment to  
18 have a better sense of what the actual needs were within  
19 the community before going ahead with the acquisition?

20 MS. BORGSTROM: I'm a little confused by  
21 the question and by the previous questions, because, on  
22 one hand, we've been asked why it wasn't all specified  
23 and determined, and, on the other hand, to wait.

24 These community needs assessments are done

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1 regularly. They are updated. They cover a whole lot of  
2 things, only a piece of which may be the direct clinical  
3 services and human power, clinical planning in these  
4 communities, so, you know, I don't think that, you know,  
5 I think these are fruits and vegetables.

6 I think the community health needs  
7 assessment is very relevant. It will be very helpful,  
8 but it is not and would not be the sole determinant of  
9 how investments are made.

10 MR. MURRAY: We have no other questions of  
11 Ms. Borgstrom. We do have questions of Mr. Cummings.

12 HEARING OFFICER HANSTED: Okay.

13 MR. MURRAY: Good afternoon, sir.

14 MR. BRUCE CUMMINGS: Good afternoon.

15 MR. MURRAY: Mr. Cummings, there's nothing  
16 in the application submitted to OHCA or in the agreement  
17 between L & M and Yale-New Haven Health System that  
18 prevents the elimination, consolidation, moving, or  
19 closing of any current medical services at L & M, is  
20 there?

21 MR. CUMMINGS: Well, as you've already  
22 pointed out, there's a joint approval process, because  
23 the local Board retains fiduciary responsibility, so any  
24 major new service, or, the flip side, any termination or

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1 substantial diminution of an existing service would  
2 require approval by both Boards, and, for that matter,  
3 the Office of Health Care Access has jurisdiction over  
4 specific services that would require the Applicant to  
5 seek permission.

6 MR. MURRAY: Okay.

7 MR. CUMMINGS: So, for example, under  
8 regulation, any material change in inpatient psychiatry,  
9 for example, requires that there be a filing with an  
10 approval by OHCA, so there are governing body  
11 responsibilities at both the local and parent level and  
12 regulatory oversight.

13 MR. MURRAY: Okay. I appreciate that. My  
14 question was a slightly different one, which was that  
15 there's nothing in the agreement or the application that  
16 guarantees the current level of services, correct?

17 MR. CUMMINGS: It's in the bylaws under  
18 Exhibit A.

19 MS. FELDMAN: I think the bylaws are a  
20 part of the agreement.

21 MR. MURRAY: Can you point out where in  
22 Exhibit A that is?

23 MR. CUMMINGS: On page 196, Item I, as in  
24 Irene, approval of major new programs and clinical

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1 services of this corporation or any affiliate or  
2 discontinuation or consolidation of such program.

3 MR. MURRAY: That deals with who makes the  
4 decisions, correct?

5 MS. FELDMAN: Can you rephrase your  
6 question?

7 MR. MURRAY: My question was that there's  
8 nothing in the application or in the agreement between  
9 Yale-New Haven Health Systems and L & M's current Board  
10 that guarantees the current level of services.

11 MS. FELDMAN: I'm going to have to object,  
12 because I think we already said that the affiliation  
13 agreement is part of the application and that the bylaws  
14 are a part of the affiliation agreement, which is also  
15 part of the application.

16 MR. MURRAY: So is that yes or no to my --

17 HEARING OFFICER HANSTED: No, she's  
18 objecting to your question.

19 MR. MURRAY: Okay.

20 HEARING OFFICER HANSTED: Do you have a  
21 response to that?

22 MR. MURRAY: I think it's an appropriate  
23 question. I want to know whether or not there's --  
24 whether the current level of services are going to be

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1 maintained post-affiliation.

2 HEARING OFFICER HANSTED: Well your  
3 question was whether or not the documents reference the  
4 current level of services and guarantee that they will be  
5 maintained, and we said earlier in the hearing that the  
6 document speaks for itself.

7 MR. MURRAY: Okay.

8 HEARING OFFICER HANSTED: So you may want  
9 to ask, and I'm not telling you what to ask, but you may  
10 want to ask if there's any understanding, besides what's  
11 written, pertaining to any guarantee of services  
12 continuing in the area.

13 MR. MURRAY: Other than what's in the  
14 application and what's in the affiliation agreement and  
15 the bylaws, is there any other agreement between the  
16 parties with respect to the current level of services?

17 MR. CUMMINGS: I'm sorry. I missed part  
18 of your question.

19 MR. MURRAY: Other than the application  
20 and the affiliation agreement and the proposed new bylaws  
21 for L & M, things that have already been submitted to  
22 OHCA, are there any other agreements between Yale-New  
23 Haven Health System and Lawrence & Memorial Corporation  
24 with respect to the continuation of the current level of

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1 services?

2 MR. CUMMINGS: Not to my knowledge, but,  
3 for that matter, there's nothing today, irrespective of  
4 Yale-New Haven or the proposed affiliation, that  
5 guarantees the continuation of existing services.

6 A key reason for doing this affiliation is  
7 precisely so we can maintain and even expand services.  
8 The absence of this affiliation will put a number of  
9 services in jeopardy.

10 MR. MURRAY: Okay. Following up on your  
11 response just now, Mr. Cummings, what services,  
12 specifically, are in jeopardy of not being continued if  
13 the affiliation doesn't happen?

14 MR. CUMMINGS: I'm not going to speculate  
15 on that. We are projected to lose \$22 million this year,  
16 and it's fair to say we're having conversations with our  
17 Board right now that are very difficult in nature about  
18 services throughout the organization, but they're not  
19 going to be discussed here.

20 MR. MURRAY: Okay. In the application, in  
21 responses to various completeness questions, one of the  
22 advantages of the acquisition, according to the  
23 Applicants, is the prevention of out migration of  
24 patients to distant, high-cost provides in Massachusetts,

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1 Rhode Island and New York. That's what's claimed in the  
2 application.

3 What are the specific mechanisms that the  
4 Applicants believe will keep patients in Connecticut and  
5 not go to those distant, high-cost providers?

6 MS. BORGSTROM: I can take a crack at that  
7 question, because, again, I think that if you look at our  
8 track record in Bridgeport and in Greenwich, you have to  
9 start first by saying we acknowledge that Yale-New Haven  
10 Hospital in New Haven is a higher-cost provider than many  
11 other providers in the State.

12 There are a lot of reasons for that, but  
13 given that we all need to move to a value equation, where  
14 care is better, safer and better coordinated and  
15 affordable to people, who are paying for some of that  
16 care out of their pockets, to pull that business into New  
17 Haven, when it can be provided locally, makes absolutely  
18 no economic sense, and it doesn't make sense to the  
19 patients and their families in these communities, so what  
20 you would find, which is very similar in Greenwich and  
21 Bridgeport, is that the depth and level of services  
22 offered in those communities has been expanded  
23 tremendously, and the practitioners, who have been  
24 brought into those communities at their request to

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1 support particularly specialty services, do the vast  
2 majority of what they do for those patients at those  
3 hospitals in their ambulatory centers, which is more  
4 convenient for the patients and more cost-effective.

5 That is the same approach that we would  
6 intend to work with Lawrence & Memorial and Westerly on.

7 MR. MURRAY: And, in answer to my  
8 question, that's the mechanism that the Applicants are  
9 going to use to prevent the outmigration to these high-  
10 cost providers out of state?

11 MS. BORGSTROM: It has kept more care in  
12 the local communities and we believe will continue to.

13 MR. MURRAY: Okay. Mr. Cummings, are  
14 there any agreements or expectations in your provider  
15 agreements with L & M employed physicians or affiliated  
16 practices that the doctors will principally or primarily  
17 refer patients to Yale-New Haven Health Systems  
18 affiliates after the acquisition?

19 MR. CUMMINGS: There is no such language  
20 in any of the agreements, and there is no such  
21 restriction or limitation today.

22 MR. MURRAY: Okay. Why did L & M end its  
23 affiliation with Dana-Farber?

24 MR. CUMMINGS: Well, in many respects, it

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1 really grew out of a fundamental change, that Dana-Farber  
2 informed us and other local affiliates throughout New  
3 England.

4 The original Dana-Farber model provided  
5 for an extremely high level of integration and  
6 coordination with the L & M Cancer Center.

7 This was a signature of the Dana-Farber  
8 model, and one of the elements of that, for example, was  
9 that a facility had to be built to Dana-Farber standards.  
10 There were particular re-staffing requirements around  
11 pharmacy, for example, and lab services to meet the Dana-  
12 Farber standard.

13 A key feature of this model and one of the  
14 things that drew us to it is that the oncologists  
15 providing services there have access to the Dana-Farber  
16 intellectual property. Use of their clinical protocols  
17 would be employed by Dana-Farber.

18 That's something we wanted. That's  
19 something they insisted upon. There was a mutuality of  
20 interest.

21 On or about April of last year, Dana-  
22 Farber informed us and their other local affiliates that  
23 they were fundamentally changing their model, that they  
24 would no longer be employing the local oncologist, and

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1 they were going to go to, these are my words, and I don't  
2 mean this in any kind of derogatory way, because we had a  
3 very good relationship with Farber, but they were going  
4 to go to more of a franchise model, far less involvement,  
5 far less control, pay a fee, be able to use the Dana-  
6 Farber name, have access to their clinical protocols, but  
7 they would be moving really much away to an arm's length  
8 relationship.

9 That was very disturbing news to our local  
10 medical oncologist, who had wanted the Dana-Farber  
11 employment and the Harvard adjunct faculty appointments,  
12 and, after consulting with them, they agreed that that  
13 was highly problematic.

14 Fortuitously and independent of the Dana-  
15 Farber matter, we had begun conversations with Yale-New  
16 Haven in January of that year, and, so, over the course  
17 of the summer, when it became apparent that there was  
18 going to be a definitive affiliation agreement, we  
19 informed Dana-Farber of those conversations, and they  
20 agreed that, between the change in their model, and they  
21 were going to go in a different direction, and our  
22 Board's decision to seek an affiliation with Yale-New  
23 Haven, that continuing the relationship did not make  
24 sense, and, so, it was mutually agreed that we would take

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1 it down at the end of calendar year.

2 MR. MURRAY: Now in response to one of the  
3 questions posed by OHCA, the Applicants responded, and  
4 this is in answer to question 27D on page 624, that if  
5 Yale-New Haven Hospital sustained an operating loss, one  
6 of the options for fulfilling its financial commitment to  
7 L & M under the terms of this application would be an L &  
8 M debt offering. Do you recall that response?

9 MS. FELDMAN: Just a second.

10 MR. CUMMINGS: I'm not the most  
11 knowledgeable person about the intricacies of bond  
12 offerings, and, so, I think having one of the financial  
13 experts speak to that would be more appropriate.

14 MR. MURRAY: Okay. I guess my question,  
15 and I'm not sure we need expert testimony, my question is  
16 that it's true, correct, that one of the, in answer to  
17 OHCA's question, about whether or not Yale would be able  
18 to meet its financial commitment, one of the answers the  
19 Applicants provided was one of the options would be an L  
20 & M debt offering, is that correct?

21 MS. BORGSTROM: An L & M debt offering or  
22 funding from existing Yale-New Haven Health System --

23 MR. MURRAY: I understand. What I'm  
24 simply saying is that L & M debt offering is one of the

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1 options that the Applicant said were open to them if  
2 there was a shortfall in the funding, correct?

3 MR. CUMMINGS: It does say that, yes.

4 MR. MURRAY: Okay, so, my question, isn't  
5 it true that, under Exhibit B of the proposed bylaws,  
6 that one of the reserve powers to the sole corporate  
7 member is the issuance and incurrence of indebtedness on  
8 behalf of the L & M Corporation?

9 MR. CUMMINGS: Yes, that's true.

10 MR. MURRAY: Okay, so, it's possible,  
11 isn't it, that, in order for Yale-New Haven Health System  
12 to meet its financial commitment under this application,  
13 it could saddle L & M with debt, for which the L & M  
14 Board would not have a power to prevent?

15 MS. BORGSTROM: I have to come back to  
16 it's a real hypothetical, and the Yale-New Haven Health  
17 System, if we determined, for whatever reason, that a  
18 debt issuance was going to allow us to support at a  
19 particular time a particular need at Lawrence & Memorial,  
20 we could do that through our obligated group at a rate  
21 level that would be far superior to what L & M could get  
22 independently, but, you know, debt is one of a mix of  
23 resources that we pursued to try and support investments  
24 that we are making throughout the system.

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1 MR. MURRAY: I understand that. I  
2 appreciate it. My question to Mr. Cummings is, given the  
3 reserve power to the sole corporate member, it's possible  
4 that, if there was an issuance of debt to L & M, the  
5 current L & M Board would not be able to prevent that,  
6 since that's the reserve power to the sole corporate  
7 member?

8 MR. CUMMINGS: You're asking a highly-  
9 speculative question. I can't say with any certainty  
10 that one of us won't be struck by a car driving home  
11 today.

12 MR. MURRAY: Well it's not written in your  
13 corporate bylaws that you won't be struck by a car. I'm  
14 simply saying, under the reserve power to the sole  
15 corporate member, if the sole corporate member decided to  
16 issue L & M debt, that's a reserved power to them,  
17 correct?

18 MR. CUMMINGS: So you're asking me a  
19 hypothetical question. Let me ask you a hypothetical  
20 question.

21 MR. MURRAY: You don't get to ask  
22 questions.

23 HEARING OFFICER HANSTED: No, no, no. Mr.  
24 Cummings, stop.

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1 MR. CUMMINGS: Let me ask a question. Let  
2 me respond.

3 HEARING OFFICER HANSTED: No.

4 MR. CUMMINGS: Why would --

5 HEARING OFFICER HANSTED: I want you to  
6 listen carefully to his question and respond to his  
7 question. I understand he's asking a hypothetical, but  
8 he needs to ask a hypothetical to get to the ultimate  
9 question that he has.

10 MS. FELDMAN: Yes, and he will answer. I  
11 really think he was making a rhetorical statement, rather  
12 than asking the attorney the question.

13 MS. BORGSTROM: Let me ask or state  
14 something. I think the reason that we're struggling with  
15 this, at least I'm struggling with this, is because it's  
16 hard for me to understand what incentive the Yale-New  
17 Haven Health System would have to add debt  
18 inappropriately to Lawrence & Memorial or any member of  
19 the system if we are trying to support a thriving, viable  
20 healthcare provider in each of our communities.

21 So I think, technically, the health system  
22 has the authority, the ultimate authority, to approve new  
23 debt issuances, but, you know, the inference, that that  
24 would be done in a way that would be detrimental to

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1 Lawrence & Memorial, doesn't ring true to me.

2 MR. MURRAY: I think I'm still waiting for  
3 the answer to my question, which is --

4 HEARING OFFICER HANSTED: Let me ask you  
5 this. Assuming Yale decided to take this action, you  
6 know, we don't know if they will or they won't, okay?  
7 Let's put that aside for the moment. Would L & M have  
8 any power to prevent it?

9 MS. BORGSTROM: Would L & M technically  
10 have any power to prevent it? I think that, if they  
11 said, you know, we can't make this work within the  
12 context of our operating budget and plan, we would tend  
13 to agree with them, because we're responsible for the  
14 authenticity of their plan, as the sole member of this  
15 organization, but we don't take on debt lightly, and,  
16 when we've done it in the past, as with a recent  
17 ambulatory project with Bridgeport Hospital, the decision  
18 was a collaborative one and actually initiated by the  
19 Bridgeport Hospital Board and subsequently endorsed by  
20 the Yale-New Haven Health System Board.

21 HEARING OFFICER HANSTED: Does that  
22 satisfy you, Attorney Murray?

23 MR. MURRAY: Well Ms. Borgstrom talked  
24 about what might happen. I'm simply asking what the

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1 language provides for, and I just want to clarify. Let  
2 me ask my question.

3 HEARING OFFICER HANSTED: Well, to be fair  
4 to Ms. Borgstrom, she was answering my question.

5 MR. MURRAY: Yeah, I'm sorry. She was  
6 answering your question.

7 HEARING OFFICER HANSTED: I didn't  
8 directly ask her about the documents.

9 MR. MURRAY: All I'm asking you, Mr.  
10 Cummings, is that it's true, isn't it, that, under  
11 Exhibit B, the incurrence of debt to L & M is a reserve  
12 power of the sole corporate member?

13 MR. CUMMINGS: Yes, as is true with any  
14 governance model.

15 MR. MURRAY: Okay, well, the governance  
16 model now is that the L & M Board of Trustees, if it  
17 wanted to encumber itself with debt, would make that  
18 decision, correct?

19 MR. CUMMINGS: Yes.

20 MR. MURRAY: Okay, so, my question simply  
21 is, post-acquisition, based on Exhibit B, the decision to  
22 saddle L & M Corporation with debt is a reserved power to  
23 the sole member, correct?

24 MR. CUMMINGS: L & M Healthcare in this

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1 model has a seat on the Yale-New Haven Health Services  
2 Board. It's inconceivable to me that the L & M Board  
3 would be asked, or, for that matter, the Yale-New Haven  
4 Board, asked to operate or make decisions that are  
5 inimical to the investments that are guaranteed in that  
6 \$85 million. Why would any organization do that?

7 MS. FELDMAN: I'm going to have to object  
8 to the continuing line of questions. At this point, I  
9 think we're trying to get a sound bite. I think that the  
10 attorney for the Intervenors is trying to have Mr.  
11 Cummings say, yes, it's true, but that is an answer in a  
12 vacuum. It's completely, again, irrelevant to how  
13 hospitals work, how healthcare systems work, and it's  
14 going on and on. For what purpose, I do not understand.

15 I mean we said earlier that the bylaws  
16 speak for themselves, and I don't see the point of  
17 badgering the witnesses.

18 MR. MURRAY: Asking questions is not  
19 badgering, but I'm not going to take umbrage with it. I  
20 will simply move on. I just have one last question for  
21 Mr. Cummings.

22 HEARING OFFICER HANSTED: Thank you.

23 MR. MURRAY: Mr. Cummings, you currently  
24 serve as the President and CEO of the L & M Corporation,

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1 correct?

2 MR. CUMMINGS: That's correct.

3 MR. MURRAY: Okay and as the President and  
4 CEO, you were selected to serve at the pleasure of the L  
5 & M Board of Trustees, correct?

6 MR. CUMMINGS: Yes, that's correct.

7 MR. MURRAY: Okay. Following the  
8 acquisition, based on the post-acquisition bylaws filed  
9 by the L & M Corporation, the President and CEO of L & M  
10 serves at the pleasure of the corporate member, correct?

11 MR. CUMMINGS: That's correct.

12 MR. MURRAY: I have no other questions for  
13 Mr. Cummings.

14 HEARING OFFICER HANSTED: Do you have any  
15 further Cross-Examination?

16 MR. MURRAY: Could you just give me one  
17 second?

18 HEARING OFFICER HANSTED: Sure. Attorney  
19 Feldman, do you have any Redirect?

20 MS. FELDMAN: I do. I do.

21 HEARING OFFICER HANSTED: Just wait one  
22 moment for Attorney Murray.

23 MS. FELDMAN: Okay.

24 MR. MURRAY: I'm sorry.

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1 HEARING OFFICER HANSTED: Attorney

2 Feldman?

3 MS. FELDMAN: Sure.

4 HEARING OFFICER HANSTED: You may proceed.

5 MS. FELDMAN: Thank you very much. Ms.

6 Borgstrom, several individuals have provided testimony

7 referring to the proposed application as a, quote,

8 "takeover," or have implied that L & M would lose all

9 control over governance if the proposal is approved.

10 How do you react to these descriptions?

11 How would you describe the proposal from the standpoint

12 of local control and governance? And I'm not talking

13 about getting into the specifics of the bylaws, but just

14 conceptually.

15 MS. BORGSTROM: So this is an affiliation.

16 It is a sole member substitution. Our practice, our

17 history, our approach is very collaborative. We are one

18 of -- I serve on a couple of national organizations. We

19 are one of the few that I know of that has preserved

20 local governance.

21 We respect the members of the Lawrence &

22 Memorial Board, as we do the Bridgeport and Greenwich

23 Boards. We have limited participation on their Boards.

24 They participate on the Health System Board.

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1                   What we have tried to do is work on behalf  
2 of a healthier system and healthier communities,  
3 respecting the role and the knowledge that local  
4 individual Board members have about the communities they  
5 represent.

6                   MS. FELDMAN: Does the composition of the  
7 L & M Board remain the same, other than the addition of a  
8 representative from Yale-New Haven Health System?

9                   MS. BORGSTROM: Yes.

10                  MS. FELDMAN: Based upon your knowledge of  
11 corporate governance at other national healthcare systems  
12 and other systems within the State, is it your opinion  
13 that the amount of control that L & M would continue to  
14 have be unusual?

15                  MS. BORGSTROM: Yes. It is not the  
16 typical practice, and, you know, I will tell you that it  
17 adds a little more to a number of people's workloads to  
18 have these local fiduciary Boards, but I think the  
19 benefits outweigh the additional work and time  
20 commitments.

21                  MS. FELDMAN: And how does it differ from  
22 other systems, such as Windham, which has been repeatedly  
23 referenced throughout this proceeding, in particular, as  
24 it relates to decisions to terminate services?

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1 MS. BORGSTROM: You know, I can't comment,  
2 specifically, on how Hartford HealthCare works, and we've  
3 spent a lot of time going through Exhibits A and B to the  
4 restated Lawrence & Memorial bylaws, but the opportunity,  
5 the decision to close or significantly change a service  
6 in either the New London or Westerly areas would have to  
7 be done in collaboration with the local Board.

8 It is not a unilateral authority that we  
9 have sought or that we think would serve the health  
10 system in the communities well.

11 MS. FELDMAN: Thank you. Now we've heard  
12 public testimony that questioned what's in it for Yale-  
13 New Haven Health. Can you please answer that question?

14 MS. BORGSTROM: You know, I think Mr.  
15 Cummings spoke to the fact that we've had a longstanding  
16 relationship on a number of levels, and I think you have  
17 to look at where healthcare, in general, is going.

18 There is no question that healthcare is  
19 too expensive right now. It is very much a sick care  
20 system, rather than focused on health and healthier  
21 communities. I don't think that there's any one reason  
22 for that.

23 I think that the current healthcare system  
24 we have has evolved over a long period of time, with a

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1 number of inputs, and, frankly, the way we've paid for  
2 healthcare has not supported the concept of value, but I  
3 think that's where we all believe, as healthcare leaders  
4 and as citizens of our own communities, it needs to go,  
5 so the value to Lawrence & Memorial and I think the Yale-  
6 New Haven Health System is quite mutual, because it will  
7 allow us to scale infrastructure to support population  
8 health investments, to rationalize key services to make  
9 care better and safer.

10 The investment in extending the Epic  
11 system there will allow us to avoid unnecessary  
12 duplication of services.

13 I know that, in some of the questions,  
14 duplication was seen, as well. We don't want, you know,  
15 the same service in New Haven or Old Saybrook as is in  
16 Lawrence & Memorial. That was not the issue.

17 What we have found in integrating  
18 information technology is that providers can act better  
19 on more reliable patient information and avoid laboratory  
20 testing, imaging services, things that both add cost and  
21 can delay the treatment of patients.

22 So, you know, I think that, you know,  
23 there are tremendous benefits to both organizations.

24 MS. FELDMAN: With respect to value-based

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1 contracting, which you made clear is here and is real,  
2 how will having L & M within your system benefit those  
3 types of contracting arrangements?

4 MS. BORGSTROM: You know, I would say  
5 value-based contracting is not here, particularly. It's  
6 an aspiration that I think the commercial insurance  
7 companies have.

8 I think Medicare is dabbling with it, and  
9 there's certainly been discussion of this at the State,  
10 but, you know, to say that it's become prevalent as a  
11 payment mechanism I think is premature, but I think that  
12 what we have to do is get ready for that, and no one  
13 organization can make both the corporate infrastructure  
14 investments and the kinds of financial and information  
15 system services that are going to be necessary to support  
16 value-based purchasing, and I think, you know, frankly,  
17 you know, the clinical care can be enhanced, and, you  
18 know, we don't have to rediscover the wheel in each  
19 community.

20 What is an evidence-based best practice in  
21 one community can more efficiently be scaled over all of  
22 the Yale-New Haven Health System associated providers.

23 MS. FELDMAN: So it might be more cost-  
24 effective, let's say, to have a patient receive their

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1 care at L & M Hospital than perhaps Yale-New Haven  
2 Hospital?

3 MS. BORGSTROM: It clearly may be, but  
4 Yale-New Haven Hospital provides services that are not  
5 available in many other hospitals, not only in  
6 Connecticut, but in the region, and that remains a  
7 resource and a backup.

8 MS. FELDMAN: Can you explain to me why  
9 the costs are higher at Yale-New Haven Hospital than  
10 let's say L & M Hospital or other hospitals within the  
11 system?

12 MS. BORGSTROM: Well now you're into one  
13 of my favorite discussions, which I won't belabor, but I  
14 think we use cost and pricing very differently, or we use  
15 them in the same way, but they mean very different  
16 things.

17 If you look at what it truly costs to  
18 provide care at a place like Yale-New Haven Hospital,  
19 there are a lot of reasons for that.

20 Yale-New Hospital is a level one trauma  
21 service that requires that you have a number of 24-by-7,  
22 365-day services available all the time.

23 If you are mowing your lawn and cut off a  
24 digit, Yale-New Haven Hospital is the only place that

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1 you're going to find that has on-site people 24-by-7, who  
2 are going to provide that care, and I could go on and on  
3 with the clinical services.

4 That costs money, because they aren't used  
5 every hour of every day 365 days a year. We have 1,300  
6 post-graduate trainees at Yale-New Haven Hospital. That  
7 is a huge program. According to the AAMC and other  
8 sources, we're one of 40 providers nationally, who are  
9 training about 50 percent of the nation's medical person  
10 power, and then, if you add technologists and PAs and  
11 nurses, a huge amount of training.

12 While it provides a certain amount of  
13 human person power, it also is costly, because these  
14 people are being educated, so there are a lot of things  
15 at Yale-New Haven Hospital that are going to make an  
16 organization like that more expensive, and, you know, and  
17 I think that's a reality.

18 The price in question, why it costs people  
19 more, I think you have to look at case mix. Yale-New  
20 Haven Hospital alone and Yale-New Haven and Bridgeport  
21 together in our health system are the largest providers  
22 of care to patients, who are medically-indigent and  
23 particularly insured by the State of Connecticut.

24 We are paid, on average, 30 cents on the

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1 dollar of cost for nearly one-quarter of our patients.  
2 That doesn't even cover our variable costs, so when we  
3 are building pricing, we are in pricing negotiations with  
4 third party payers, which, by the way, is about a third  
5 of our business, two-thirds of it is governmental payers,  
6 they don't negotiate with us, it's very clear they know  
7 and we know that part of it is the cost, maybe the cost  
8 of a place like Yale-New Haven Hospital, but a big part  
9 of it is the underpayment for the significant services  
10 that we are providing.

11 MS. FELDMAN: So, in Mr. Hyde's rebuttal  
12 to Dr. Noether on page two, I think it was dated July 6,  
13 2016, Mr. Hyde says that information from the Department  
14 of Social Services will shortly be made available to a  
15 task force, studying Certificate of Need in Connecticut.

16 This information will directly impact one  
17 question, namely, to what extent does the State of  
18 Connecticut pay Medicaid rates, which reflect monopoly  
19 pricing by Yale-New Haven Health?

20 I believe you just stated that -- well let  
21 me backup and ask you does Yale-New Haven Hospital, by  
22 way of example, negotiate with the Department of Social  
23 Services its Medicaid rates?

24 MS. BORGSTROM: No.

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1 MS. FELDMAN: And what percentage of your  
2 payer mix is actually Medicaid?

3 MS. BORGSTROM: It's about 22 percent, I  
4 believe.

5 MS. FELDMAN: And for every dollar of  
6 expense that you incur, can you tell me what you receive  
7 approximately from the Medicaid program?

8 MS. BORGSTROM: I'm not sure I understand  
9 the question.

10 MS. FELDMAN: So if you spent a dollar in  
11 providing services to a patient, what is your  
12 reimbursement from Medicaid?

13 MS. BORGSTROM: Thirty cents. Thirty  
14 cents.

15 MS. FELDMAN: I have no more questions for  
16 Ms. Borgstrom.

17 HEARING OFFICER HANSTED: Okay, thank you.

18 MS. FELDMAN: I do have one question for  
19 Mr. Cummings.

20 HEARING OFFICER HANSTED: Go ahead.

21 MS. FELDMAN: Okay, thank you. Mr.  
22 Cummings, there has been some testimony, wherein there  
23 has been some questioning regarding how it was determined  
24 what the specific needs were of L & M and what type of

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1 resource commitment Yale-New Haven Health was making.

2 Can you tell me a little bit about the  
3 process that you engaged in to determine what your actual  
4 resource commitment needs were?

5 MR. CUMMINGS: Yes. The senior team at L  
6 & M sat down over a period of days and were assisted by  
7 an independent outside consulting firm, Chartis. Chartis  
8 is a firm that works around the United States, has  
9 independent advisors to hospital Boards that are  
10 contemplating mergers, affiliations, or acquisitions.

11 Together, we mapped out, we took stock of  
12 what we projected to be our capital needs over a five-  
13 year period, and those totaled almost somewhere between  
14 \$325 million and \$400 million, and those, broadly  
15 speaking, those categories included the need to create  
16 the wherewithal to engage in population health.

17 That includes the development of a data  
18 warehouse, various predictive and analytical tools, none  
19 of which we had available. We estimated that was  
20 somewhere between \$5 and \$10 million to expand ambulatory  
21 services, particularly primary care services in the  
22 community that we serve that range from Old Lyme to the  
23 west to Westerly in the east, about \$75 million for  
24 additional capacity to provide ambulatory care services.

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1                   We also estimated we'd need about between  
2                   \$30 and \$40 million to replace our McKesson IT system and  
3                   to migrate to Epic. We estimated between \$35 and \$45  
4                   million would be needed for routine replacement of lab  
5                   imaging and pharmacy technology, and then somewhere  
6                   between \$180 million and \$230 million to update our  
7                   inpatient units, to upgrade our cardiac cath labs, to  
8                   create additional procedural space, because more and more  
9                   care is now being provided on an outpatient rather than  
10                  an inpatient basis, including, specifically, to come up  
11                  with more appropriate space for behavioral health  
12                  services.

13                  So when we added up all those buckets, it  
14                  was somewhere between \$325 and \$400 million. We  
15                  presented that finding to the Yale-New Haven Health  
16                  System staff, and, in relatively short order, we agreed  
17                  upon the \$300 million commitment over five years that  
18                  you've heard referenced throughout the hearing.

19                  MS. FELDMAN: No further questions.

20                  HEARING OFFICER HANSTED: Okay. Do you  
21                  have any further Direct at all?

22                  MS. FELDMAN: None.

23                  HEARING OFFICER HANSTED: Okay. Attorney  
24                  Murray, do you have any?

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1 MR. MURRAY: Just a follow-up question for  
2 Ms. Borgstrom. Ms. Borgstrom, you indicated, in answer  
3 to counsel's question, about the mix of patients at Yale-  
4 New Haven Hospital, the percent that are government  
5 payers, and government payers would include both Medicaid  
6 and Medicare?

7 MS. BORGSTROM: Um-hum.

8 MR. MURRAY: Okay and --

9 MS. FELDMAN: I just want to clarify. I  
10 believe her answer was in response to the percentage of  
11 Medicaid patients, not all governmental payers.

12 MR. MURRAY: Okay, well, she agreed with  
13 me, so I don't know.

14 MS. FELDMAN: I thought you said  
15 governmental payers, and that includes -- governmental  
16 payers would include Medicare.

17 MR. MURRAY: Yeah, that's what I just  
18 said, Medicare and Medicaid.

19 MS. FELDMAN: Oh, I'm sorry, then.

20 MR. MURRAY: Yeah. I thought we  
21 understood each other.

22 MS. FELDMAN: Okay.

23 MR. MURRAY: And it's true, isn't it, when  
24 you talked about value-based contracting, it's true,

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1 isn't it, that Yale-New Haven Hospital and Yale Medical  
2 Group have just submitted a proposal to DSS for value-  
3 based procedures for Medicaid patients in the State of  
4 Connecticut?

5 MS. BORGSTROM: I will embarrass myself,  
6 but I don't know that we've submitted a proposal. We  
7 have had discussions with DSS about using consulting  
8 support that we've engaged to understand how other states  
9 are looking at that, but we haven't made a proposal.

10 MR. MURRAY: Okay, so, as far as you know,  
11 there's no proposal?

12 MS. BORGSTROM: Not that I'm aware of.

13 MR. MURRAY: Okay. I have no other  
14 questions.

15 HEARING OFFICER HANSTED: Okay. Do you  
16 have any further Cross-Examination, Attorney Murray?

17 MR. MURRAY: No, I don't.

18 HEARING OFFICER HANSTED: No, okay. At  
19 this point, we will take a break. Please be back here by  
20 5:10, so we can get started with the rest of the hearing.  
21 Thank you.

22 (Off the record)

23 HEARING OFFICER HANSTED: Okay, we're back  
24 on the record. Attorney Murray, you stated you were

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1 completed with your Cross-Examination completely,  
2 correct?

3 MR. MURRAY: Yes, I am.

4 HEARING OFFICER HANSTED: Okay. We are  
5 going to move on to the next application involving this  
6 hearing, and that is Docket No. 15-32032-CON. Attorney  
7 Feldman, if you'd like to begin?

8 MS. FELDMAN: We're going to start with  
9 some testimony from Dr. Lehrach.

10 DR. CHRISTOPHER LEHRACH: Good evening,  
11 Attorney Hansted. Can you hear me?

12 HEARING OFFICER HANSTED: Yes, I can.

13 DR. LEHRACH: And to the rest of the OHCA  
14 staff?

15 HEARING OFFICER HANSTED: Can everyone  
16 hear him in the back? I think your mike is off.

17 DR. LEHRACH: How about that?

18 HEARING OFFICER HANSTED: No.

19 DR. LEHRACH: How about that?

20 HEARING OFFICER HANSTED: That's better.

21 DR. LEHRACH: So good evening.

22 HEARING OFFICER HANSTED: Good evening.

23 DR. LEHRACH: My name is Dr. Christopher  
24 Lehrach. I'm a clinically-active, Board-certified family

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1 physician. I'm also a Connecticut native, with advanced  
2 degrees in business and medicine from Yale and the  
3 University of Connecticut.

4 Currently, I serve as the President of the  
5 Lawrence & Memorial Medical Group, and I have over 20  
6 years of experience in medicine and medical practice  
7 management. I adopt my pre-filed testimony as my own.

8 My primary goal is ensuring access to  
9 quality-coordinated and cost-effective care close to  
10 home. Our goals are your goals. Everyone in this room  
11 has the same goal, quite frankly, but, right now, as we  
12 stand here in 2016, those goals are threatened, and  
13 they're threatened for three main reasons, as it relates  
14 to the Lawrence & Memorial Medical Group, and this boils  
15 down to issues of scale.

16 Number one, the L & M Medical Group has  
17 historically and continues to have tremendous  
18 difficulties around recruiting and retaining physicians  
19 and non-physician providers, and that extends to both  
20 specialists and primary care.

21 That has a lot to do with the fact that  
22 our service area is relatively small. Our lack of  
23 academic affiliation and our goal in considering a full  
24 merger with the Northeast Medical Group is to bring in

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1 new physicians and to bring new non-physician providers  
2 to our local service area to provide care close to home.

3 Number two, our ability to be successful  
4 in an accountable care or risk-based environment is  
5 unlikely, without merging with a larger organization,  
6 and, again, that has to do with scale.

7 The number of patients that we serve, the  
8 sheer demographics of the area, what the insurance  
9 companies would call covered lives, are not here.

10 We also need to invest heavily and to gain  
11 expertise in data analytics and data warehousing. We  
12 need to gain expertise in care management tools and  
13 predictive analytics, and, as I said, we need to scale to  
14 manage risk.

15 As anyone in the insurance industry would  
16 tell you, without scale, you can't effectively manage  
17 risk.

18 And, lastly, given our small size, the  
19 fixed overhead associated with our small size, we cannot  
20 be cost-effective with the various back office functions  
21 that we engage in. These include revenue cycle,  
22 scheduling, purchasing, communications and others.

23 So how does a merger with the Northeast  
24 Medical Group help us? Well just like everyone else in

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1 this room, I'm very concerned about access to care. You  
2 cannot underestimate the power of the Yale brand. The  
3 Yale brand will help us expand and enhance access to new  
4 physicians and non-physician providers in the L & M  
5 community, and this concept, which has primacy, is in  
6 contradistinction to what Mr. Hyde argues in his pre-  
7 filed testimony, where care will leave our community. We  
8 aim to do just the opposite.

9                   Secondly, as it relates to access to  
10 subspecialists, we have an insufficient patient base to  
11 support a full-service line of various subspecialties.  
12 It becomes very difficult to offer such specialty care  
13 when you only have enough need for one physician or half  
14 a physician.

15                   By merging completely with the Northeast  
16 Medical Group and affiliating with Yale-New Haven  
17 Healthcare, we can more appropriately match capacity to  
18 demand. The academic and research interests of our  
19 Applicants will also be met by the affiliation.

20                   And very important to me and close to home  
21 is primary care. Many of our local providers have  
22 stopped accepting Medicaid, as you know, given the poor  
23 reimbursement that's been documented recently.

24                   This is critically-important for our

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1 community, that we can continue to offer access to  
2 Medicaid. Only through a merger with the Northeast  
3 Medical Group can we continue to execute on our mission  
4 of improving the health of this region for all  
5 individuals, regardless of their ability to pay.

6 Just like everyone else in this room, I'm  
7 very concerned about the value that we offer to our  
8 patients. We have been doggedly focused on cost and  
9 being efficient, so that we can reduce the total cost of  
10 care, and we will continue to make this our chief focus.  
11 We want to offer care in the lowest cost, highest quality  
12 setting.

13 So why NEMG? Why a merger? Well they  
14 have expertise in various functions that will help us  
15 reduce the total cost of care. This includes care  
16 coordination, so that we can reduce redundant care. They  
17 have various clinical pathways and evidence-based  
18 protocols.

19 They have operational efficiencies,  
20 process innovation, and experience with so-called lean  
21 technologies, which will help our operational  
22 efficiencies, and, as I've previously stated, we seek  
23 their scale to help us with our back office synergies.

24 Just like everyone else in this room, we

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1 are interested in being successful around participating  
2 in Accountable Care Organizations and taking on risk in  
3 our new world of population health.

4 Right now, the likelihood of us being  
5 successful alone is limited. Having a single electronic  
6 health record in the form of Epic will get us partly  
7 there, but, as I previously stated, we need the expertise  
8 of the data analytics, the predictive analytics, the data  
9 warehousing, the clinical decision support tools, the  
10 patient engagement tools, the care coordination tools,  
11 the telehealth tools, the homecare tools, all the things  
12 that we can't possibly develop on our own, given our  
13 small size.

14 All of this is designed, so that we can  
15 intervene with our patients to keep them less sick. We  
16 want to improve lives. We want to keep patients out of  
17 the expensive emergency department. We want to keep  
18 patients from being readmitted to our hospital, and we  
19 need to be successful in population health for the  
20 benefit of our patients.

21 Just like everyone else in this room, I'm  
22 troubled by the costs associated with our medical group  
23 and the financial losses that they incur on our L & M  
24 healthcare system.

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1                   Now while this is largely an accounting  
2                   issue, given the fact that all of the work their  
3                   physicians do, the downstream revenue from that is  
4                   attributed to the hospital, leading to hospital margins,  
5                   while the medical group has a negative margin, we can do  
6                   better if we have scale.

7                   To some degree, this is going to become  
8                   necessary, so that we can ensure continued Medicaid  
9                   access.

10                  Lastly, I want to make a point about a  
11                  statement that Mr. Hyde made in his pre-filed testimony.  
12                  Unfortunately, he made the odious comment, by stating  
13                  that physicians under an employment arrangement have  
14                  been, quote, "bought off," unquote.

15                  As an employed physician for over 20  
16                  years, I find this very offensive. Clearly, Mr. Hyde has  
17                  never directly managed physicians. Had he, he would know  
18                  that they are amongst the most intelligent, independent-  
19                  thinking and autonomous professionals with whom you can  
20                  deal.

21                  They are strident advocates for their  
22                  patients, and that is where their value stems from. We  
23                  want to encourage autonomy. We want to encourage their  
24                  patient-centered focus, and we will continue to do that

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1 under a model, where we work with NEMG.

2 Just like everyone else in this room, I'm  
3 concerned about a loss of local control. Our governance  
4 structure with the Lawrence & Memorial Medical Group  
5 addresses this issue.

6 Members of our Board will sit on the NEMG  
7 Board. We will have a local Physician Operating  
8 Committee that advises the Board, as we have now.

9 NEMG and Yale-New Haven Healthcare has  
10 made it crystal clear over the last 18 months that they  
11 understand that all medicine is local.

12 So just like everyone else in this room, I  
13 appreciate the work that OHCA does. By design, this is a  
14 very thoughtful, contemplative, yet somewhat tedious  
15 exercise, so that the needs of our patients are served.

16 Our challenges are related to scale. The  
17 Northeast Medical Group merger allows us to improve  
18 access to primary care and specialty care, to decrease  
19 the total cost of care, to participate and succeed in  
20 Accountable Care Organizations, where we take on risk,  
21 and to maintain local control for our patients.

22 And one final point that I would make is  
23 that the Governor's Executive Order does not specifically  
24 address the NEMG LMMG merger. It is outside of the

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1 Certificate of Need presently under discussion.

2 For the aforementioned reasons, I would  
3 strongly urge you to approve the application, as  
4 submitted. Thank you very much.

5 MS. FELDMAN: Dr. Varkey will now provide  
6 some testimony.

7 DR. PRATHIBHA VARKEY: Good evening,  
8 Attorney Hansted and OHCA staff. My name is Prathibha  
9 Varkey. I'm a Board Certified Internal Medicine and  
10 Preventive Medicine physician and the newly-appointed  
11 Chief Executive Officer of the Northeast Medical Group.  
12 I would like to adopt my pre-filed testimony as my own.

13 I do appreciate the opportunity to speak  
14 about the CON application before you for the L & M  
15 Physician Association to merge into the Northeast Medical  
16 Group.

17 Given my short tenure at NEMG, Mr.  
18 Christopher O'Connor, who is the Chief Operating Officer  
19 of Yale-New Haven Health, was also presented a -- will  
20 also be available to answer questions.

21 Dr. Lehrach outlined specific reasons why  
22 LMP desires this affiliation. I would like to focus my  
23 testimony on what I consider are key community issues  
24 related to, A, access, and, B, population health and

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1 quality of care that the overall affiliation will assist  
2 it.

3 I'd like to first address the topic of  
4 access. New London and its surrounding towns have a  
5 significant problem in access. In fact, the proportion  
6 of emergency room visits per community member in New  
7 London is, for example, higher than anywhere in the  
8 nation.

9 Because of a variety of factors, including  
10 low reimbursement for patients with government insurances  
11 and the administrative burden related to healthcare  
12 reform, more and more providers nationally are moving to  
13 be part of large medical groups.

14 In fact, a recent national survey from  
15 about three weeks back pointed that about 26 percent of  
16 providers in independent practices nationally moved to  
17 large medical groups for the very same reasons.

18 It has also become increasingly difficult  
19 for small medical groups to hire providers. In fact,  
20 recent surveys have suggested that most new graduates  
21 want to work with large health systems.

22 LMP's affiliation with the Yale-New Haven  
23 Health System will certainly increase the capability of  
24 the L & M physician associates to hire more providers to

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1 the community, because of our reach to a larger pool of  
2 candidates and because of our affiliation to a larger  
3 academic health system.

4 Our physicians in the Northeast Medical  
5 Group live and work in the same communities that our  
6 patients live and work in, and we take great pride in  
7 providing high-quality care to our patients.

8 In fact, this is the very mission and  
9 reason behind the creation of the Northeast Medical Group  
10 six years back to provide high-value healthcare and  
11 access to the communities we serve.

12 Being community providers, we at NEMG have  
13 a strong mission also to provide care from a population  
14 health perspective, which is also very important to us,  
15 and we have been actively working on the same for several  
16 years.

17 In 2015, NEMG was selected as one of 89  
18 new Medicare shared savings programs, Accountable Care  
19 Organizations nationally to provide Medicare  
20 beneficiaries with access to high quality coordinated  
21 care.

22 In fact, to be an ACO, one needs access to  
23 at least 5,000 covered lives and integrated electronic  
24 medical record, a significant infrastructure of care

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1 coordinators that follow patients from hospital  
2 discharges that manage chronic diseases, data analytics  
3 and financial resources to support the same, most of  
4 which typically cannot be met by small physician  
5 organizations, such as LMP, as Dr. Lehrach alluded to.

6           Once the affiliation with NEMG occurs,  
7 however, LMP physicians will be able to participate in  
8 the NEMG Medicare ACO and avail of our population health  
9 capabilities.

10           Additionally, shared clinical and  
11 utilization data across locations allows for greater  
12 clinical integration, information sharing between  
13 physicians, and physician collaboration while minimizing  
14 wasteful duplicative utilization of scarce resources.

15           Our physicians at the Northeast Medical  
16 Group currently receive regular dashboards, sorry,  
17 dashboard reports regarding their adherence to a number  
18 of quality indicators, such as screenings, preventive  
19 care, medications, as well as the frequency of the  
20 emergency room visits of their patients, allowing for a  
21 discussion and analysis and improvement between and among  
22 providers, all of which are critical to work towards cost  
23 effective care.

24           In affiliating with the Northeast Medical

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1 Group, LMP physicians will also gain access to much  
2 needed expert clinical pathways and protocols to provide  
3 evidence-based practice information to guide physicians  
4 in selecting the most appropriate evidence-based tests  
5 and clinical interventions for the patients.

6 The LMP physicians, in addition, will also  
7 have access to our lean quality improvement methodology  
8 tools, leadership development opportunities, and patient  
9 experienced training. Again, none of these currently  
10 exist at LMP.

11 The affiliation will also help LMP to be  
12 better positioned to respond to MACRA, which is a  
13 sweeping overhaul of the Medicare physician payment model  
14 that significantly will influence Medicare physician  
15 reimbursements to shift towards value-based metrics by  
16 2018.

17 Finally, I would like to briefly address  
18 some of the points made by Dr. Hyde in his pre-filed  
19 testimony. Like Dr. Lehrach, I find it offensive and  
20 inflammatory that he suggests that our physicians have  
21 been paid off, and, so, no longer care about our  
22 patients, or about the financial challenges that our  
23 patients face.

24 I've run large system affiliated medical

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1 practices in states across the country, including Texas  
2 and Minnesota, and, like the physicians in the Northeast  
3 Medical Groups, the physicians in these practices care  
4 deeply about their patients.

5 In fact, most physicians have joined  
6 medical foundations like Northeast Medical Group, because  
7 they care, and because they're looking for the best and  
8 most efficient way to deliver high-quality, high-value  
9 healthcare services to a diverse set of populations.

10 In fact, at the Northeast Medical Group  
11 I'm pleased to report that our outpatient satisfaction  
12 scores are higher than national outpatient satisfaction  
13 scores.

14 This is something we take very seriously,  
15 and our Chief Patient Experience Officer spends  
16 considerable time coaching and evaluating our providers  
17 on patient-centered care, which is very important to us.

18 In summary, to address the critical needs  
19 of access for patients to community providers and to  
20 optimize efficiency by providing the infrastructure  
21 resources necessary to take care of population health, I  
22 believe it is critical and time sensitive to approve this  
23 affiliation.

24 I thank you for your time and attention

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1 and do urge you to consider and approve this CON  
2 application.

3 HEARING OFFICER HANSTED: Thank you,  
4 Doctor.

5 MS. FELDMAN: Mr. Cummings would like to  
6 provide some testimony.

7 MR. CUMMINGS: Thank you, Joan, and good  
8 evening, Attorney Hansted and OHCA staff. My name is  
9 Bruce Cummings. I'm the President and CEO of L & M  
10 Healthcare, which includes Lawrence & Memorial Hospital,  
11 the Westerly Hospital, the Visiting Nurse Association of  
12 Southeastern Connecticut, and, for purposes of the  
13 application now before you, the L & M Physician  
14 Association, doing business as the L & M Medical Group.

15 I hereby adopt my pre-filed testimony in  
16 connection with the proposed merger of the medical groups  
17 as my own.

18 I thought I would just step back briefly  
19 to describe the genesis of the L & M Physician  
20 Association, a non-profit affiliate of L & M Hospital.

21 This entity was established roughly six  
22 years ago, because of the problem of access in our  
23 community and the difficulty of recruiting physicians  
24 into a private practice model.

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1                   And, as you've heard from Dr. Lehrach,  
2                   increasingly in our community by the practitioners of all  
3                   stripes have stopped seeing Medicaid patients, and,  
4                   increasingly, they're no longer accepting new Medicare  
5                   patients, as well.

6                   So against this backdrop, the L & M  
7                   Physician Association was created to recruit new  
8                   physicians and non-physician providers to the community.  
9                   At no point have we ever purchased a physician practice.

10                   Some physicians previously in private  
11                   practice, for reasons that you've heard from my  
12                   colleagues here, decided they could no longer afford to  
13                   stay in business as a private practitioner and asked to  
14                   be employed. Their practice was not purchased.

15                   We also recruited additional new  
16                   physicians to the community, but, as you've heard from  
17                   Dr. Lehrach, even with the advent of the medical group,  
18                   we've reached a turning point, where simply it's good,  
19                   but it's not good enough to meet the requirements of the  
20                   new environment in which we are operating.

21                   And, particularly, I think, in the  
22                   Southeastern Connecticut, an additional challenge, in  
23                   addition to a high percentage of Medicaid patients, we  
24                   also see a lot of TRICARE patients, because of the

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1 submarine base and active military personnel located in  
2 this area and military retirees, so between the hospital  
3 and the medical group, this is the two entities really  
4 collaborate to provide access into the community.

5 So you've heard our case, as to why L & M  
6 Healthcare should affiliate with Yale-New Haven, and it's  
7 an affiliation, not a merger. By contrast, the medical  
8 groups is a true merger, in order to provide the scale  
9 required to recruit the next generation of physicians to  
10 our community and to promote access here.

11 And just a reminder, that one of the  
12 reasons why it is a merger and not an affiliation, it's a  
13 State law that specifically stipulates that there can  
14 only be one medical foundation within a given healthcare  
15 system.

16 We understand people in the community are  
17 worried about the fate of their local hospital and their  
18 local medical group and what will happen to prices for  
19 the future of healthcare in the future.

20 We share those concerns, as the future of  
21 healthcare is very uncertain and change can be  
22 frightening, but one thing is certain. Without bold  
23 changes, without finding a partner, one for the medical  
24 group and one for the balance of L & M Healthcare, our

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1 local healthcare system will continue to deteriorate, and  
2 both access and efficiency will suffer.

3 Just a reminder, we received approval from  
4 the Federal Trade Commission, which is due to expire by  
5 September 8th. Thus, if this affiliation of L & M  
6 Healthcare and Yale-New Haven is not completed by  
7 September 8th, then we will need to engage in a costly  
8 and lengthy regulatory review process with the FTC again,  
9 which only further delays the needs. I will stop there.  
10 Thank you.

11 HEARING OFFICER HANSTED: Thank you.

12 MS. FELDMAN: That's all the testimony we  
13 have.

14 HEARING OFFICER HANSTED: Attorney Murray,  
15 do you have any presentation on this application?

16 MR. MURRAY: Yes, we do. We have two  
17 individuals. We'll first call on Dr. Fred Hyde, and then  
18 he'll be followed by Dr. Ellen Andrews.

19 DR. HYDE: Mr. Hansted, members of the  
20 staff, ladies and gentlemen, I'm going to adopt my pre-  
21 filed testimony, to the extent it's pertinent to this  
22 application, and spend as few minutes as possible, given  
23 the hour, on my testimony, but would like to preface my  
24 testimony with a description of what I've seen, so that

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1 you will perhaps understand whatever merits or demerits  
2 my testimony might have.

3 I mentioned in the first hearing that I  
4 had been the first Director of the Faculty Practice Plan  
5 at Yale. I was chosen for that job by the Department  
6 Chairman at Yale, and, while having nothing but respect  
7 for their professional activities, it was the beginning  
8 of my education in the financial relationships between  
9 doctors and hospitals and doctors and doctors.

10 Subsequently, I spent time working with a  
11 network of hospitals in Connecticut, who were attempting  
12 to get their doctors signed up for a preferred provider  
13 organization with Blue Cross, and we were successful in  
14 creating the only such enterprise then or since, signing  
15 up 1,200 new physicians, the largest number since the  
16 merger of Blue Cross and Blue Shield in 1959 in  
17 Connecticut, all about who gets paid what for doing what.

18 When the Connecticut State Medical Society  
19 organized a physician-owned HMO, called MD Health Plan, I  
20 was their person to arrange the strategy for  
21 compensation, how to figure out how the doctors were  
22 going to pay themselves, because we had men and women in  
23 the Northeastern part of the state, who were not too many  
24 years from taking produce, and we had the Gold Coast,

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1 where they had a very elevated sense of the worth of  
2 their professional services, all about the business  
3 aspect. Nothing about professional. All about the  
4 business.

5 Since that time, I've run a surgery center  
6 owned by physicians, 50 credentialed surgeons, and have  
7 testified in more than 50 cases as an expert on  
8 hospital/physician financial relationships. Who pays who  
9 what and with what consequence?

10 So it's not economics. It's real life.  
11 It's not disrespectful of doctors. It's respectful of  
12 your job, which is to figure out how the public is going  
13 to get its money's worth out of any transaction involving  
14 large physician groups.

15 Let me begin by stating that I can see the  
16 problem. If you look at the financial statements for  
17 September 30, 2015 from the Lawrence & Memorial  
18 Corporation and look at the supplementary material, which  
19 has the revenues and expenses associated with different  
20 divisions, you can quickly see the problem, also.

21 The 73 physicians have net revenue of less  
22 than \$30 million, and they have a deficit of \$21 million,  
23 so we're not going to have these physicians survive very  
24 long losing as much money as they bring in, nor is the

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1 Lawrence & Memorial Corporation going to be happy about  
2 that. I think it's not anybody's fault. It's what's  
3 happened. What has happened?

4 Beginning in 1989, physicians found their  
5 compensation regulated. The new resource-based relative  
6 value scale became the basis for the CPT-based  
7 reimbursement, which led physicians into the first wave  
8 of, if you will, associating themselves financially with  
9 hospitals.

10 We had physician hospital organizations,  
11 we had physician practice management plans, actually  
12 begun by a Connecticut resident, Mr. Abe Gosman. We had  
13 a lot of scurrying in the early 1990s to try to find safe  
14 harbors, because it was perfectly clear that  
15 standardization of physician compensation was going to  
16 lead to limitation. It already severely compromised  
17 primary care physicians right out of the bat, right out  
18 of the shoot.

19 The solution became a little more apparent  
20 once hospitals under the outpatient perspective  
21 reimbursement system that began in 1997, which limited,  
22 just like DRGs did for the inpatient, limited outpatient  
23 reimbursement. How were both physicians and hospitals  
24 going to survive?

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1                   Beginning in the year 2000, we had,  
2                   through Medicare, something called a site of service  
3                   differential. This is familiar to people, who are going  
4                   to a doctor, and, suddenly, the doctor is part of a  
5                   hospital-based system, and they get two bills; one bill  
6                   for the professional services, one bill to help keep the  
7                   hospital open.

8                   It's taken us 15 years to get rid of this  
9                   site of service differential. It is going away with  
10                  rules being set now for execution January 1, 2017, which  
11                  may help explain some of the haste behind this  
12                  application. Some things have to be done, in order to be  
13                  reimbursable under the historical site of service  
14                  differential rules, and, if they are not done, based on  
15                  commitments entered into prior to that time or  
16                  implemented at that time, they may not be reimbursable at  
17                  the higher, that is dual reimbursement rate, which the  
18                  general accounting office in one of the publications  
19                  we've provided to you estimates for office visits at  
20                  about \$50 an office visit.

21                  We know that there are some studies that  
22                  have been done, and I'm going to just draw your attention  
23                  to two or three of them. I realize we've given you a big  
24                  bibliography. There won't be any quiz at the end, but

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1 two or three of these articles may help.

2 The GAO study, which we gave you December  
3 2015, about hospital/physician consolidation, both the  
4 vertical, if you will, and the horizontal, highlighting  
5 the need for payment reform, we gave you an article,  
6 which was Pritchett(phonetic), from 2010 from Health  
7 Affairs about unchecked provider clout in California,  
8 leading to higher than necessary payments, and we now  
9 have, six years later, an article by Melnick in the  
10 Journal of Health Care Organization Provision and  
11 Financing in April of this year, which we also gave you,  
12 that basically says because they had before and after  
13 numbers. You don't have them, and we don't have them.  
14 Nobody apparently has them.

15 They studied California Hospital and  
16 physician utilization and found about \$4,000 per  
17 discharge for the hospitals that had gotten bigger. They  
18 found increased utilization and higher prices for the  
19 doctors, who had been brought along for the ride.

20 There are other articles, again, quite  
21 recent. We have the Baker Physician Practice prices paid  
22 by private insurers for office visits. We have the  
23 Association of Financial Integration between physicians  
24 and hospitals with commercial healthcare prices higher

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1 than necessary. We even have total expenditures for  
2 patient in hospital-owned versus physician-owned  
3 organizations, and, as Dr. Smith testified, even the new  
4 Accountable Care Organizations have shown that the  
5 independent physician directed Accountable Care  
6 Organizations were the only ones to show any  
7 efficiencies.

8 Now why is that? I can tell you why it  
9 is. If I walked into a surgeon's lounge and confronted  
10 the orthopods with the idea they shouldn't be paying  
11 \$7,000 for an elbow titanium, because Medicare was paying  
12 me \$5,000, they'd laugh me out of the room and, by the  
13 way, did.

14 I can tell you, having been Chief  
15 Executive of some physician practices, as well as the  
16 surgery center, when the doctors confront one other about  
17 why we're paying \$6,000 for a titanium elbow, it's a  
18 different conversation.

19 Dr. Smith testified that, for better or  
20 worse, productivity somehow gets compromised when these  
21 large organizations become even larger. Mr. Gosman from  
22 Connecticut was famously quoted, front page of Business  
23 Week at the time, why he was getting out of this field.  
24 He said I found, when I hired doctors, I got low

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1       handicappers.

2                       What he meant was that the doctors focus  
3       on actually getting paid for what you do, which is very  
4       tricky, somewhat disappeared.

5                       The expenses somewhat increased. If it's  
6       the trash being picked up three times a week instead of  
7       twice, what do you care, because you're not paying for  
8       it?

9                       The entire nature of the organization  
10      changed once there was the bureaucratization, the levels  
11      of opacity, the loss of accountability to the patient.  
12      The patient may have an unpaid bill. Not my fault. I  
13      don't have any influence over the accounts receivable  
14      management, even though that I know has a reputation for  
15      abusive billing.

16                      So, in summary, this application, unlike  
17      the other, should not at a minimum be deferred. We know  
18      the fault of the other application, which is you don't  
19      have, nobody has, apparently, numbers on which they can  
20      agree that show the progress before and after of the  
21      acquisition of community hospitals.

22                      We do know that a big part of the  
23      prosperity of the price leader in this field is the  
24      capacity to charge academic medical center rates for

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1 community hospital services. Neither here, nor there.

2 This application is a very different, a  
3 horse of a very different color. It is such a bad idea,  
4 based on such literature as we have and common sense.  
5 I'm testifying in front of you, hopefully, as an expert  
6 on the financial relationships between doctors and  
7 hospitals, but you don't need that expertise. You know  
8 what will happen when we have these large organizations  
9 of doctors, who are able to command prices that are  
10 consistent with their financial aspirations, whether or  
11 not that fits community needs.

12 I'm sorry if candid talk about money is  
13 offensive, especially the younger practitioners. Nothing  
14 I can do about that, but I think we all owe each other a  
15 straight look in the eye about what the financial  
16 consequences are of allowing this merger to take place.

17 Once it's done, you will have insurance  
18 companies that must have these doctors, and it will be  
19 very, very difficult to undo. Thank you.

20 MR. MURRAY: Dr. Andrews?

21 DR. ELLEN ANDREWS: Thank you. I'd like  
22 to adopt my pre-filed testimony, as it relates to this  
23 application.

24 I'd like to, just in a few minutes, talk

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1 about the Medicaid, what's been suggested about Medicaid  
2 underpayments and why that's such a driver here. The  
3 last study -- I know I'm sworn under oath, and I didn't  
4 memorize the study. It's been a little while since I saw  
5 it, but the last study that I know of around Medicaid  
6 rates found that Connecticut's were 99 percent average,  
7 99 percent of Medicare, which may not sound great. It's  
8 one percent below Medicare, but that's better than either  
9 all or all, but one, other state.

10 Connecticut is very generous in its  
11 Medicaid rates, and I know they don't like that. And we  
12 heard that Yale-New Haven in Connecticut is a high-  
13 priced, high-cost provider, so, while it may be a stretch  
14 and it may not be as generous as, you know, people would  
15 like, it's still very generous, given the, especially  
16 given the State's finances right now.

17 The only cuts that have happened since  
18 then have been in dental rates, I believe it's two or  
19 three percent, and, also, home health medication  
20 administration, which are serious cuts. They're not  
21 unimportant, but I think, as a consumer advocate, I'm  
22 deeply troubled by the eligibility cuts for Husky  
23 parents, 10,000 losing coverage at the end of this month.  
24 Those are really serious and severe cuts, and I think

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1 that needs to be put in perspective.

2 Also, I believe it was four years ago, we  
3 made some major changes to our Medicaid program.  
4 Connecticut took it from an insurer capitated system to  
5 one that is focused on patient-centered medical homes.

6 We have saved money per member per month.  
7 It was down 5.9 percent last year. Not off of trend, but  
8 down from zero. I mean it was actually down, which is  
9 remarkable, and I can't say that enough.

10 We have improved quality, fewer people  
11 going to the emergency room with non-urgent visits, but  
12 we also increased the number of providers by 32 percent,  
13 and it wasn't just about rates. We learned that. But it  
14 was also about operational changes that needed to be  
15 made, making life easier, paying on time, things like  
16 that that made a huge difference in our Medicaid program,  
17 so I think that that needs to be recognized, that our  
18 Medicaid program has come a long way and should not be  
19 used as a reason for requiring this merger.

20 Also, DSS right now is in the midst of  
21 solicitation for value-based purchasing, a shared savings  
22 program, MQISSP, which I can't remember what it stands  
23 for, for our Medicaid program, and DSS reported to me in  
24 an e-mail that I'm happy to share that Northeast Medical

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1 Group and the Yale Medical Group have both sent in  
2 letters of intent.

3 The proposal is not due until August 2nd  
4 by 2:00 in the afternoon, is my understanding, so there  
5 is no proposal yet, but they have signed a letter of  
6 intent. It's non-binding.

7 That and the fact that they are  
8 participating in Medicare shared savings shows that there  
9 is a sophistication there. There's a lot of  
10 sophistication and risk profiling and analytics that are  
11 required for those programs, and those are, the addition  
12 of this section of the State, will add a great deal,  
13 given that attribution will be through primary care  
14 providers, will add a huge amount to their market share,  
15 in terms of the power of them and how many lives are  
16 attributed to them and how many are -- they will be under  
17 their shared savings.

18 They will benefit from savings that are  
19 achieved, based on those patients, so this is a huge  
20 increase, and Yale-New Haven's market power, Northeast  
21 Medical Group's medical power in the market, and, so I  
22 would urge you strongly not to approve this until the  
23 hospital decision is made and a larger decision can be  
24 made. Thank you.

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1 HEARING OFFICER HANSTED: Thank you,  
2 doctor.

3 MR. MURRAY: We have no further witnesses.

4 HEARING OFFICER HANSTED: Okay, thank you.  
5 Attorney Feldman, do you have any Cross?

6 MS. FELDMAN: I do not.

7 HEARING OFFICER HANSTED: Attorney Murray,  
8 do you have any Cross.

9 MR. MURRAY: I do not.

10 HEARING OFFICER HANSTED: Okay.

11 MS. FELDMAN: I have one Redirect.

12 HEARING OFFICER HANSTED: Sure.

13 MS. FELDMAN: For Dr. Lehrach. I believe  
14 that Dr. Hyde commented that there is a site of service  
15 differential that LMPA presumably takes advantage of with  
16 respect to providing services to those in the community,  
17 and I'm not sure he used the right terminology, but  
18 perhaps he is thinking about a provider-based facility  
19 fee that some hospitals have medical groups provide.

20 Does LMPA provide -- is it a provider-  
21 based practice?

22 DR. LEHRACH: No.

23 MS. FELDMAN: So there's no associated  
24 facility fee with LMPA services?

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1 DR. LEHRACH: That is correct.

2 MS. FELDMAN: Thank you.

3 HEARING OFFICER HANSTED: Anything

4 further?

5 MS. FELDMAN: No.

6 HEARING OFFICER HANSTED: Okay.

7 MR. MURRAY: I just have a Redirect of Dr.

8 Hyde.

9 HEARING OFFICER HANSTED: Sure.

10 MR. MURRAY: Dr. Hyde, when you were

11 making that comment, were you referring to L & M?

12 DR. HYDE: No. As a matter of fact, I was

13 indicating the problem. The problem is that, on net

14 patient service revenue for \$29 million, they're losing

15 \$21 million.

16 The site of service differential, which  
17 became part of the Medicare rules in 2000, is going away,  
18 and one question worth asking is are there plans to, in  
19 fact, incorporate a site of service differential through  
20 the rearrangement of physician/hospital relations, or is  
21 that so far from the Applicant's intent that, in fact,  
22 they would agree not to do so?

23 MR. MURRAY: Thank you.

24 MS. FELDMAN: I have another Redirect in

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1 response to Dr. Hyde's comment. Dr. Lehrach, are you  
2 aware of the fact, in November of 2015, that Congress  
3 passed a new law, eliminating provider-based locations  
4 and site of service, as Dr. Hyde refers to it, so it no  
5 longer can be an option for anyone, any hospital?

6 DR. LEHRACH: My understanding is that,  
7 for applications already in process by the date of the  
8 law, November of '15, those would go through, but no new  
9 applications after November of '15 would be legal.

10 MS. FELDMAN: And do you have an  
11 application in process?

12 DR. LEHRACH: We do not.

13 MS. FELDMAN: Thank you.

14 HEARING OFFICER HANSTED: Attorney Murray,  
15 anything further?

16 MR. MURRAY: Doctor, I'm just going to ask  
17 you, based on the last witness's response, do you have  
18 any further information to add?

19 DR. HYDE: We know that the rules are  
20 still in formation. We know that hospitals are unhappy.  
21 It's a very simple question. If Yale-New Haven and  
22 Lawrence & Memorial have no intention, whatsoever, of  
23 essentially inflicting site of service differential  
24 payments on the patients in this area, a mere statement

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1 to that effect would suffice, as opposed to arguing about  
2 where the regulations are now, what the meaning of the  
3 statement in place by June 30th, the implementation by  
4 January 1st, the legislation sign November 15th might be,  
5 very simply addressed. That's my only point. Thank you.

6 HEARING OFFICER HANSTED: Okay, thank you.

7 MS. FELDMAN: We're done.

8 HEARING OFFICER HANSTED: Thank you.

9 MR. MURRAY: No other questions.

10 HEARING OFFICER HANSTED: Thank you, both.

11 And it's my understanding, before we get to OHCA's  
12 questions, it's my understanding we have a couple of  
13 elected officials here, who would like to give a  
14 statement. I'm going to take them at this time.

15 MS. KAILA RIGGOTT: Ernest Hewett.

16 MR. ERNEST HEWETT: Good afternoon.

17 HEARING OFFICER HANSTED: Good afternoon.

18 MR. HEWETT: Can you hear me? It's almost  
19 like I've been sitting in a judiciary meeting, waiting  
20 for the last three hours.

21 Good afternoon, Attorney Hansted. My name  
22 is Representative Ernie Hewett, and I'm a State Rep for  
23 the 39th District representing the City of New London.

24 As you can imagine, I've been keenly

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1 interested and concerned about the impact this  
2 acquisition has on the individuals and families that live  
3 and work in this city.

4 Several months ago, I expressed my support  
5 for the Yale/Lawrence & Memorial affiliation, based upon  
6 the facts and information that I had at the time. Most  
7 importantly, I was concerned about the negative impact  
8 this merger might have had on working families, those  
9 employed at Lawrence & Memorial Hospital.

10 I've agreed to support the proposed deal  
11 when I receive assurances from the Union and the  
12 hospitals that job protections would be in place and  
13 secure.

14 Since that time, I have received new  
15 information that raises significant concerns about the  
16 benefits of this acquisition to the community,  
17 specifically related to local control, cost and price,  
18 and sustained healthcare services to our community.

19 Local control. The initial statements by  
20 Yale-New Haven and Lawrence & Memorial management were  
21 assured that a local Board of Directors will control L &  
22 M. I have recently learned that, in fact, according to  
23 the proposed bylaws for Lawrence & Memorial Health  
24 Corporation, Yale-New Haven is designated as the sole

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1 corporate member of Lawrence & Memorial Health. In other  
2 words, Yale-New Haven will have total control over  
3 membership and will ultimately have control over  
4 decisions made about our community hospital.

5 It is essential we have an honest, upfront  
6 conversation about what this acquisition means to our  
7 community. This newly-revealed information about the  
8 power and authority held by Yale over the community  
9 hospitals undermines our trust in the key players within  
10 this proposed deal and calls into question Yale-New Haven  
11 and Lawrence & Memorial's commitment to transparency and  
12 authentic bylaws with this community.

13 Cost and pricing. According to a report  
14 at the beginning of this year, if this acquisition is  
15 approved, Yale will control 60 percent market share from  
16 New York to Rhode Island and more than 80 percent in  
17 Lawrence & Memorial primary service area.

18 Consolidation in such markets can lead to  
19 price increases of 20 percent or more. This would be a  
20 significant blow to our community and would further  
21 accelerate challenges in accessing affordable healthcare  
22 services.

23 I understand that OHCA has asked Yale-New  
24 Haven Hospital to provide data on how previous Yale-New

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1 Haven mergers affected prices in the case of Bridgeport,  
2 Greenwich and St. Raphael's acquisition, helping us to  
3 potentially dispel some of these concerns.

4 To date, Yale has not provided this data.  
5 It does not make sense for OHCA to move forward with this  
6 acquisition without this crucial data.

7 Access to local services. My colleagues,  
8 who represent constituents in the Windham area, recently  
9 briefed me on changes made to critical healthcare service  
10 at Windham Hospital.

11 Several years ago, Hartford Hospital  
12 promised improvements and no cost to services within  
13 their community. These promises were not kept, and  
14 Windham Hospital closed its critical care unit,  
15 necessitating patients to drive and fly on helicopters to  
16 get normal healthcare.

17 What assurances do we have that this will  
18 not be the fate, as well? Lawrence & Memorial Hospital  
19 is a vital and crucial institution within this community,  
20 and its continued service to the individual families  
21 residing throughout the New London area must remain  
22 secure.

23 In order for me to have confidence and  
24 support in this proposal, these issues must be addressed.

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1 I strongly urge OHCA to require Yale-New Haven Hospital  
2 and Lawrence & Memorial Hospital to enter into a signed,  
3 legally-enforceable community benefits agreement,  
4 negotiating with broader cross-section of the community  
5 before we move forward with this, allowing any kind of  
6 change to the community hospital.

7 I just want to end by saying this merger  
8 almost sounds like a Bill coming down from the Senate at  
9 the end of session.

10 The Bill comes down from the Senate, and  
11 it's a good Bill, it comes to the House, and we're forced  
12 to not change anything in that Bill to make it a better  
13 Bill, because if it goes back to the House, the time is  
14 going to run out, and we lose the Bill.

15 My opinion, I think we should just take a  
16 couple of those mays out of this law or this merger and  
17 put some shalls in there and put some teeth in it to make  
18 this a better Bill. Thank you.

19 HEARING OFFICER HANSTED: Thank you. Are  
20 there any other elected officials that want to give  
21 public comment on this matter?

22 A FEMALE VOICE: (Indiscernible - too far  
23 from microphone).

24 HEARING OFFICER HANSTED: Would you like

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1 to make --

2 A FEMALE VOICE: I signed up.

3 HEARING OFFICER HANSTED: Okay, thank you.

4 I'll take public comment from the community after OHCA  
5 has completed its question and answer session, which  
6 we're going to get to right now at this point, okay?

7 So, as I just stated, OHCA has some  
8 questions on both applications, primarily the 15-32033,  
9 which is the Lawrence & Memorial Hospital and Yale-New  
10 Haven Health Services, Health System, sorry.

11 So we're going to start. The first  
12 question, and I believe it's the only question we have  
13 pertaining to the physician group, we're going to ask  
14 first, and then the rest will be to the affiliation.

15 MR. BRIAN CARNEY: Okay, good evening. My  
16 name is Brian Carney. I'm an analyst with the Office of  
17 Health Care Access.

18 I have a question relating to the merger  
19 of physicians' group practices. How will the merger of L  
20 & M Physician Group and Northeast Medical Group impact  
21 the diversity of providers and patient choice in the  
22 region?

23 DR. LEHRACH: So, in a nutshell, it will  
24 expand access to both primary care and specialty care. I

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1 don't know if that qualifies as diversity, but it will  
2 expand access.

3                   If your question specifically was asking  
4 if there would be new services offered, then the answer  
5 is also yes. Presently, given the size of the market, we  
6 couldn't possibly recruit certain specialists and  
7 subspecialists, because there just isn't enough demand in  
8 the community to support that, however, as part of a  
9 larger system, as I said in my comments, we can better  
10 match capacity to demand by having specialists and  
11 subspecialists present in our community seeing patients  
12 in our community on a part-time basis.

13                   MR. CARNEY: And do you have a list of  
14 those services that you could provide us?

15                   DR. LEHRACH: It's something we can  
16 submit.

17                   MS. FELDMAN: We could do it as a late  
18 file.

19                   MR. CARNEY: Okay. That would be great.

20                   HEARING OFFICER HANSTED: That will be  
21 Late File No. 1.

22                   I just want to follow-up on that question.  
23 When we talk about, when the statute talks about  
24 diversity of providers in an area, what it's really

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1 talking about is -- let me give you an example.

2 For whatever reason, there's a community  
3 member that doesn't want to see a Yale physician. I  
4 don't know why. If this proposal is approved, will there  
5 be doctors in this area outside of Yale doctors, Yale  
6 physicians, that that community member could see?

7 DR. LEHRACH: If I'm to understand you  
8 correctly, Attorney, you're asking if there will be  
9 physicians in our community, who are not under the employ  
10 of NEMG?

11 HEARING OFFICER HANSTED: Correct.

12 DR. LEHRACH: Currently, I don't know the  
13 actual breakdown, but there are many, many privately-  
14 employed physicians. There are physicians in front of  
15 you, who are employed by federally-qualified health  
16 centers.

17 There are physicians, who are employed by  
18 other large medical groups, including ProHealth. There  
19 are physicians owned by the Hartford HealthCare system,  
20 under Backus. I wouldn't expect any of that to change.

21 HEARING OFFICER HANSTED: Okay.

22 MR. CUMMINGS: If I could just add to  
23 that? We have a number of private practice specialty  
24 groups that have agreements with L & M, so the

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1 anesthesiologists are a private practice group, not  
2 affiliated with Yale. The hospitalists are a private  
3 practice group. The emergency physicians are a private  
4 practice group, and the radiologists are a private  
5 practice group, so if you were to add up (papers on  
6 microphone) largest groups in our community are the  
7 emergency physicians and the hospitalists.

8 HEARING OFFICER HANSTED: Okay.

9 MR. CUMMINGS: Both in private practice.

10 HEARING OFFICER HANSTED: Thank you, both.

11 MS. FELDMAN: Attorney Hansted, I just --  
12 perhaps, Dr. Lehrach, you can explain that we're not,  
13 regarding our plans to recruit existing physicians in the  
14 community versus recruiting physicians from out of the  
15 community to join the practice.

16 DR. LEHRACH: So the intention is to bring  
17 novel physicians and physician services to our community.  
18 If they're primary care, they would be recruited de novo.  
19 If they're specialty care, they may or may not be sourced  
20 through the NEMG YMG network, or they might be recruited  
21 independently from the outside.

22 Our goal is not to necessarily take on any  
23 additional practices that are presently here. We love  
24 the private practice model. I wish more doctors would

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1 stay in private practice, but, unfortunately, the  
2 economics are conspiring against many private  
3 practitioners and they're knocking on our door.

4 HEARING OFFICER HANSTED: All right, thank  
5 you.

6 MS. RIGGOTT: I actually have a question  
7 for Dr. Hyde first. You talked about asking the simple  
8 question about inquiring whether there would be  
9 instituting a site of service differential.

10 DR. HYDE: Yes.

11 MS. RIGGOTT: If that's going away in  
12 January, I guess I'm not, we're not entirely clear on why  
13 we would want to inquire about that.

14 DR. HYDE: Right. We're in a transition  
15 period. As you know, Congress finally responded to a  
16 recommendation from MedPAC that the site of service  
17 differential, that is the additional charge levied for  
18 the so-called facility fee on top of the professional  
19 fee, no longer be allowed, but there were exceptions for  
20 commitments that were entered into by June 30th of this  
21 year, which commitments would be implemented by January 1  
22 of next year.

23 What were those exceptions? As you know,  
24 there's a rule-making process underway, so we don't have

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1 final resolution. My point was twofold. One is that all  
2 of us need to be wary about hospitals subsidizing  
3 doctors. Where does the money come from? We know where  
4 it's coming from. From the year 2000 forward, by  
5 capitalizing, if you will, a site of service  
6 differential.

7 If, in fact, this particular practice has  
8 no intention of entering into an arrangement, which would  
9 allow such a levy, they have a simple solution to my  
10 point, which is to say so. Very simple.

11 So I'm pointing to a problem, which is  
12 that when hospitals acquire physician practices,  
13 productivity plummets and expenses go up.

14 I'm pointing to a solution found in the  
15 hospital physician industry, if you will, a business  
16 solution, which is to charge more for the same services,  
17 and I'm suggesting a resolution in this case, which is  
18 commitment by the Applicants not to, in fact, levy  
19 facility fees associated with professional services,  
20 would make my point moot.

21 MS. RIGGOTT: Thank you. I guess my next  
22 question is for the Applicant, then. Is there an intent  
23 of instituting a site of service or facility fee?

24 MS. FELDMAN: I think the transcript will

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1 reflect that that question was posed to Dr. Lehrach. I  
2 can ask the question. He said no.

3 DR. LEHRACH: I'm willing to restate it.  
4 Mr. Hyde's point is moot. There is none.

5 MS. FELDMAN: And I could also ask the  
6 same question of Dr. Varkey, and the answer would be?

7 DR. VARKEY: No.

8 MS. FELDMAN: Thank you.

9 HEARING OFFICER HANSTED: That's all the  
10 questions we have pertaining to the NEMG matter, so if  
11 you want to switch chairs, just to make it easier at this  
12 point for you?

13 DR. LEHRACH: Dr. Varkey and I appreciate  
14 the comments about our youthful appearance, however.  
15 (Laughter)

16 MR. CARNEY: Okay. There's been some  
17 general concerns regarding Yale's market share post-L & M  
18 acquisition. I took a look at some data, and, based on  
19 FY-2015 inpatient discharge data, Yale and L & M combined  
20 would capture more than 80 percent of inpatient  
21 discharges in L & M's primary service area.

22 This is only the inpatient portion of the  
23 market. Have you done a more comprehensive analysis of  
24 the before and after market share of L & M's service area

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1 in regard to this proposal? For example, an analysis  
2 that includes outpatient care, including emergency care  
3 and group practices.

4 MS. FELDMAN: Dr. Noether will respond.

5 MR. CARNEY: Okay, thank you.

6 DR. NOETHER: I guess, to answer your  
7 question, first of all, unfortunately, there are no  
8 comparable data to the inpatient discharge data that  
9 enable us to calculate shares on the inpatient side, on  
10 the outpatient side, or the physician side for that  
11 matter, so one can't do the kind of comprehensive  
12 analysis that you request.

13 I wouldn't have great reason to believe  
14 that it's going to be hugely different on the outpatient  
15 side, though there are more independent outpatient  
16 producers generally than inpatient hospitals. We just  
17 heard testimony about there being a lot of independent  
18 physicians, so, again, they're probably lower there, but  
19 I think the more relevant point is that the reason that  
20 the share will be substantial post-affiliation is because  
21 L & M already enjoys a substantial market share in its  
22 own service area north of 70 percent, so the incremental  
23 change resulting from this transaction is really pretty  
24 minor, and that's certainly one of the reasons I suspect

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1 that the Federal Trade Commission chose not to challenge  
2 the transaction.

3 MR. CARNEY: Okay. Following up on a  
4 similar question to before, then how would the market  
5 share composition following the affiliation impact the  
6 diversity of providers and patient choice in the region,  
7 as far as hospitals?

8 DR. NOETHER: Again, I don't think it's  
9 going to have much effect at all. As I noted in my pre-  
10 filed testimony, there isn't a lot of direct competition  
11 between Yale-New Haven Health or Yale-New Haven Hospital  
12 and L & M Hospital or L & M Health currently.

13 Really, they are serving different patient  
14 populations. They are 50 miles apart. There really  
15 isn't a lot of direct competition now, so there's no  
16 competition to be reduced and, therefore, no impact on  
17 diversity of providers.

18 MR. CARNEY: Okay, thank you. The next  
19 set of questions is sort of financial related. I'm not  
20 sure your CFO would be the most appropriate person, but  
21 I'll start off with a question, and you can determine.

22 How is pricing determined for hospital  
23 services? What factors are included in the negotiation  
24 with insurance companies regarding reimbursement amounts?

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1 MS. FELDMAN: We have multiple people that  
2 can answer that.

3 MR. CARNEY: Okay, great.

4 MR. TANDLER: Sure. So when we look at  
5 pricing, the first thing we have to understand is that  
6 the preponderance of the payer mix is governmental.  
7 We're talking about one of the highest governmental payer  
8 mixes in the State at Lawrence & Memorial.

9 We do not dictate prices. We don't even  
10 negotiate prices with our governmental payers. Those are  
11 not negotiated.

12 For those that are, for those that are  
13 negotiated, those are done at arm's length. We don't  
14 reveal any rates, and I think we've covered during this  
15 discussion our ability to share rates between the  
16 parties. At this point, we are unable to do that, but,  
17 going forward, as a result of this transaction, we have  
18 committed to honoring the terms of the existing  
19 agreements for their duration.

20 Following the term of those existing  
21 contracts, we will negotiate those at arm's length with  
22 the various managed care commercial payers, and those go  
23 into a variety of factors.

24 Those are each, for all the Yale-New Haven

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1 Health System affiliates, are negotiated separately. In  
2 fact, we are one of the only health systems that doesn't  
3 have a single rate for all of our member hospitals.

4 Each hospital negotiates separate rates,  
5 based on the economic circumstances of each affiliate.  
6 Those go into matters, like the factors that fall into  
7 that could be the cost index in that geographic region.  
8 It includes the perceived quality at each hospital.

9 It includes the shortfall from  
10 governmental payers. That is one of the independent  
11 variables that goes into the pricing with managed care  
12 payers, but, like I said before, we are honoring the  
13 existing agreements for the duration, and, following  
14 that, we would negotiate at arm's length, based on those  
15 factors I just described.

16 COURT REPORTER: Can you identify yourself  
17 for the record, please?

18 MR. TANDLER: Keith Tandler, Executive  
19 Director.

20 MR. CARNEY: Is market share one of the  
21 factors included in those discussions?

22 MR. TANDLER: No.

23 MR. CARNEY: Would that be a factor?

24 MR. TANDLER: No. Again, the economic

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1 factors include perceived quality, the cost structure at  
2 each organization, various cost indices in each  
3 geographic region, and governmental payer shortfalls, as  
4 well as the hospital tax factors into that.

5 MR. CARNEY: Okay, thank you.

6 HEARING OFFICER HANSTED: You mentioned  
7 that you're unable to share the negotiated rates. What  
8 is the basis for that?

9 MR. TANDLER: So, as part of this  
10 transaction, we are not privy to the Lawrence & Memorial  
11 rates. We're not able to estimate any price change as a  
12 result of any negotiation.

13 If we were not honoring those existing  
14 agreements, there would be no ability for us to even  
15 gauge what that differential is.

16 MS. FELDMAN: I just want to make an  
17 observation generally, that most managed care contracts,  
18 if not, all, have confidentiality provisions, which  
19 prohibit a provider from disclosing to a third party  
20 their negotiated rates.

21 HEARING OFFICER HANSTED: And is that the  
22 case here?

23 MS. FELDMAN: I assume so.

24 MR. TANDLER: Yes. Yes. I mean counsel

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1 has advised us that, and we've been following that as  
2 part of any business combination or affiliation that  
3 we've ever worked with.

4 HEARING OFFICER HANSTED: Okay.

5 MR. SETH VanESSENDELFT: If I could just  
6 add a comment? The two other things that would be  
7 important to kind of add onto Keith's statement is one is  
8 the expectation of pricing neutrality, so, as we go  
9 forward with these commercial payers, there is absolutely  
10 an expectation of pricing neutrality.

11 The second part is, in your prior  
12 question, many times we're thinking about this in kind of  
13 a same state for the same services that we would somehow  
14 negotiate a higher price or charge more.

15 I think what we're missing in that is  
16 really what's been tried -- we've tried to convey  
17 throughout this, that, for all of those services that  
18 have to leave the area and seek care at a higher level of  
19 care in the tertiary setting, when it could be provided  
20 in the community setting, and that's really what we're  
21 advocating here, there is a pretty significant price  
22 improvement in those cases.

23 So, for example, if we have lost a  
24 thoracic surgeon and we can't replace that surgeon, we

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1 can't recruit for them, and all of that care then gets  
2 sent to Hartford, or to Yale, or to Providence, all of  
3 those cases will be at a much higher level than if we  
4 were able to continue to retain that in the existing  
5 service area, and that's absolutely what we've been  
6 advocating.

7 And probably the third point that's  
8 critical to this thinking is that, as we negotiate  
9 services going forward, there is an expectation that  
10 greater and greater portions of that will be risk-based,  
11 quality-adjusted, and, so, those are another thing that  
12 we try to advocate.

13 COURT REPORTER: State your name for the  
14 record.

15 MR. VanESSENDELFT: Seth VanEssendelft.  
16 I'm the CFO at L & M.

17 MS. FELDMAN: Attorney Hansted, I would  
18 also think it might be helpful if Dr. Noether explained  
19 the reasons why, from a legal standpoint, anti-trust laws  
20 would prohibit the sharing of that data.

21 HEARING OFFICER HANSTED: Okay.

22 DR. NOETHER: Let me first start by  
23 caveating that I'm not an attorney, but I've spent a lot  
24 of time with anti-trust attorneys and involved in

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1 mergers, and it's certainly my understanding that it is  
2 inappropriate and, in fact, illegal for parties prior to  
3 having their merger ultimately approved or affiliation  
4 approved and consummated to share competitive  
5 information, which includes, certainly, pricing.

6 HEARING OFFICER HANSTED: I'd like to see  
7 that law, where it prevents the disclosure. I'm not  
8 familiar with it. I'm not saying it doesn't exist. I  
9 would just like to see the cite for it, if you could  
10 provide that as a late file.

11 MS. FELDMAN: I could tell you that you  
12 could find that in Section 1 of the Sherman Act. If you  
13 told us tonight that OHCA was going to approve the  
14 proposed application, we'd be happy to share information,  
15 but since we are not integrated, Section 1 of the Sherman  
16 Act would prohibit that type of information not among  
17 hospitals.

18 In addition, to the extent that they are  
19 commercial contracts, we have contractual provisions that  
20 would limit our disclosure to another hospital. As you  
21 can imagine, the payers would not want that information  
22 to be made public.

23 HEARING OFFICER HANSTED: Okay, thank you.

24 DR. NOETHER: Let me just add that there

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1 have been a number of anti-trust cases brought precisely  
2 as violations of the Sherman Act that involve essentially  
3 allegations of price fixing among competitors.

4 HEARING OFFICER HANSTED: Okay, thank you.

5 MR. CARNEY: I just have another follow-up  
6 for Dr. Noether about the whole risk adjust pricing. I  
7 keep hammering away here.

8 You said, basically, that that information  
9 there's no metric that's appropriate to use. What about  
10 -- why is it not possible or appropriate to provide  
11 hospital prices utilizing diagnostic related groups using  
12 MSDRGs, which do categorize patients by treatment type  
13 and severity of illness?

14 DR. NOETHER: That certainly is a first  
15 step, and looking at case mix adjusted prices would be  
16 essentially adjusting prices for the DRG weight by  
17 essentially taking an unadjusted price and dividing it by  
18 a DRG weight, which I will say, parenthetically, it  
19 appeared, from when we looked at the Milliman Study, that  
20 they, in fact, implemented any kind of case weight  
21 adjustment incorrectly, because they multiplied instead  
22 of dividing.

23 The point I was trying to make earlier was  
24 that the DRG weight assumes that all patients within a

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1 DRG are the same, and that's not the case.

2 MR. CARNEY: Don't they have --

3 DR. NOETHER: DRGs -- sorry.

4 MR. CARNEY: Don't they have several  
5 categories, like without comorbidities? They do have  
6 some separation, do they not? Three different  
7 categories, I believe?

8 DR. NOETHER: Yes, sir, you're correct.  
9 There are, at least for some DRGs, there's a with and  
10 without complications and comorbidities, so that starts  
11 to make some adjustments, but even within those two  
12 categories you can have a broad spectrum of patients,  
13 and, certainly, the Medicare program, for example,  
14 recognizes that teaching hospitals have higher costs for  
15 a number of different reasons and pays them more.

16 One of those reasons is it does recognize,  
17 as has been discussed earlier, that teaching hospitals  
18 have a higher range of services and tend to attract  
19 sicker patients, so that's just one example.

20 MR. CARNEY: Okay, thank you. All that  
21 being said, what evidence can you provide OHCA with that  
22 will help us evaluate whether or not healthcare costs  
23 will be adversely affected by this proposal?

24 DR. NOETHER: Is that a question for me?

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1 MR. CARNEY: That can be for anyone.

2 DR. NOETHER: I can start, but I suspect  
3 others have some. I mean I think, you know, it gets back  
4 to what we were saying before, which is there really, at  
5 least from an economist perspective, there's no  
6 diminution of competition, because there hasn't been much  
7 competition between Yale-New Haven and L & M  
8 historically.

9 If anything, there will be efficiencies  
10 that will be generated through the transaction that  
11 should enable costs to be reduced and/or quality to be  
12 enhanced.

13 MR. TANDLER: So I can just add to that.  
14 There's various elements of our strategy over the years  
15 that has allowed us to reduce costs. Some of those areas  
16 we've covered today.

17 Access to capital was an area we covered  
18 regarding the ability to borrow. Scale has been part of  
19 our ability to reduce the cost per unit, specifically  
20 where we have increasing amounts of fixed costs. We're  
21 increasingly a capital-intensive organization, and those  
22 fixed costs get spread out over a greater number of  
23 patient visits.

24 This is one piece of our overall strategy.

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1 We've actually been successful in that, as well, if you  
2 look back at some of our own history with the Hospital of  
3 St. Raphael. That's a recent example of where we've been  
4 successful.

5 Insurance is another area. We've had  
6 examples, where we're able, because of our size and  
7 because of our ability to tolerate and manage risk, we've  
8 been able to use our size and expertise around risk,  
9 whether it's malpractice, property casualty, or any other  
10 type of risk, to withstand that and reduce costs, and  
11 these are three examples of areas that are compelling  
12 that are part of our strategy.

13 MR. CARNEY: Okay and those, combined  
14 with, say, the anticipated cost savings opportunities  
15 that have been presented following the acquisition, how  
16 will that translate to, you know, potentially lowering  
17 prices for patients?

18 MS. BORGSTROM: Let me maybe take a crack  
19 at that, because these are very complicated issues, as  
20 you're well aware, and, to answer that factually, there's  
21 a great deal of speculation.

22 One, as we said in the application, we  
23 have stipulated price neutrality for Lawrence & Memorial  
24 and Westerly, and, after their contracts expire, as Mr.

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1 VanEssendelft said, those will be negotiated, based on  
2 Lawrence & Memorial's costs and what's happening in this  
3 particular geography.

4 We also said earlier that the hope is that  
5 we keep more patients in the local community here, rather  
6 than having them treated, because the subspecialists are  
7 not in this community. That will make it less expensive,  
8 because this is a lower cost setting in some of those  
9 patients, who may be being transferred to New Haven.

10 You know, in the past five years, the  
11 Yale-New Haven Health system has reduced on an annualized  
12 basis its operating costs by over \$200 million. That has  
13 not translated into a price reduction or what people may  
14 feel when they go to the hospital or physician for a  
15 couple of reasons.

16 One, as we've taken the \$200 million out,  
17 we are now the largest taxpayer in the State of  
18 Connecticut, paying over \$185 million in taxes. That,  
19 combined with reductions in payment rates for things like  
20 laboratory services and outpatient services, has more  
21 than eclipsed what we have saved.

22 Second, what people are feeling out of  
23 their pockets is, to a certain extent, based on employer  
24 designed insurance offerings, and we don't have any

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1 control over that, and, as we move further in healthcare  
2 reform and the present Health Care Act organizations  
3 looking to avoid taxes, are going to put more  
4 responsibility on employees and consumers whether or not  
5 that has anything to do with the actual prices or  
6 negotiated rates with payers.

7 So the issues are very complicated, but we  
8 recognize that we've got to continue to try and take  
9 costs out and manage care most effectively, so that it's  
10 the right patient getting the right care in the right  
11 setting at the right time.

12 MR. CARNEY: Thank you. I just have one  
13 more follow-up on the contracts, saying that Yale-New  
14 Haven will honor L & M Hospital's and Westerly Hospital's  
15 existing contracts. Do we have time frames for those  
16 individual contracts? Obviously, they're probably not  
17 the same expiration dates, or do they have to be  
18 renegotiated? That will give us a feeling for how long  
19 those prices would stay the same.

20 MR. VanESSENDELFT: That is correct. I  
21 would say our larger contracts extend at least for two  
22 years and some of them up to three years, but you are  
23 correct. There are different periods, different renewal  
24 dates for each of the payers.

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1 MR. CARNEY: And could we get a possible  
2 listing of those contracts and the dates?

3 MR. VanESSENDELFT: You can.

4 MR. CARNEY: Okay, that would be great. I  
5 appreciate that.

6 HEARING OFFICER HANSTED: That will be  
7 Late File No. 2.

8 MS. FELDMAN: Attorney Hansted, these late  
9 files relate to which application now?

10 HEARING OFFICER HANSTED: This is 32033.

11 MS. FELDMAN: And the first late file, is  
12 that related to 32, which was a list of --

13 HEARING OFFICER HANSTED: Yes, that's 32.

14 MS. FELDMAN: Okay.

15 HEARING OFFICER HANSTED: 32032.

16 MR. MURRAY: Attorney Hansted, could you  
17 remind me what Late File No. 1 was? My notes seem  
18 unintelligible.

19 MR. CARNEY: It's a list of additional  
20 services that will be offered.

21 MR. MURRAY: Okay, thank you very much.

22 MR. CARNEY: Okay. I think this is  
23 getting close to the end of my list. We've touched upon  
24 the capital commitment, bits and pieces in Cross-Exam.

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1 I'd sort of like to hear from the CFO in sort of layman's  
2 terms for our benefit and the benefit of the public, so  
3 let me just read my question.

4 Yale is committed is deploy \$300 million  
5 in resources in the Eastern Connecticut and Western Rhode  
6 Island region over a period of five years for the purpose  
7 of enhancing L & M's clinical and operational  
8 capabilities and services, is basically your language.

9 Please walk us through the funding sources  
10 and planned allocation of the \$300 million commitment.

11 MR. TANDLER: As far as the funding  
12 sources, there's a first tranche, which is comprised of  
13 the \$85 million. That's cutup into two sections. I  
14 think there's one tranche, which is \$41 million, where we  
15 have been able to get preliminary recommendations on the  
16 deployment and the use of those funds, and those are for  
17 some of the outlined areas that we've covered.

18 There are some areas of physician  
19 recruitment, including primary care, and infrastructure  
20 for population health and IT.

21 There's a second \$45 million. That second  
22 \$45 million would come, regardless of any outcome,  
23 regardless of any return that we discussed earlier, which  
24 would come at the onset as a follow-up investment, but

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1 without any contingencies attached to it, and that would  
2 come from some area of the health system.

3 It could include the Yale-New Haven Health  
4 Services parent, and it could include Lawrence &  
5 Memorial's funds, if it's part of the health system,  
6 depending on the appeal of those, who follow on  
7 investments.

8 The use of those investments could be  
9 similar specialties, primary care in the surrounding L &  
10 M area. So that's the first \$85 million.

11 We discussed, also, the 215 that follows,  
12 or the balance of the total \$316 million, and that's made  
13 on a -- that will be made we described as an iterative  
14 process. It would be based on the ongoing measurement,  
15 using various metrics of success, whether they're  
16 quality, patient satisfaction.

17 They could include our ability to manage  
18 population health, any of the program service  
19 initiatives.

20 MR. CARNEY: So would that be out of L & M  
21 operations?

22 MR. TANDLER: Yes. That would be --

23 MR. CARNEY: -- 215?

24 MR. TANDLER: The source of that funding

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1 would also come from our ability to stabilize operations  
2 and the operating income of Lawrence & Memorial. That  
3 would come from ways of redeploying resources within  
4 Lawrence & Memorial, bringing resources to the area,  
5 growing the medical practice, creating new positions to  
6 support those.

7 We do expect in our plan, and we've done  
8 this in the past, to plan and execute a changed  
9 management over the course of that period.

10 MR. CARNEY: And the source of the \$85  
11 million again was from?

12 MR. TANDLER: So the \$85 million is coming  
13 from -- \$41 million is coming from the initial cash  
14 outlay and infrastructure, again, not based on L & M  
15 performance.

16 MR. CARNEY: Cash outlay, okay.

17 MR. TANDLER: There's an additional \$44  
18 million, and that is the anticipated margin from further  
19 clinical expansion, so we do expect some of those  
20 investments to pay for themselves.

21 There is a balance to these programs, and  
22 our ability to plan and manage those programs will make  
23 up the balance of that \$85 million.

24 MR. CARNEY: Okay. One final question I

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1 have is, given the financial commitment is dependent on  
2 operational performance, return on investment, and/or  
3 potential synergies and efficiencies, how will this  
4 commitment be met if these results fall short of  
5 projections?

6 MR. TANDLER: Well --

7 MR. CARNEY: Tough question.

8 MS. FELDMAN: I think there's some  
9 confusion, in terms of the financial commitment. I think  
10 what's important here to understand from the application  
11 is that there's a commitment to reinvesting money in the  
12 Eastern Connecticut region. That's the \$215 million.

13 The \$85 million is not contingent on  
14 anything, other than this application getting approved.  
15 That is ready to go, if the application is approved, so I  
16 think that is -- they're not the same. They're  
17 different.

18 If L & M is able to get in a position,  
19 where it is financially-stable, as you know, their bond  
20 rating was just downgraded, if we can turn that, we  
21 expect them to be, with this \$85 million infusion, we  
22 expect them to be able to generate money, and that money  
23 will be reinvested in the Eastern Connecticut region.

24 MR. CARNEY: So the \$85 million is sort of

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1 a hard investment that you're hoping to stabilize L & M,  
2 in order for them to do better and be able to reinvest  
3 that \$215 million out of their success?

4 MS. FELDMAN: Correct.

5 MS. BORGSTROM: And I think Attorney  
6 Feldman has made a very important distinction, because  
7 there are health systems nationally, where improved  
8 performance in an organization just brings in a crude  
9 strength to the system balance sheet.

10 The difference here is, you know, we are a  
11 mission-driven organization. Every one of our providers  
12 has a commitment to serve the communities they do.

13 There's a woman, a religious woman, who  
14 ran a big health system in the Midwest, who famously  
15 coined the term "No Margin, No Mission." This is about  
16 restoring Lawrence & Memorial Healthcare to clinical,  
17 fiscal and community health, so that we can invest as a  
18 health system in this geography.

19 MR. CARNEY: And did you see those kind of  
20 positive results at Bridgeport and Greenwich Hospitals?

21 MS. BORGSTROM: We absolutely did, and,  
22 you know, I think that, in testimony from Bridgeport and  
23 I know that there's a member of their community here, who  
24 is also on their Board, they can describe that very

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1 tangibly to you.

2 The hospital of St. Raphael acquisition,  
3 which was a different forum, we made a commitment on cost  
4 savings and investments, and we have exceeded all of  
5 those commitments we made to the Office of Health Care  
6 Access.

7 MR. CUMMINGS: If I could just build on  
8 Marna's comments, one of the -- let me just raise two  
9 observations that I think will be helpful.

10 One is that, one of the things that gave  
11 our Board great comfort about going forward into this  
12 relationship was the opportunity to meet with and hear  
13 directly from representatives from Bridgeport about their  
14 experience and whether the commitments made to that  
15 organization indeed were honored. Did things work out  
16 the way it had planned?

17 Were the operational improvements  
18 realized? Did the governance model work the way it had  
19 been described? And our Board and management was very  
20 impressed upon hearing directly, without any filter, what  
21 the Bridgeport experience had been.

22 The other comment I wanted to make about  
23 this \$85 million is really to prime the pump. It's  
24 investments in not just physician recruitment and program

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1 development, but in population health, information  
2 technology and so forth.

3 In other words, to help us get ready for  
4 the changes that are coming in the future to the  
5 healthcare landscape.

6 You've heard references here about the  
7 shift from volume to value, about the expected emergence  
8 of accountable care arrangements in this state. It's  
9 been slow to get here, but we believe it is coming, and  
10 that was part of our Board's thinking about seeking an  
11 affiliation, that we did not have the wherewithal to be a  
12 survivor, much less even an effective participant, and  
13 the new healthcare landscaping will be dominated by  
14 accountable care, taking on risk and so forth, that what  
15 made sense then to be effective, to continue to confer  
16 value on our community was to partner with Yale-New  
17 Haven, which has many of those capabilities already in  
18 place.

19 We were convinced by the experience in  
20 Greenwich and Bridgeport about being able to lower their  
21 overall cost, about being able to increase the value  
22 proposition in those communities, so, you know, I think  
23 words matter, and it's appropriate that OHCA read  
24 carefully the representations in the application, but,

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1 above and beyond that, we wanted to field test this, in  
2 terms of talking to real people, Board members, employees  
3 at the Yale-New Haven Health affiliates, to say has this  
4 actually been your experience? And the answer was,  
5 resoundingly, unequivocally, yes.

6 HEARING OFFICER HANSTED: I just want to  
7 get some clarification on the \$215 million again. I'm  
8 sorry to be so thick about this.

9 Is that the investment ceiling for a  
10 specific period of time, or is that it, in terms of the  
11 region?

12 MR. VanESSENDELFT: If I could just  
13 comment? The 215 was really developed, if you go back to  
14 Bruce's comment earlier, about the needs of the health  
15 system and kind of coming up with the \$300-plus million,  
16 and, as we thought about it, it was the investment that  
17 Yale-New Haven was willing to make upfront that we've  
18 been talking about, \$85 million, that gets the  
19 infrastructure in place and almost 20 new physicians in  
20 our market.

21 That, then, spawns additional stability,  
22 as Marna went over, to generate returns. Those returns  
23 coming out of the system would be we kind of looked at a  
24 baseline of what we would generate through capital.

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1 Normally, we would look at \$20 or \$25  
2 million a year boding over time, and that's kind of that  
3 150, 163 number that we've been talking about, and then  
4 just between 63 or 68, depending on what number you're  
5 referencing, of kind of new vitality and earnings being  
6 generated by the combination and partnership of what  
7 we're able to create through this new investment.

8 Those are kind of the way, at least in my  
9 head, I keep it straight, is those three different  
10 buckets and sources of funding and then how we're  
11 deploying them.

12 HEARING OFFICER HANSTED: Right, right.  
13 No, I understand.

14 MR. VanESSENDELFT: It's over five years.

15 HEARING OFFICER HANSTED: I understand  
16 that. I guess my ultimate question is, once the \$215  
17 million is reinvested into the community, it doesn't stop  
18 there. It will, as L & M makes money, that money will  
19 continue to be invested into the community beyond the 215  
20 million.

21 MS. FELDMAN: So, you know, I think it's a  
22 great question, and I think what you have to look at is  
23 the history of this health system, so Bridgeport came in,  
24 and I may be off a year, in 1996.

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1 Bridgeport came in in 1996. Greenwich  
2 followed about 18 months later. Yale-New Haven has  
3 clearly been a founding member of this. The St.  
4 Raphael's integration occurred almost four years ago.

5 We are responsible, as a mission-driven  
6 health system, for the care in those communities through  
7 what we directly provide through partnership with others,  
8 and we can only be successful if we continue to invest in  
9 those communities, and, so, we view this as a marriage  
10 without possibility of divorce. We are responsible.

11 HEARING OFFICER HANSTED: Okay. All  
12 right, thank you.

13 MR. CARNEY: Finally, I just want to touch  
14 upon the clinical services, seeing that's very dear to  
15 many people's hearts that live in the area, just sort of  
16 one more time. I just wanted to double check.

17 Following the change of ownership, are  
18 there currently any plans to reduce or consolidate any  
19 existing programs offered at L & M?

20 The second part of the question is if any  
21 new programs or services will be created as a result of  
22 this proposal, and where will those services be located?

23 MR. CUMMINGS: To the first part of your  
24 question, there are no plans to reduce or restrict

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1 services as a byproduct of this affiliation.

2 With respect to the second part of your  
3 question and in keeping -- that's why the first tranche  
4 of \$41 million and the following tranche of the \$44  
5 million, i.e., the \$85 million that is irretrievably  
6 committed to this, regardless of financial performance, a  
7 significant part of that is about physician recruitment,  
8 expansion of clinical services.

9 This is a growth-oriented strategy.  
10 Expand access, gross services, retain services in the  
11 community. We've agreed broadly, and I'll come back to  
12 why I'm using the qualifier broadly, about these  
13 categories, and I think you've heard from both Ms.  
14 Borgstrom and myself those are primary care, behavioral  
15 health, maternal and child health services, emergency and  
16 critical care services, and surgery.

17 We are limited, again, I'm not an  
18 attorney, but in the same way that we can't share pricing  
19 information, so, too, are there restrictions, limitations  
20 on the amount of discussions that we can have about  
21 specific services, how they'll be provided, by whom they  
22 will be provided, in what setting they'll be provided, so  
23 we've been cautioned by counsel to avoid what would be  
24 tantamount to gun-jumping by getting too far ahead of the

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1 process.

2 So we've agreed on broad categories.  
3 There are a lot of things that fit under that broad  
4 rubric, but, again, it's about promoting access and  
5 growth.

6 MR. CARNEY: Thank you very much.

7 MR. STEVEN LAZARUS: Steven Lazarus. Just  
8 going back to a couple of financial things, just to wrap  
9 up that category, can we get two late files, please?

10 The first late file will be the financial  
11 attachments that were part of the CON application. Some  
12 of them, because of the time frame where we are in the  
13 application process, it's been a while, so we'd like to  
14 get those updated.

15 MS. FELDMAN: That's financial Attachment  
16 A?

17 MR. CARNEY: Yes. Yes.

18 HEARING OFFICER HANSTED: That will be  
19 Late File No. 3.

20 MS. JENNIFER WILLCOX: And that's for both  
21 dockets?

22 MR. LAZARUS: Yes, for both dockets. And  
23 we just want to clarify that we'd like those for -- at  
24 least for the 32033. It should include the L & M System,

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1 L & M Hospital, the hospital only, as well as the  
2 consolidated, and for the Yale-New Haven Health System.  
3 You can use the same format as was used in the financial  
4 Attachment A.

5 And, for the next late file, we would like  
6 you to provide year-to-date financial measurement  
7 indicators through June 2016. The ones in the  
8 application I believe I think the last time we got them  
9 were on page 863, I believe. That was resubmitted as  
10 part of the completeness, so we would like those to be  
11 updated for June 2016.

12 HEARING OFFICER HANSTED: That will be  
13 Late File No. 4.

14 MR. LAZARUS: The next couple of questions  
15 I have have to do with the Community Needs Health  
16 Assessment, so, generally speaking, the current Community  
17 Needs Health Assessment that's in place for L & M it had  
18 talked about six priorities that were brought out in it.

19 Based on the implementation plan, can you  
20 discuss what steps have been taken by L & M to make  
21 improvements in those areas, and are there any type of  
22 measurements or statistics that were collected for the  
23 outcomes on those?

24 MR. CUMMINGS: Thank you for that

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1 question. The plan that you alluded to was prepared in  
2 2013.

3 MR. LAZARUS: Yes.

4 MR. CUMMINGS: And we're in the process of  
5 completing a new Community Health Needs Assessment in  
6 partnership with Ledge Light Health District, the public  
7 health agency for this region.

8 Our content expert for the Community  
9 Health Needs Assessment I think is here. Laurel Holmes.  
10 Is she still here? I'm going to ask. Laurel is the  
11 Director of Community Partnerships and Population Health,  
12 and she is responsible not only for tabulating our  
13 community benefit summary, but she personally oversees  
14 many of these initiatives that I think are behind your  
15 question.

16 MR. LAZARUS: Perfect.

17 MS. HOLMES: Good evening. I'm Laurel  
18 Holmes --

19 COURT REPORTER: I don't know if that  
20 microphone is on.

21 MR. LAZARUS: Hold on one second.

22 MS. HOLMES: Hi, again. I'm Laurel  
23 Holmes, Director of Community Partnerships and Population  
24 Health for Lawrence & Memorial Healthcare.

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1                   Your question referred to the Community  
2                   Health Implementation Plan of 2013, on which we have  
3                   implemented a number of initiatives to address the needs  
4                   found through our Community Health Needs Assessment. As  
5                   Mr. Cummings stated, we are in the process of completing  
6                   our 2016 Community Health Needs Assessment, and, so, our  
7                   attention is now turned to priorities identified there,  
8                   which will be in some ways similar and in some ways  
9                   somewhat different from the 2013 priorities.

10                   The areas we will be addressing going  
11                   forward have to do with behavioral health, mental health  
12                   and substance abuse. In particular, opioid abuse and  
13                   anxiety and depression, particularly among minority  
14                   populations.

15                   We will be working on supporting and  
16                   nurturing healthy lifestyles, in particular, related to  
17                   diabetes, and insuring access to care, and the issues  
18                   that emerge there are having to do with maternal and  
19                   child health and access to care for low income  
20                   populations.

21                   That plan is in development with many  
22                   community partners presently, and, so, I can't speak to  
23                   anymore specifics on that.

24                   MR. LAZARUS: Thanks for that. Could you

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1 talk a little bit about some of the areas that did  
2 improve in relation to those six priorities in 2013,  
3 where L & M had concentrated, and what were the outcomes,  
4 based on those?

5 MS. HOLMES: Yes, well, we, as you  
6 mentioned, identified six priority areas, some of which  
7 we deferred to community partners for intervention, due  
8 to resource constraints, but we were successful in  
9 implementing interventions to address a number of the  
10 others, including pediatric obesity, which we implemented  
11 a program that showed positive outcomes for all  
12 participating children in that program.

13 For example, 60 percent of participants in  
14 that program experienced an improvement in healthy living  
15 and also experienced some weight loss.

16 As it relates to access to care, we  
17 implemented a Dispensary of Hope Program, which is a  
18 program, which provides free prescription medications to  
19 individuals with limited access, and that has been we've  
20 realized a \$20,000 community benefit investment through  
21 our Dispensary of Hope Program since its inception, and  
22 that program is ongoing.

23 As it relates to cancer, we implemented  
24 the Connecticut Early Detection and Prevention Program,

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1 which delivers health screenings to women, mammogram and  
2 pap smears. There was a colonoscopy component to that  
3 program, which has since been discontinued, but, there  
4 again, we have delivered essential care to many community  
5 members, who would not otherwise have been able to access  
6 those services through implementing this program.

7 As it relates to mental and behavioral  
8 health, our focus has been on reconnecting the homeless  
9 program, which involves our partnership with the Homeless  
10 Hospitality Center here in New London.

11 We've been supportive of their respite bed  
12 program, and, additionally, we have a social worker  
13 dedicated to working with homeless individuals, who  
14 ensures that they have access to the supports within the  
15 community that they need to have more positive health  
16 outcomes and more permanent housing, and that's been a  
17 primary focus of that social worker's work, in addition  
18 to the Homeless Hospitality Center's work. Our community  
19 benefit investment in that program exceeds half a million  
20 dollars.

21 And, finally, as it relates to asthma, we  
22 have implemented a school-based program in two schools in  
23 New London, working with 28 children and their families,  
24 and additionally have a dedicated community health

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1 worker, who is working in our Emergency Department to  
2 intervene with individuals, who are not receiving or not  
3 managing their asthma well and potentially not receiving  
4 the community-based care or hadn't been receiving the  
5 community-based care that they needed, in order to manage  
6 their asthma.

7 She has been successful in reducing  
8 Emergency Department utilization for individuals with  
9 asthma in her work and finding them more appropriate care  
10 in the community setting, so their asthma outcomes are  
11 positive.

12 MR. LAZARUS: All right, thank you. You  
13 mentioned the 2016 Community Needs Health Assessment.  
14 Are you incorporating the CDC's 618 initiatives?

15 MS. HOLMES: We're looking for a number of  
16 benchmarks in establishing our Community Health  
17 Implementation Plan. That still is very much in process.

18 We are conducting that planning process in  
19 a very collaborative manner with over 30 partner  
20 organizations participating, so it's not solely our  
21 decision, as to what the strategies will be going  
22 forward, but, certainly, we will be looking to any  
23 benchmarks, including Healthy People 2020 benchmarks that  
24 we can utilize.

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1 MR. LAZARUS: Now is that due out this  
2 September?

3 MS. HOLMES: It will be approved by  
4 September 30th.

5 MR. LAZARUS: Has Yale participated in the  
6 2016 Community Needs Health Assessment for the L & M  
7 area? Has it been part of this process, or is that  
8 something you're waiting?

9 MS. BORGSTROM: We have system-wide robust  
10 Community Health Needs Assessments. We have not done  
11 anything with Lawrence & Memorial on theirs,  
12 specifically.

13 MR. LAZARUS: Okay, but, moving forward,  
14 obviously, Yale would have to be partners in all the  
15 priorities that are going to be set as part of this?

16 MS. BORGSTROM: Yes.

17 MR. LAZARUS: So they would be in full  
18 support?

19 MS. BORGSTROM: Yes, absolutely.

20 MR. LAZARUS: Okay. Turning to community  
21 benefit, I was on your website for L & M, and you have a  
22 very nice way of laying out the community benefits and  
23 category-wise and stuff, so, looking at the past three to  
24 four years, you have like a total community support

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1 number up there. I'm not sure who I should address this  
2 to. Okay.

3 MR. CUMMINGS: Laurel is actually  
4 responsible for both the needs assessment and for the  
5 community benefit summary, and it was she, who actually  
6 came up with that very nifty summary that you saw online.

7 MR. LAZARUS: Kudos to you.

8 MS. HOLMES: Thank you.

9 MR. LAZARUS: For the total community  
10 support, and then you go down to breakout the community  
11 benefit, bad debt and Medicare shortfall, in 2012, you  
12 actually had other subsidized services, and then I  
13 noticed later on that category was dropped off. What was  
14 included in that other subsidized services?

15 MS. HOLMES: I would have to look back at  
16 our 2012 report to specifically address subsidized  
17 services within that report.

18 MR. LAZARUS: Oh, okay.

19 MS. HOLMES: Typically, that category  
20 includes support for behavioral health services in the  
21 community, women's and children's health services, those  
22 sorts of services that, for example, like cancer  
23 screening grant program represents.

24 MR. LAZARUS: Oh, so, they're probably

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1 still continuing. They're just categorized differently  
2 I'm assuming?

3 MS. HOLMES: Yes.

4 MR. LAZARUS: All right. That's good.  
5 Moving forward, do the Applicants plan to commit to  
6 providing similar levels of funding toward the community  
7 benefits, as reported on the website on those reports  
8 and, also, on the 990s, in particular, with this Schedule  
9 H for L & M community?

10 MS. BORGSTROM: Yes.

11 MR. LAZARUS: And that would include the  
12 community benefits, as well as community buildings for  
13 both?

14 MS. BORGSTROM: I'm not sure I understand  
15 your question.

16 MR. LAZARUS: Well, on Schedule H,  
17 there's, you know, there's two categories. There's  
18 community benefits, as well as community building, and,  
19 so, we just want to know the commitment would be for  
20 similar levels on both those, because those combined are  
21 generally known as community benefits, putting it simply.

22 MS. BORGSTROM: Yes.

23 MR. LAZARUS: Okay.

24 MS. AUGUSTA MUELLER: I didn't hear the

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1 question. Augusta Mueller. I'm the Community Benefits  
2 Manager for Yale-New Haven Health.

3 MR. LAZARUS: Okay. We were talking about  
4 the community benefit and, in particular, Schedule H,  
5 where you have the community building and the community  
6 benefits, and, looking at the historical moving forward,  
7 we were trying to see if the commitment is going to be  
8 similar, at the similar levels for each of those  
9 categories.

10 MS. MUELLER: It should be. I don't see  
11 why it would change. As you know, or as you may be  
12 aware, the IRS has been looking at various components of  
13 the community building activities and have been shifting  
14 those to community benefits, so areas, such as housing,  
15 food access, now are community benefits, where, years  
16 ago, they were community building activities, but, you  
17 know, I don't see why they would change.

18 MR. LAZARUS: Okay. That helps. If this  
19 proposal is approved, how will this affiliation with Yale  
20 improve L & M's community benefit?

21 MS. BORGSTROM: That's very speculative,  
22 because I think, what I know of L & M, they've been very  
23 engaged. They've had a very robust Community Benefits  
24 Assessment we have throughout the Yale-New Haven Health

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1 System, as well, and I think, again, you know, sort of  
2 strength in numbers, ideas, experiences, because we've  
3 shared best practices across the health system, and, you  
4 know, two of our hospitals, Bridgeport and Yale-New  
5 Haven, are located in two of the top 24 mid-size cities  
6 in the United States, so the needs have been great, the  
7 work has been terrific, so I would just imagine that the  
8 opportunities to collaborate will be even greater.

9 MR. LAZARUS: All right, thank you.

10 MR. CUMMINGS: If I can just add to that,  
11 certainly, I've highlighted why we are approaching this  
12 with a focus on access and growth, and to the extent that  
13 L & M is in a more financially-secure position as a  
14 result of this affiliation and the ensuing investments,  
15 it will increase our capacity to confer greater community  
16 benefit.

17 MR. LAZARUS: Thank you.

18 MS. FELDMAN: Mr. Lazarus, I would also  
19 point you to page 95 of the CON application, which sets  
20 forth the affiliation agreement and specifically  
21 addresses ongoing community benefit support in Section  
22 2.3.

23 MR. LAZARUS: Is that the \$11 million --

24 MS. FELDMAN: Yes. Yes, sir.

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1 MR. LAZARUS: -- that was referenced in  
2 there? Was that per year, or was that for a time period?

3 MS. FELDMAN: I believe it's five years.

4 MR. LAZARUS: Five years. Is that \$11  
5 million total, or is it \$11 million --

6 MS. FELDMAN: It's a minimum amount.

7 MR. LAZARUS: Minimum.

8 MS. FELDMAN: Which is the current level.

9 MR. LAZARUS: The current level.

10 MS. FELDMAN: Yeah.

11 MR. LAZARUS: Okay.

12 MS. MUELLER: Can I add a comment? I  
13 think that, in addition to what Marna mentioned and,  
14 also, Mr. Cummings, that our corporate structure is very  
15 supportive of community benefit activities, so, I mean,  
16 Laurel and I have served together on the Community  
17 Benefits Committee at the Connecticut Hospital  
18 Association for years, so there's an opportunity for us  
19 to continue that learning, but our corporate structure we  
20 have corporate tax, corporate legal, you know, community  
21 benefits that really are I just feel so supportive, you  
22 know, organizationally, and no other hospital, you know,  
23 to my knowledge has that in the state.

24 Even corporate finance, you know, the

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1 things that we have in place are very different.

2 MR. LAZARUS: All right, thank you.

3 Moving on, regarding quality, if L & M can, probably  
4 addressed to you, Mr. Cummings, what was the result of  
5 the most recent DPH survey performed at L & M?

6 MR. CUMMINGS: Can you be more specific?

7 MR. LAZARUS: Yeah. This has to do with  
8 the Licensing Division. They come and do the surveys, so  
9 we want to know what was the most recent.

10 MR. CUMMINGS: Are you talking about our  
11 licensure survey?

12 MR. LAZARUS: Yes.

13 MR. CUMMINGS: I think we'd have to get  
14 you that information as a late filing.

15 MR. LAZARUS: A late file? Okay. In that  
16 case, can you --

17 MS. FELDMAN: I can tell you they're still  
18 licensed. (Laughter)

19 MR. LAZARUS: That's good. We'd like a  
20 copy of the survey, as well as all communications between  
21 the hospital and DPH.

22 HEARING OFFICER HANSTED: That will be  
23 Late File No. 5.

24 MR. MURRAY: Mr. Lazarus, can I just

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1 clarify? When you say all communications between DPH and  
2 L & M, with respect to the licensure and the survey?

3 MR. LAZARUS: Yes.

4 MR. MURRAY: Okay.

5 MS. FELDMAN: Do you have a particular  
6 survey date in mind?

7 MR. LAZARUS: If we give you a written  
8 list, I can try to give you a date.

9 MR. CUMMINGS: We certainly want to make  
10 sure you have the information.

11 MR. LAZARUS: Sure. We can be more  
12 specific in our request, yes. We'll get you the date.

13 MS. FELDMAN: Thank you.

14 MR. LAZARUS: All right. Considering all  
15 the testimony that we've heard, especially specifically  
16 in the first day of the hearing, there were a lot of  
17 public concern and comments that were raised regarding L  
18 & M Hospital's community access to information related to  
19 the hospital's future, transparency regarding the  
20 process, if any of the changes were going to be made  
21 regarding any of the services at L & M, the impact of  
22 this proposal on the quality of care of L & M.

23 Can the Applicants address some of the  
24 concerns that were brought up by the various individuals

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1 and the organizations, and we can list them here, but if  
2 you can just go down one-by-one?

3 First, we've talked a little about earlier  
4 the costs and pricing to the consumer and the healthcare  
5 system, L & M's community access to services and  
6 physicians locally, quality of care at L & M, community  
7 input and access to information related to L & M Hospital  
8 after the closing.

9 MS. FELDMAN: Can you repeat the last one,  
10 please?

11 MR. LAZARUS: Community input/access to  
12 information related to L & M Hospital after the closing.

13 MS. FELDMAN: Before we answer the  
14 question, I just want to clarify a statement made by Mr.  
15 Cummings before with respect to plans to terminate any  
16 services by virtue of the proposal, and I want to just be  
17 clear that his answer was directed at that specific  
18 question.

19 There may, in fact, be plans for L & M  
20 right now, based on insufficient demand, to request  
21 termination of a particular service that has nothing to  
22 do with this proposal, so I just wanted to be clear about  
23 that and not to mislead, in terms of our response.

24 MR. LAZARUS: Okay, thank you.

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1 MS. FELDMAN: I think there has been a lot  
2 of testimony regarding the issue of pricing. If you  
3 would like us to respond to that again, we can.

4 In terms of access, I think, you know, in  
5 terms of deployment of the \$85 million and what the  
6 purpose is behind that and the testimony from Dr.  
7 Lehrach, I thought he was addressing the access issue,  
8 but we're happy to restate it, if it would be helpful to  
9 OHCA.

10 HEARING OFFICER HANSTED: Let's do this.  
11 It's been a while since our last break, and, just to give  
12 you some time to think about your answers, let's take a  
13 10-minute break, and then we'll reconvene.

14 MS. FELDMAN: Okay, thank you.

15 (Off the record)

16 HEARING OFFICER HANSTED: Folks, we're  
17 going to get started here again. The Applicants want to  
18 address our last question at this point. We'd appreciate  
19 it.

20 MR. LAZARUS: And before we actually go  
21 back to that, Kaila has a follow-up.

22 MS. RIGGOTT: I have a follow-up kind of  
23 in relation to that. As you know, OHCA is required to  
24 evaluate whether or not an Applicant has met our

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1 statutory criteria, and with respect to pricing data for  
2 consumers we know that the Comptroller has some data on  
3 State employee costs and prices, and I believe there may  
4 be some Medicaid data from DSS that may be made available  
5 to the task force.

6 We understand the limitations of the  
7 Sherman Act, but I just want to ask the Applicants is  
8 there any data, even if from multiple sources, that you  
9 can provide to OHCA that will assist us in evaluating our  
10 statutory criteria related to whether or not healthcare  
11 costs to consumers will be adversely affected by this  
12 proposal?

13 MS. FELDMAN: In all due respect, Kaila, I  
14 think we tried to answer that, and it might be helpful to  
15 restate some of what you heard.

16 A couple of things. One is there is no  
17 plan to raise prices. I think the testimony included the  
18 fact that there would be price neutrality for the  
19 remainder of the contract terms, hence the late file.

20 There was also testimony, saying that, in  
21 the future, negotiations with payers, to the extent that  
22 there are negotiations with payers, because, as we've  
23 provided in our application, over 70 percent of our payer  
24 mix is governmental payers, we also have TRICARE, so we

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1 not only have Medicare and Medicaid, but we have TRICARE,  
2 so there's really very little room for negotiation, but,  
3 again, it will be based on L & M's cost structure, not  
4 Yale-New Haven Hospital's cost structure, and I think  
5 that is the very reason that the Comptroller said in his  
6 e-mail that, when that Milliman Study was done, it was  
7 done thinking that the prices of Yale-New Haven Hospital  
8 would become the prices of L & M Hospital, and we're here  
9 to say that is not what will happen.

10 So we don't have access to the data that  
11 you're requesting. I don't know whether the Milliman  
12 data is, you know, where it came from, whether it  
13 represents the entire universe of claims, so I'm not sure  
14 how we can respond to the request, without giving the  
15 appearance, as it's been stated by the Intervenors, that  
16 we're trying to hide the ball.

17 That's simply not the truth. We've given  
18 every representation we can to reassure OHCA that, by  
19 virtue of the affiliation, should it be approved, that  
20 this will not trigger price increases for L & M.

21 MS. RIGGOTT: Thank you.

22 MR. CUMMINGS: Returning to your question,  
23 Mr. Lazarus, I think Attorney Feldman has already touched  
24 upon the pricing and cost, but I'll come back to that,

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1 just to add to my own comments a little bit later, but,  
2 as I understand it, you wanted to hear about that, about  
3 access, about quality and community input, is that  
4 correct?

5 MR. LAZARUS: Yes.

6 MR. CUMMINGS: So let me start with the  
7 access area. I hope we've demonstrated we pursued this  
8 relationship, and I want to bring you back to the initial  
9 hearing.

10 It was L & M, who initiated this  
11 relationship, as we took stock of the changes that were  
12 occurring in the landscape, and our concern, about  
13 whether we would be able to continue to serve the  
14 community with the highest level of quality and access in  
15 the face of declining revenues, and we concluded we could  
16 not.

17 Through this affiliation, as you've heard,  
18 \$85 million will be made available over five years,  
19 regardless of the financial reforms. No strings  
20 attached. That's to invest in growth and access.

21 The parties are committed to recruiting at  
22 least 20 physicians, who would be new to the community.  
23 These are not, quote, "purchased practices." These are  
24 new physicians, providing new capabilities in our

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1 community.

2           You've also heard that we've agreed in  
3 broad strokes to focus on behavioral health and expanding  
4 access there, primary care, maternal and child health  
5 services, emergency and critical care, and surgical  
6 capabilities.

7           We want to make sure, and I think you've  
8 heard this from Ms. Borgstrom, that patients do not have  
9 to travel out of the area for routine care.

10           The model that we are talking about is to  
11 maximize the potential for people in this area to receive  
12 care locally for routine services, for what's called  
13 primary and secondary level services.

14           We are not a teaching or research  
15 institution today. We will not be one post-affiliation.  
16 That role is really performed by Yale-New Haven Hospital,  
17 and what we want to have happen is those services that  
18 appropriately can be done in this community at this  
19 hospital remain here and that we are actually able to add  
20 to those capabilities.

21           Patients overwhelmingly prefer to receive  
22 care locally when they possibly can, and the cost for  
23 receiving that care is a lot lower in a community  
24 hospital than it is in an academic medical center for all

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1 the reasons that you heard from Ms. Borgstrom.

2 And, in the future, as I commented just  
3 before we took the 10-minute break, part of our shared  
4 view between Yale-New Haven Health and L & M is where  
5 healthcare is going in the future, and a premium will be  
6 placed on value or results at the lowest possible cost.

7 It would be inimical to the interests of  
8 both parties to have, particularly in a risk-based  
9 environment, which is where we're headed, for patients to  
10 receive care in a higher cost setting when a lower cost  
11 setting was available, so between the investments, the  
12 \$85 million that you heard about, the minimum of 20 new  
13 physicians in the area, the investments in these five  
14 categories, program categories I alluded to, we are  
15 confident we will be able to markedly increase access to  
16 locally-available services in Southeastern Connecticut  
17 and Southwestern Rhode Island.

18 The flip side of that equation is, if this  
19 affiliation is not approved, access for patients and jobs  
20 for staff will be in jeopardy.

21 In the area of quality, one of the things  
22 that drew us to Yale-New Haven is not only their  
23 excellent reputation, but the wherewithal that they have  
24 around fostering evidence-based practices.

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1                   Yale-New Haven Hospital, in particular,  
2                   because it has three missions, clinical medicine,  
3                   teaching and research, makes available to its affiliates  
4                   the capabilities that would otherwise not be available,  
5                   in terms of best practices, and we're excited about the  
6                   fact that these evidence-based practices will be not only  
7                   immediately available to us upon affiliation, but will  
8                   continue to be updated, as the latest literature suggests  
9                   would be appropriate.

10                   I don't recall whether it was specifically  
11                   mentioned at the original hearing, but Yale-New Haven  
12                   Health System has a quality council, in which there are  
13                   representatives from all of the affiliates, and we look  
14                   forward to being part of that, so that the Chief Medical  
15                   Officers and the Chief Nursing Officers and the Chief  
16                   Quality Officers are able to learn from one another and  
17                   further potentiate best practices.

18                   On the area of community input, as you  
19                   heard from Laurel Holmes, my colleague, a few minutes  
20                   ago, we are committed to and the continuation of both the  
21                   Community Needs Assessment and the resulting community  
22                   benefits, that doesn't change under this affiliation,  
23                   that commitment.

24                   L & M has a, as many hospitals do, a

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1 Patient and Family Advisory Council we established about  
2 a year and a half ago that allows us to get direct input  
3 from former patients and family members about their  
4 experience, what went well, what didn't go well, how can  
5 we approve upon it, are there additional needs that we  
6 should be meeting in the community and in the lives of  
7 our patients? We found that very resonant in our  
8 thinking.

9 We routinely survey our patients, and from  
10 that, again, get extraordinary insight into what we're  
11 doing well and how we can improve.

12 We are, first and foremost, a community-  
13 governed and community-oriented organization. Post-  
14 affiliation, will still be local staff, local clinicians,  
15 local physicians caring for their community. There  
16 really will be no change in the people, who face forward  
17 to those patients.

18 We're here today. We'll be there tomorrow  
19 if the affiliation is approved. There may be fewer of  
20 them if it is not approved.

21 And I think, finally, I wanted to comment  
22 that, you know, both L & M and Yale-New Haven are non-  
23 profit, mission-driven organizations. We share the same  
24 values. We have a similar view of where healthcare is

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1 heading. It was one of the reasons why, for our Board,  
2 it was a relatively easy decision to say Yale-New Haven  
3 Health is really the partner of choice for us.

4 We have not made the decision, we didn't  
5 even consider making a decision that some hospitals have  
6 made about seeking a for-profit partner, where community  
7 input and community need would be a far lesser  
8 consideration, and, indeed, that was one of the things  
9 that motivated the L & M Healthcare Board a couple of  
10 years ago to pursue the then bankrupt Westerly Hospital,  
11 because we knew that there were three venture capital-  
12 backed, for-profit actors, who were looking to acquire  
13 it.

14 We thought that would be injurious not  
15 only to the Westerly community, but for the approximately  
16 one-third of Westerly's patients, who originate from  
17 Connecticut.

18 We thought it would be bad for that  
19 community, it would be bad for our community, it would be  
20 bad for the staff, who are employed at L & M, if a  
21 venture capital-backed, for-profit had acquired Westerly.

22 Those commitments to community input and  
23 community governance that I think we've highlighted here,  
24 a local Board, with true fiduciary responsibilities, to

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1 approve budgets, to set priorities, to make  
2 determinations whether a service should be added, or, the  
3 flip side, discontinued, originate at that local level  
4 that's there today and will be there post-affiliation.

5 MR. LAZARUS: Thank you very much. As you  
6 may be aware, that with some of the other recent CON  
7 decisions regarding changes of ownership, there have been  
8 some conditions that were placed on the approvals.

9 If this was approved down the line, would  
10 the Applicants have any issues or challenges for, say,  
11 allowing for a community representative, either picked by  
12 the local Mayor's office or by OHCA, on its local Board  
13 holding informational public forums, say, twice a year  
14 and possibly having an independent monitor ensuring  
15 compliance with any of the conditions OHCA or DPH as a  
16 whole would set forth?

17 MS. BORGSTROM: You know, there's a lot in  
18 that, and I think that, you know, we need to discuss. We  
19 feel we are community organizations right now. We do not  
20 condone and we are not supporting representative Boards.

21 Board members should be elected, in my  
22 opinion, based on their talent, their commitment, their  
23 service. We have multiple forums through which we  
24 currently account for what we do, and this is not to get

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1 out of being accountable and responsible, but, you know,  
2 I think that the way you have described this could be  
3 problematic for us, and we would need to have discussion  
4 about what's intended and what we're really looking for.

5 MS. FELDMAN: With respect to the  
6 community forums, did you want to specifically respond to  
7 that?

8 MR. LAZARUS: And just to clarify, we're  
9 not looking for, I'm not looking for a commitment today.  
10 I just wanted to see if there were any issues and  
11 concerns that you have at this point.

12 MS. FELDMAN: I think that, if this is  
13 what's between us and approval, in all honesty, I think,  
14 from what Mr. Cummings just described, that this is an  
15 organization that's very committed to its community and  
16 getting feedback by way of its Community Needs  
17 Assessment, its Board, which is made up of folks from the  
18 community, who receive their services at L & M.

19 If you're talking about having forums,  
20 where input is provided by the community, I don't think  
21 that's a problem at all.

22 MR. LAZARUS: All right. Just to wrap up  
23 my questions, this application has been in front of us  
24 for a while now, so, just to sort of bring things a

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1 little up-to-date, can you give us a little update, as  
2 far as, if this was approved, what are you thinking, as  
3 far as a closing date for this process?

4 MS. FELDMAN: As I believe it was  
5 mentioned earlier, I can't remember who provided the  
6 testimony, but according to our approval from the FTC, we  
7 must be closed by September 8th of 2016, so we would need  
8 to begin closing the week prior.

9 MR. LAZARUS: Are there any other State or  
10 Federal approvals that are required, besides the CON  
11 approval, for the Applicants to move forward towards the  
12 closing?

13 MS. FELDMAN: I think it was mentioned  
14 maybe at the last hearing, I don't recall, but we're in  
15 the process of also going through a parallel proceeding  
16 in Rhode Island, and that is moving along very  
17 positively.

18 MR. LAZARUS: Is there a possibility for  
19 the Applicants to request any kind of extension for that  
20 September 8th date?

21 MS. FELDMAN: No, there is not.  
22 Absolutely not. We've already vetted that with experts  
23 in Hart-Scott-Rodino filings, folks that do nothing, but  
24 that, and it cannot be extended.

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1                   If the application is not approved in  
2 time, we would have to start all over and incur a  
3 significant expense, in terms of going through that  
4 process again.

5                   MR. LAZARUS: Thank you. If this proposal  
6 is approved after the closing, what are the planning or  
7 process priorities that the Applicants would have with L  
8 & M for, say, for the first six months? What would be  
9 the priority to get the process moving forward, in  
10 general?

11                   MS. BORGSTROM: I'll take a crack at this,  
12 because I think, in other affiliations and integration  
13 we've done, you know, these are complicated processes.

14                   Believe it or not, sometimes the approvals  
15 are the easy part. The hard part is actually making this  
16 work and getting the integration, so job one is making  
17 sure that people feel they are communicated with, they  
18 understand what's happening.

19                   Our commitments are to our patients,  
20 seamless care, continuous care to our employees, toward  
21 integrating business services in a way that is not  
22 disruptive to operations, is basically, you know,  
23 starting the integration and just getting the basic  
24 functioning going, and then engage in, you know, broader

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1 planning opportunities than we've been able to, because a  
2 lot of what we've done up until now I think, as Mr.  
3 Cummings and others have said, has been through third  
4 party consultants, because we haven't really been able  
5 to, you know, get into the details, so to speak, between  
6 the Yale-New Haven Health System and Lawrence & Memorial,  
7 but the goal would be to move very quickly on getting the  
8 information systems upgrade completed, determining the  
9 clinical priorities, beginning physician recruitments  
10 that can support perceived needs in New London.

11 I'll walk back to my previous comment,  
12 which, you know, we are community organizations. We're  
13 in the community all the time. We have to be accountable  
14 to the communities in which we operate.

15 A lot of what we need to do is be out  
16 there and explaining what this is, what it isn't, what  
17 people can expect from this.

18 Change is very difficult, but I think  
19 that, when people start to see the same faces, the same  
20 people working on their clinical care, on their accounts  
21 receivable, on whatever it is, you realize that the  
22 change is much more -- is longer horizon change than  
23 dramatic short-term change.

24 It really is the process of beginning to

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1 blend the families.

2 MR. LAZARUS: Thank you. Thank you. I'm  
3 all set.

4 HEARING OFFICER HANSTED: That concludes  
5 OHCA's questioning, so, at this point, we'd like to go  
6 back to the public comment section of our hearing, and  
7 those individuals, who wish to give public comment,  
8 should have signed up on the sheet outside of this door.

9 If you don't wish to speak, keep in mind  
10 that you can give comments in writing, and the address to  
11 send those comments is on the information sheet, which is  
12 also on the table outside the door, so we're going to  
13 call individuals up in the order that you've signed up.

14 (Whereupon, the public spoke.)

15 HEARING OFFICER HANSTED: Just one bit of  
16 housekeeping. The late files that were ordered are due  
17 August 5th, and, at this time, I'll allow counsel to give  
18 a brief closing statement, if they choose to.

19 MR. MURRAY: Mr. Hansted, before that, Mr.  
20 Hansted, could we ask? There's a question we'd like to  
21 ask, just to clarify something for the record of the  
22 Applicants about the patient mix at Lawrence & Memorial  
23 Hospital.

24 There seems to be some confusion, at least

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1 on our end here on the record, about what was stated.

2 Would that be permitted?

3 HEARING OFFICER HANSTED: Do you have any  
4 objection to that, Attorney Feldman?

5 MS. FELDMAN: It's past my bedtime, so,  
6 yes, I do. No.

7 HEARING OFFICER HANSTED: Okay.

8 MR. MURRAY: I don't know, Joan, who  
9 should answer. I just wanted to clarify, because we've  
10 heard 70 percent, and I've heard two-thirds, in terms of  
11 government payers, mostly Medicaid and Medicare, and I  
12 just wanted to clarify what it is at Lawrence & Memorial  
13 Hospital.

14 MS. FELDMAN: We'll have our CFO answer  
15 the question.

16 MR. VanESSENDELFT: Is this mike on? So I  
17 think you may have heard maybe two of those comments.  
18 The medical group, which we spoke about in the second CON  
19 request, was in that kind of two-thirds area, around 60  
20 percent or so. At L & M Hospital, it's closer to that 75  
21 percent or around that area, including TRICARE.

22 So when we were talking about that, we  
23 were looking at Medicare, Medicaid and TRICARE.

24 MR. MURRAY: Okay. The reason I ask is

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1 that, taking a look at, and maybe this is something you  
2 could clarify for the Commission, looking at note two on  
3 the consolidated fiscal year '14 and '15 statements for L  
4 & M, it indicates that the combined patients for Medicare  
5 and Medicaid in fiscal year '15 was 48 percent, and, in  
6 fiscal year '14, it was 46 percent. That's why there was  
7 some confusion we wanted to clarify.

8 MR. VanESSENDELFT: Can you show me what  
9 you're looking at?

10 MR. MURRAY: It's in a document submitted  
11 by -- oh, here it is. On page 746 of the submission for  
12 the acquisition at L & M, it says revenues from services  
13 to patients and charity care, and it goes over and says,  
14 during 2015 and 2014, approximately 36 percent and 35  
15 percent, respectively, have met patient service. Revenue  
16 was received under the Medicare program, and 12 percent  
17 and 11 percent, respectively, under the State Medicaid  
18 Program. We needed some clarification, because --

19 HEARING OFFICER HANSTED: Absolutely.

20 MS. VanESSENDELFT: And thanks for  
21 clarifying. That was helpful. What you're really  
22 struggling with is what we're all struggling with, is the  
23 payer mix I gave you was gross revenue. That's  
24 essentially the portion of services provided. The 35 or

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1 45 percent, the numbers you just referenced, was net  
2 patient revenue. That's what we're actually being paid,  
3 so there is a significant difference in the amount of  
4 services being provided, which is based on charges, or  
5 amount of services provided, versus the net revenue,  
6 which is what we're getting paid to provide those  
7 services, and that really highlights much of the  
8 challenge that we're having.

9 MR. MURRAY: So does the, in terms of  
10 fiscal year '15, does that mean that 42 percent of net  
11 revenue is paid from other sources, other than government  
12 payers?

13 MR. VanESSENDELFT: I'm sorry. Cite that  
14 again?

15 MR. MURRAY: So if the net revenue is 48  
16 percent in fiscal year '15 from government payers,  
17 Medicare and Medicaid, does that mean that, in fiscal  
18 year '15, the net revenues from commercial payers was 52  
19 percent?

20 MR. VanESSENDELFT: It would mean that the  
21 non-government payers, which would include commercial and  
22 other means, would be the remainder of that.

23 MR. MURRAY: Okay, thanks very much.  
24 Thank you. I wanted to clarify that. Thank you.

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1 HEARING OFFICER HANSTED: Okay. Attorney  
2 Feldman, if you want to give a brief closing statement?

3 MS. FELDMAN: Yes. I'm going to keep this  
4 very short.

5 HEARING OFFICER HANSTED: Thank you.

6 MS. FELDMAN: As a favor to OHCA. This  
7 has very clearly been a very unusual proceeding, based on  
8 my own experience, and despite everything we submitted in  
9 four volumes of documents, reiterated several times and  
10 made painfully clear, we said these things to reassure  
11 those in the community that they would not be affected  
12 adversely.

13 Unfortunately, the proposal has become the  
14 currency by which various parties have bid their own  
15 agendas, so I respectfully request that OHCA please  
16 disregard some of the hyperbole, some of the self-serving  
17 statements, some of the flawed testimony and mistruths.

18 By way of example, the continued reference  
19 to this affiliation as leading to a monopoly situation,  
20 and there are many other examples that I'm not going to  
21 go through, but I do ask OHCA to please rely on the  
22 statutory criteria and the documents before you, as you  
23 know better than me.

24 There's 12 criteria. Even if three of

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1 those criteria are not found in favor of this  
2 application, we believe there's convincing evidence in  
3 the record with respect to the hospital affiliation 32033  
4 that it should be approved.

5           Regardless of your decision on that  
6 application, the merger between LMPA and NEMG should be  
7 viewed independently.

8           While I understand that the affiliation  
9 agreement ties those two transactions integrally  
10 together, I think it's up to the parties to decide how  
11 they would handle any decision by OHCA.

12           That is all I have to say. I want to  
13 thank you.

14           HEARING OFFICER HANSTED: Thank you.  
15 Attorney Murray?

16           MR. MURRAY: Thank you, Attorney Hansted.  
17 I wish I could say my remarks would be very brief, but I  
18 think it's the statutory and I think the public policy  
19 framework we're doing, within which you are considering  
20 this, I think need to be considered.

21           Since 2003, the Connecticut General  
22 Assembly has progressively strengthened the state's laws  
23 governing healthcare providers.

24           In 2014, the legislature instituted the

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1 first requirement for Certificate of Need, review of  
2 physician practice acquisitions, expanded OHCA, and the  
3 State Attorney General's power to review and modify the  
4 conversion of non-profit hospitals to for-profit  
5 hospitals, and dramatically raised the bar for approval  
6 of hospital acquisitions by requiring OHCA to make  
7 findings that an Applicant for such an acquisition has  
8 affirmatively proven that a consolidation will not  
9 adversely impact cost, access, or diversity of providers.

10 In 2015, the General Assembly passed  
11 Public Act 15-146, a sweeping Consumer Protection law  
12 that makes Connecticut a leader among states attempting  
13 to cope with the dramatic changes in our healthcare  
14 system.

15 Among the policy changes made by the law,  
16 our first ever ban on some facility fees, restrictions on  
17 other facility fees, caps on surprise bills for patients,  
18 who unwittingly receive care from out-of-network  
19 providers, and a ban on the use of electronic medical  
20 records, like Epic, as a tool for market leverage.

21 Perhaps, most importantly, as of January  
22 1, 2017, Connecticut's Healthcare Insurance Exchange will  
23 publish the actual allowed amounts, paid by fully-insured  
24 health plans, to each provider for the most common

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1 diagnoses and procedures.

2 Public Act 15-146 demonstrated a  
3 Connecticut bipartisan commitment to creating the most  
4 transparent healthcare system in the nation.

5 While it's not a panacea, transparency on  
6 price, quality and access is essential if the proposed,  
7 the various proposed changes in reimbursement and  
8 acquisitions are to benefit patients, rather than to  
9 simply reshuffle money between the pockets of insurers  
10 and providers.

11 The transparency provisions of Public Act  
12 15-146 are relevant here, precisely because of the  
13 dispute that's in these proceedings about whether or not  
14 the Applicants or their insurance carriers have the data  
15 that OHCA requested, and the Applicants claim that the  
16 data do not exist that the insurance companies have, and,  
17 even if it did exist, they couldn't produce it, because  
18 it's arguably either protected by proprietary contracts  
19 with the insurers, or because it's a proprietary trade  
20 secret.

21 Whether or not the health industry, as a  
22 whole, possess a perfect risk assessment tool to  
23 interpret the data, the raw unadjusted prices will become  
24 public in less than six months.

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1           The Applicant should produce the  
2 information requested by OHCA as raw price data, and then  
3 OHCA could have an expert analyze it, if necessary. In  
4 addition, given the impending release of these data on  
5 January 1, 2017, it's hard to understand the Applicant's  
6 insistence that the release of the information implicates  
7 any proprietary information or contracts that they may  
8 have with the insurers.

9           The actual language of Public Act 146  
10 reads, in relevant part, "On or after January 1, 2016, no  
11 contract entered into or renewed between a healthcare  
12 provider and a health carrier shall contain a provision  
13 prohibiting disclosure of, one, billed or allowed  
14 amounts, reimbursement rates, or out-of-pocket costs,  
15 and, two, any data to the all-payer claims database,  
16 program established under Section 38a-1091 of the General  
17 Statutes, for purpose of assisting consumers and  
18 institutional purchasers in making informed decisions  
19 regarding their healthcare and informed choices among  
20 healthcare providers."

21           Thus, any contracts renewed or entered  
22 since the beginning of the year, OHCA could demand that  
23 data, irrespective of any claims about trade secrets or  
24 protections from contracts with the insurers.

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1 Continued withholding of this data from  
2 OSHA(sic), that OSHA(sic) requested, for the purposes of  
3 evaluating these applications we think is simply  
4 unwarranted, given the public policy environment under  
5 which they're being considered.

6 Moreover, PA 15-146 requires that the  
7 Health Insurance Exchange publish, as I mentioned, the  
8 allowable amounts that fully-insured plans pay to each  
9 provider for 50 of the most common inpatient diagnoses  
10 and procedures in the state, the 50 most common  
11 outpatient procedures, and the 25 most common surgical  
12 and imaging procedures.

13 Thus, the claim, that the data is  
14 protected from disclosure to the public, we think is a  
15 bogus claim and should be disregarded by the agency.

16 There really is nothing that we see that  
17 prohibits OSHA, excuse me, OHCA from requesting that data  
18 in any respect. We think that, since this data is going  
19 to be available, this pricing data is going to be  
20 available to OHCA in less than six months, then OHCA  
21 ought to simply keep the record open on this particular  
22 issue until it has that pricing data within which to  
23 evaluate whether or not this particular acquisition does  
24 have a negative impact on the pricing and the costs in

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1 the New London area.

2 Throughout these proceedings, the  
3 Intervenors have raised the important issue of continuing  
4 access to health care in New London following the  
5 acquisition, and we've asked OHCA to draw lessons from  
6 the Hartford HealthCare takeover of Windham Hospital.

7 Not surprisingly, the Applicants argue  
8 that Windham Hospital, the events at Windham Hospital are  
9 irrelevant. This isn't true, if you take a look at  
10 OHCA's final order on the Windham case, which said, "The  
11 Applicants also stated that, currently, they will not be  
12 terminating any services, however, OHCA realizes that, in  
13 the future, the reduction of duplicate services may be  
14 necessary to further strengthen the financial viability  
15 of the system."

16 The vague promises made by Hartford  
17 HealthCare about the reduction in services at Windham  
18 demonstrate that such representations are, at best,  
19 untrustworthy.

20 The applications before you contain long  
21 passages, promising unspecified expansion of clinical  
22 programs and the devotion to the financial stability of L  
23 & M.

24 These mirror in many respects the promises

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1 made by Hartford HealthCare at a time it was proposed  
2 acquiring Windham Hospital.

3           Given the subsequent cuts in critical  
4 services at Windham Hospital, the public in Eastern  
5 Connecticut may be given a healthy skepticism of such  
6 promises.

7           The application should not be approved in  
8 the absence of clear, binding, legally-enforceable  
9 commitments to the Greater New London community regarding  
10 the maintenance of services.

11           One of the most puzzling aspects of the  
12 application is the Applicant's insistence that L & M will  
13 remain locally-controlled.

14           As the testimony and documents submitted  
15 to OHCA make clear, this simply isn't true. The plain  
16 language of the proposed L & M bylaws demonstrate the  
17 crucial decision-making authority will not reside in New  
18 London.

19           As a sole corporate member, Yale will  
20 elect all the trustees to the L & M Board and can remove  
21 them. The President and CEO of L & M is appointed not by  
22 the L & M Board, but by Yale-New Haven Health Services.

23           And, importantly, as I think we pointed  
24 out in Cross-Examination, all the major financial and

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1 strategic decisions reside with the sole corporate  
2 member.

3 With respect to the alleged \$300 million  
4 investment, we believe OHCA should be troubled by the  
5 Applicant's unwillingness to specify the exact details  
6 and nature of the investment and whether it truly is an  
7 investment.

8 Surrendering control of its community  
9 hospital should yield tangible benefits to Greater New  
10 London, yet it has taken OHCA several sets of questions  
11 to get specifics on the first \$41 million of that  
12 investment, which consists of software installation,  
13 training, branding, and other intangibles.

14 It took multiple rounds of questioning for  
15 the Applicants to state that the second \$44 million would  
16 be actual new money from Yale-New Haven Healthcare  
17 assets, however, the details of these investments still  
18 remain vague.

19 Their most recent responses indicated that  
20 it will be split between clinical recruitment and support  
21 staff, and, despite the assurances made by Ms. Borgstrom  
22 here today, unless there's an actual assurance to OHCA  
23 that the money geared towards physician recruitment is  
24 going to go to actual recruitment of new physicians in

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1 the New London area, rather than the acquisition of  
2 physician practices, it is going to be very hard for OHCA  
3 to evaluate the impact on the Greater New London area.

4 If one accepts the fact that the initial  
5 \$85 million that Yale has committed to invest in OHCA is  
6 I think one of the expressions used by one of the  
7 Applicant's witnesses was hard money, the same can't be  
8 said for the remaining \$215 million.

9 The Applicant's response is to this, of  
10 where that \$215 million is going to come from, is vague,  
11 at best. In fact, the language used tonight was that it  
12 is a reinvestment of L & M's operating revenues into the  
13 viability of the system.

14 Finally, we want to suggest to OHCA that  
15 there's some precedent that it ought to look to in  
16 situations like this, where control of a community  
17 hospital is transferred to an out-of-market entity.

18 In the case of the transfer of non-profit  
19 hospitals to for-profit status in both Eastern  
20 Connecticut Health Network and the Waterbury Hospital  
21 case, the Attorney General required a substantial amount  
22 of money, \$105 million in the case of Eastern Connecticut  
23 and \$55 million in the case of Waterbury, to be placed in  
24 community trust for the exclusive use by the local

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1 communities in furtherance of community health needs.

2 We're fully aware that those decisions  
3 occurred under a different statutory context, and it  
4 involved the change from non-profit to for-profit status,  
5 which doesn't apply here, however, in both cases, as it  
6 does here, one of the chief concerns expressed was the  
7 loss of control of an essential community asset to an  
8 out-of-market player.

9 We think the precedent set by the Attorney  
10 General should also inform OHCA's decision regarding the  
11 applications in this case.

12 Although the Intervenors' views vary on  
13 whether or not there's a viable acquisition is ultimately  
14 possible, we believe that the applications, as currently  
15 submitted to OHCA, do not fulfill the community's needs  
16 and respectfully request that OHCA deny them. Thank you.

17 HEARING OFFICER HANSTED: Thank you,  
18 Attorney Murray. And, with that, I thank everyone for  
19 attending this evening, and this hearing is adjourned.

20 (Whereupon, the hearing adjourned at 9:17  
21 p.m.)

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## CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore 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, this 3rd day of August, 2016.



Paul Landman  
President

**Post Reporting Service**  
**1-800-262-4102**

## Greer, Leslie

---

**Subject:** FW: Docket Numbers 15-32032 and 15-32033  
**Attachments:** Letter to Kevin Hansted.pdf

**From:** Feldman, Joan [<mailto:JFeldman@goodwin.com>]  
**Sent:** Friday, August 12, 2016 10:51 AM  
**To:** Hansted, Kevin; Riggott, Kaila; Carney, Brian; Lazarus, Steven  
**Cc:** [hfmurray@lapm.org](mailto:hfmurray@lapm.org); [jennifer.willcox@ynhh.org](mailto:jennifer.willcox@ynhh.org)  
**Subject:** Docket Numbers 15-32032 and 15-32033

Dear Attorney Hansted:

Attached you will find a letter requesting the addition of new information to the above-referenced records. We believe it is relevant in that Intervenor provided testimony (Mr. Hyde) relating to hospitals having positive operating margins.

Thank you.

Joan

**Shipman & Goodwin** LLP  
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August 12, 2016

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Re: Docket Numbers 15-32032 and 15-32033

Dear Kevin:

Please add the attached Fitch Ratings report issued on August 10, 2016 regarding Lawrence & Memorial Hospital's financial rating to the above-mentioned records.

If you have any questions, please feel free to contact me.

Respectfully submitted,

Lawrence + Memorial Corporation  
Yale New Haven Health Services Corporation

By

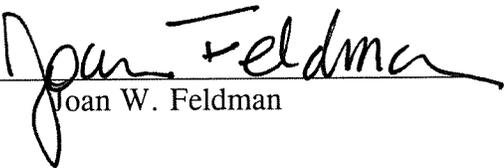
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CERTIFICATE OF SERVICE

I hereby certify that the foregoing was served by e-mail on August 12, 2016 to the following counsel of record:

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Joan W. Feldman

# Fitch Ratings

## Fitch Downgrades Lawrence & Memorial Hospital (CT) Revs to 'A-'; Outlook Revised to Negative

Fitch Ratings-New York-10 August 2016: Fitch Ratings has downgraded to 'A-' from 'A' the rating on \$47.9 million State of Connecticut Health and Educational Facilities Authority revenue bonds, series F (2011) issued on behalf of Lawrence & Memorial Hospital (LMH).

The Rating Outlook is revised to Negative from Stable.

LMH also has outstanding approximately \$58 million in other long-term debt and leases, which are not rated by Fitch.

### SECURITY

The bonds are secured by a pledge of gross revenues and a mortgage.

Fitch reports on the results of the consolidated Lawrence+Memorial Corporation (LMC), as defined in the Credit Profile section of the press release.

### KEY RATING DRIVERS

**CONTINUED OPERATING LOSSES:** The downgrade to 'A-' is driven by continued trend of weakening profitability stemming from softer volumes, shift to outpatient utilization, less favorable reimbursement and the escalating Connecticut provider tax burden. The revision of the Outlook to Negative is based on Fitch's expectation that despite management's significant efforts at reversing the losses, a return to positive margin will only be achieved once the benefits from the anticipated joining of the Yale New Haven Health System (YNHHS; 'AA-', Stable Outlook) will be realized, which could take some time. Operating margin was a negative 4.1% in fiscal 2014 and 2.2% in fiscal 2015 (fiscal year-end [FYE] Sept. 30) and losses continued through the nine months ended June 30, 2016 with negative operating margin of 4.2%.

**ANTICIPATED BENEFITS FROM JOINING YNHHS:** LMC and YNHHS entered into an affiliation in July 2015 and the transaction has received FTC approval, but the Certificate of Need (CON) for the corporate member substitution has met regulatory delays at the state level. LMC and YNHHS already cooperate clinically in several areas, but the full integration with YNHHS would bring significant positive financial benefits to LMC, estimated at \$9 million-\$15 million annually, returning LMC to positive operating territory. Additionally, YNHHS has committed to directly contribute approximately \$85 million to LMC.

**ADEQUATE LIQUIDITY:** Despite the operational challenges, liquidity metrics have remained largely sound and the balance sheet provides the organization with a sufficient cushion to weather the delay in implementation of the full integration with YNHHS. Cash to debt of 167.6% and cushion ratio of 19.8x at June 30, 2016 are consistent with Fitch's respective 'A' medians of 144% and 18.5x, but days cash on hand (DCOH) of 147.4 lags the median of 205.3 days.

**MANAGEABLE DEBT BURDEN:** LMC's debt burden remains light for the rating category, as evidenced by maximum annual debt service (MADS) at 1.9% of revenue in 2015, which compares favorably against the median of 3.6%. However, weak cash flows resulted in MADS coverage by EBITDA declining to 1.8x through the interim period from 3.8x in fiscal 2015.

**SOLID MARKET POSITION:** LMC has a dominant market share of approximately 67% in the combined primary service area (PSA) of the two LMC hospitals. The ability to use YNHHS in physician recruitment and the planned investment in clinical programs, once the full affiliation is realized, should further secure market share.

### RATING SENSITIVITIES

**RETURN TO IMPROVED PROFITABILITY:** The 'A-' rating is contingent upon Lawrence+Memorial Corporation executing the full YNHHS affiliation which is expected to generate improved financial performance through efficiencies and benefits of scale. The return to Stable Outlook would require Lawrence+Memorial Corporation to demonstrate the traction of the Yale New Haven Health System relationship, leading to material improvement in operating performance.

## CREDIT PROFILE

Lawrence+Memorial Corporation operates Lawrence & Memorial Hospital, consisting of Lawrence & Memorial Hospital (LMH) in New London, Connecticut with 198 staffed beds, and Westerly Hospital in Washington County (Westerly), Rhode Island with 40 staffed beds, as well as a number of other subsidiaries, including the L&M Physician Association (LMPA). The obligated group includes LMH and the LMC Parent only. For fiscal year ended Sept. 30, 2015, LMC had total revenues of \$460 million.

## BENEFITS OF JOINING YNHHS

LMC and YNHHS signed an affiliation agreement in July 2015 and the full merger would take the form of a member substitution, whereby YNHHS would become the sole corporate member of the LMC, but LMC would not be a member of the YNHHS obligated group, similar to the status of Greenwich Hospital ('AA-', Stable Outlook) in YNHHS. The merger with YNHHS is expected to bring significant benefits to LMC, estimated at \$300 million over the next five years. Of this amount, approximately \$85 million represents a direct commitment from YNHHS with half contributed fairly quickly once the formal corporate reorganization is completed for various initiatives, including population health management, rebranding, IT investment and physician recruitment focused on several specialty areas, in addition to primary care. The balance of the \$300 million benefit will be realized from further clinical investments and from LMC operations and efficiencies and synergies and gained scale from being part of the large, fully integrated YNHHS, with revenues of \$3.5 billion.

## CONTINUED WEAK PROFITABILITY

LMC continues to be affected negatively by soft volumes, shift to observation patients and to outpatient utilization, and lower state and federal reimbursement rates. A significant contributor to the lower profitability is the escalating provider tax in Connecticut; the net impact of the provider tax offset by supplemental payments increased from a negative \$3.9 million in 2014 to negative \$9.1 million in 2015 and is expected to be as high as \$13 million in this fiscal year, even after the recent reinstating of some of the supplemental payments.

Operating losses were \$18.7 million in fiscal 2014 and \$10.3 million in 2015, equal to negative operating margins of 4.1% and 2.2%, and operating loss through the nine months ended June 30, 2016 was reported at \$14 million, a 4.2% negative operating margin. Management expects to end the 2016 fiscal year with an operating loss of \$22.3 million, with the most significant variances from the \$8.7 million budgeted loss stemming from the LMPA medical group and Westerly hospital. A number of initiatives from an earlier consulting engagement have already been operationalized, with over \$36 million of expenses taken out. Based on initiatives continuing to be implemented currently and additional expense management likely to be realized, the 2017 budget would be close to \$10 million-\$13 million loss. Management has been successful in negotiating a new union contract in the spring of 2016, ahead of the expiration of the prior contract. Any relief in the state provider tax would further help improve profitability.

## ADEQUATE LIQUIDITY AND LOW DEBT BURDEN

LMC's liquidity in relation to its debt remains solid for the rating category, with cash of \$175.4 million at June 30, 2016 equal 167.6% of debt and cushion ratio of 19.8x at June 30, 2016, both above Fitch's category medians. Overall, Fitch considers LMC's liquidity position as a partial mitigant against its compressed profitability, providing a temporary cushion until such time as LMC can see the benefits of the integration into YNHHS.

LMC's debt burden is light with MADS equal to 2% of revenues through the nine-month interim period. MADS coverage by EBITDA of 1.8x and by operating EBITDA of 1.5x were both weak against Fitch's 'A' medians at 4.2x and 3.5x, respectively, somewhat offset by a relatively conservative debt structure with 80% of debt in fixed rate mode.

## DISCLOSURE

LMH covenants to provide quarterly and annual financial disclosure to the Municipal Securities Rulemaking Board's EMMA system.

Contact:

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**Applicable Criteria**

Revenue-Supported Rating Criteria (pub. 16 Jun 2014)  
([https://www.fitchratings.com/creditdesk/reports/report\\_frame.cfm?rpt\\_id=750012](https://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=750012))  
U.S. Nonprofit Hospitals and Health Systems Rating Criteria (pub. 09 Jun 2015)  
([https://www.fitchratings.com/creditdesk/reports/report\\_frame.cfm?rpt\\_id=866807](https://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=866807))

**Additional Disclosures**

Dodd-Frank Rating Information Disclosure Form  
([https://www.fitchratings.com/creditdesk/press\\_releases/content/ridf\\_frame.cfm?pr\\_id=1010219](https://www.fitchratings.com/creditdesk/press_releases/content/ridf_frame.cfm?pr_id=1010219))  
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## Greer, Leslie

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**From:** Greer, Leslie  
**Sent:** Wednesday, September 07, 2016 9:58 AM  
**To:** jfeldman@goodwin.com; 'hfmurray@lapm.org'  
**Cc:** Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Ciesones, Ron  
**Subject:** Closure of Public Hearings DN's 15-32032-CON & 15-32033-CON  
**Attachments:** 32032 Closures of Hearing.pdf; 32033 Closure of Hearing.pdf

<b>Tracking:</b>	<b>Recipient</b>	<b>Delivery</b>
	jfeldman@goodwin.com	
	'hfmurray@lapm.org'	
	Lazarus, Steven	Delivered: 9/7/2016 9:58 AM
	Carney, Brian	Delivered: 9/7/2016 9:58 AM
	Riggott, Kaila	Delivered: 9/7/2016 9:58 AM
	Hansted, Kevin	Delivered: 9/7/2016 9:58 AM
	Martone, Kim	Delivered: 9/7/2016 9:58 AM
	Ciesones, Ron	Delivered: 9/7/2016 9:58 AM

Please see attached closure of public hearing for DN's 15-32032-CON & 15-32033-CON.

Thank you,

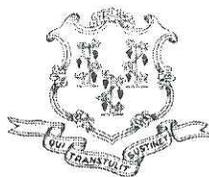
Leslie

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
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# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Raul Pino, M.D., M.P.H.  
Commissioner

### Office of Health Care Access

September 7, 2016

VIA EMAIL ONLY

Joan Feldman, Esq.  
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Hartford, CT 06103-1919

Henry F. Murray, Esq.  
Livingston, Adler, Pulda, Meiklejohn & Kelly, P.C.  
557 Prospect Avenue  
Hartford, CT 06105-2922

RE: Certificate of Need Application; Docket Number: 15-32032-CON  
Transfer of Ownership of Group Practice by Merger of L&M Physicians Association into  
Northeast Medical Group  
**Closure of Public Hearing**

Dear Ms. Feldman and Mr. Murray:

Please be advised, by way of this letter, the public hearing held on July 11 and July 26, 2016 in the above referenced matter is hereby closed as of September 7, 2016. OHCA will receive no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact Steven Lazarus at (860) 416-7012 or Brian Carney at (860) 418-7014.

Sincerely,

A handwritten signature in blue ink, appearing to read "Kevin T. Hansted".

Kevin T. Hansted  
Hearing Officer



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
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*Affirmative Action/Equal Opportunity Employer*

## Greer, Leslie

---

**From:** Greer, Leslie  
**Sent:** Thursday, September 08, 2016 3:46 PM  
**To:** jfeldman@goodwin.com; 'hfmurray@lapm.org'  
**Cc:** Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Ciesones, Ron  
**Subject:** Docket Number 15-32032-CON Agreed Settlement  
**Attachments:** 32032 Agreed Settlement.pdf

<b>Tracking:</b>	<b>Recipient</b>	<b>Delivery</b>
	jfeldman@goodwin.com	
	'hfmurray@lapm.org'	
	Lazarus, Steven	
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	Riggott, Kaila	
	Hansted, Kevin	Delivered: 9/8/2016 3:46 PM
	Martone, Kim	
	Ciesones, Ron	
	Downes, Maura	
	Wolf, Brie	

Attorney Feldman and Attorney Murray,  
Attached is the Agreed Settlement for Northeast Medical Group, Inc., L&M Physician Association, Inc. d/b/a L+M Medical Group, Lawrence + Memorial Corporation and Yale New Haven Health Services Corporation's certificate of need application.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
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# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.  
Commissioner



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

### AGREED SETTLEMENT

**Applicants:**

**Northeast Medical Group, Inc.**  
99 Hawley Lane, Stratford, CT 06614

**L&M Physician Association Inc., d/b/a L+M Medical Group**  
365 Montauk Avenue, New London, CT 06320

**Lawrence + Memorial Corporation**  
365 Montauk Avenue  
New London, CT 06320

**Yale New Haven Health Services Corporation**  
789 Howard Avenue  
New Haven, CT 06519

**Docket Number:** 15-32032-CON

**Project Title:** Transfer of Ownership of Group Practice by the Merger of L&M Physician Association into Northeast Medical Group

**Project Description:** Northeast Medical Group, Inc. ("NEMG"), L&M Physician Association, Inc. ("L&MPA"), Lawrence + Memorial Corporation ("L+M") and Yale New Haven Health Services Corporation ("YNHHSC"), herein collectively referred to as the ("Applicants") seek authorization to transfer ownership of a group practice by the merger of L&MPA into NEMG.

**Procedural History:** The Applicants published notice of their intent to file a Certificate of Need ("CON") application in the *New Haven Register* and *The Day (New London)* on July 27, 28 and 29, 2015. On October 7, 2015, the Office of Health Care Access ("OHCA") received the CON application from the Applicants for the above-referenced project and deemed the application complete on May 10, 2016. On June 17, 2016, OHCA received a petition from a coalition of organizations led by New England Health Care Employees Union, District 1199 SEIU ("District 1199") requesting intervenor status with full rights of cross-examination. The Hearing Officer granted the petition of District 1199 ("Intervenor") on June 24, 2016. On June 22, 2016, the Applicants were notified of the date, time, and place of the public hearing. On June 24, 2016,

Commissioner Raul Pino designated Attorney Kevin T. Hansted as the hearing officer in this matter and a notice to the public announcing the hearing was published in the *The Day*.

Thereafter, pursuant to Connecticut General Statutes (“Conn. Gen. Stat.”) § 19a-639a (f)(2), a public hearing regarding the CON application was initially held on July 11, 2016 and continued on July 26, 2016. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a (f)(2). The record was closed on September 07, 2016. In rendering the decision, Deputy Commissioner Addo considered the entire record in this matter.

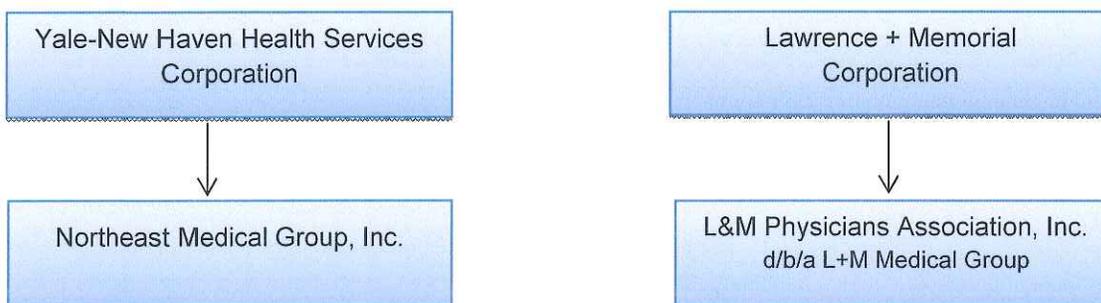
### **Findings of Fact and Conclusions of Law**

1. NEMG is a not-for-profit multispecialty medical foundation that provides physician-related services to Bridgeport, Greenwich, and Yale-New Haven Hospitals and their surrounding communities. NEMG is an affiliate of Yale-New Haven Health Services Corporation (“YNHHSC”), its sole member/parent. Ex. A, p. 179
2. YNHHSC is a Connecticut non-stock, tax-exempt corporation that was organized in 1983 to provide support services to Yale New Haven Health System (“YNHHS”), a network of affiliated health care providers, the foremost being Yale-New Haven Hospital. Ex. A, p. 22
3. L&MPA is a not-for-profit multispecialty medical foundation that provides physician-related services at multiple locations throughout southeastern Connecticut and southwestern Rhode Island. L&MPA does business under the name “L+M Medical Group.” Ex. A, pp. 22
4. L&MPA is a subsidiary of L+M. L+M is the parent corporation of a delivery network known as L+M Healthcare, whose main providers are L&MPA, Lawrence + Memorial Hospital (“L+MH”), Westerly Hospital of Rhode Island (“Westerly”) and the Visiting Nurse Association of Southeastern Connecticut. Ex. A, pp. 22, 146.
5. In conjunction with the proposed request to transfer ownership of L+M to YNHHSC (Docket Number 15-32033-CON) and due to Connecticut law<sup>1</sup>, which limits the number of medical foundations allowed by a hospital or health care system, the Applicants have requested authorization to transfer ownership of L&MPA by merging the group practice into NEMG. Ex. A, p. 21
6. Based on the terms of the affiliation agreement of the parent companies and the merger plan, NEMG will be the surviving corporation of the merger and the NEMG Board of Trustees will be expanded to include two physicians on the medical staff of L+MH or Westerly, as well as the President of L+M or designee. Ex. A, pp. 23
7. The organizational structure of the L&MPA and NEMG before and after the transactions are listed below:

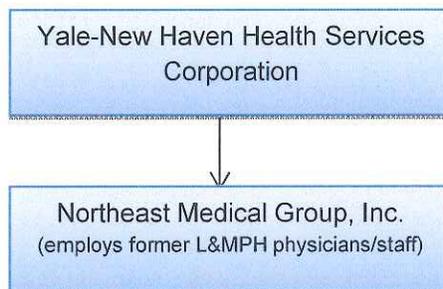
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<sup>1</sup>Connecticut General Statute, section 33-182bb states that a hospital, health system or medical school may organize and become a member of no more than one medical foundation.

**CHART 1**  
CURRENT GROUP PRACTICE ORGANIZATIONAL STRUCTURE



**CHART 2**  
PROPOSED GROUP PRACTICE ORGANIZATIONAL STRUCTURE



Ex. A, pp. 208, 209 and 211

8. L&MPA is a multispecialty<sup>2</sup> group with approximately 70 physicians located at various practices throughout southeastern Connecticut and Rhode Island. L&MPA is also a certified medical home with six sites, Groton, New London, Niantic, Old Lyme, Mystic and Stonington holding a Level III (highest level) Patient Centered Medical Home accreditation. Ex. A, pp. 23, 197
9. Under the proposal, current L&MPA physicians will become employees of NEMG. Ex. D, p. 217
10. The proposed merger will improve the ability of L&MPA to coordinate care across the region and enhance clinical integration and collaboration among physicians by utilizing NEMG's enhanced:
  - patient health information;
  - clinical and utilization data;
  - dashboard reports regarding the adherence to a number of quality indicators, shared clinical protocols;
  - care management services and coordinators.

Ex. D, pp. 213-214

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<sup>2</sup> Specialties include: family practice, internal medicine, dermatology, endocrinology, general surgery, orthopedic surgery, neurosurgery, sleep medicine, neurology, rehabilitation medicine, obstetrics, gynecology, cardiology and interventional pain management.

11. The proposal will enable L&MPA to utilize the same electronic medical record software (“EMR”) used at NEMG practices, permitting access to patient information for all providers at any NEMG or YNHHS hospital location. Clinical and utilization data collected by this same EMR system and shared across NEMG practices will also be available. Ex. D, p. 213
12. NEMG physicians currently receive regular dashboard reports that examine quality indicators such as screenings, preventive care and medication adherence. NEMG also prepares regular reports that enable physicians to view the entirety of an episode of care including the utilization of hospital services, emergency room visits, primary care visits and post-acute care across a physician’s patient panel. Ex. D, p. 213
13. NEMG physicians will share clinical pathways and protocols with L&MPA physicians to provide evidence-based practice information to providers to help guide them in selecting appropriate tests and interventions. Ex. D, p. 213
14. NEMG offers care management services through care coordinators to address post-acute care needs and to focus on reducing emergency room visits and 30-day hospital readmissions. These services will be extended to L&MPA and help patients understand their care plan, gain access to needed services and receive timely and appropriate follow-up. Ex. D, p. 214
15. The Applicants reported the following historical volumes for fiscal years (“FYs”) 2012-2015:

**TABLE 1  
HISTORICAL VISITS BY SERVICE AND FISCAL YEAR**

Service:	NEMG				L&MPA			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2012	FY 2013	FY 2014	FY 2015
Behavioral Health	14,356	16,410	15,385	16,943	-	13,850	21,884	19,861
Cardiology	118,515	118,654	118,301	129,726	36,313	67,994	68,736	62,237
Dermatology	-	-	-	-	-	3,265	11,292	10,283
Endocrinology	4,269	5,330	7,471	6,996	-	831	8,396	13,670
Gastroenterology	2,254	2,904	20,372	19,899	-	-	-	-
General Surgery	45,972	45,351	59,426	69,517	12,051	16,034	21,671	21,774
Geriatrics	28,021	29,622	29,181	31,397	-	-	-	-
Infectious Disease	-	-	-	-	-	-	126	1,801
Internal Medicine	116,845	138,821	153,191	177,796	-	-	-	-
Neonatology	9,850	10,457	10,190	14,334	2	2	5,195	1,573
Neuropsychology	-	-	-	-	1	3	-	253
Neurology	-	-	-	-	710	2,804	2,879	2,916
Neurosurgery	-	-	-	-	7,892	8,240	6,142	6,509
Obstetrics and Gynecology	40,212	47,620	46,308	50,951	5,496	11,082	17,089	15,919
Oncology	15,262	19,869	20,696	20,865	-	-	-	-
Orthopedics	-	-	-	-	105	5,559	9,176	9,858
Pain Management	877	1,142	1,366	1,197	-	2,934	10,849	12,205
Palliative Care	2,379	3,611	4,297	3,132	-	98	481	62
Pediatrics	21,839	48,406	63,354	74,404	-	894	3,176	3,872
Podiatry	5,181	4,792	5,388	7,430	-	-	-	-

Primary Care	59,204	155,441	339,887	649,703	53,947	60,792	70,848	71,872
Psychiatry	-	-	-	-	9,692	9,615	10,520	9,686
Plastic surgery	-	-	-	-	1,528	10	-	-
Rheumatology	4,154	5,408	5,994	10,233	-	-	-	-
Sleep medicine	7,083	7,350	7,461	6,730	-	-	1,721	4,807
Vascular Surgery	-	-	-	-	-	-	-	3,206
Wound care	3,004	4,455	4,777	4,897	-	-	-	35
<b>Total</b>	<b>499,277</b>	<b>665,643</b>	<b>913,045</b>	<b>1,296,150</b>	<b>127,737</b>	<b>204,007</b>	<b>270,181</b>	<b>272,399</b>

Ex. D, p. 219, 220

16. YNHHS will support the enhancement of clinical services by adding physicians in L+MH's service area in the following disciplines subject to community need and the opportunity to provide these services locally at a lower cost over a five-year period:

- primary care (6);
- surgical specialties (e.g., cardiovascular, women's and children's, neurosurgery) (9)
- medical specialists (e.g., oncology, cardiology) (10)
- behavioral health (1)

Late File 1, submitted August 2, 2016

17. The Applicants project an increase in overall volume from FY16 through FY19:

**TABLE 2  
 PROJECTED VISITS BY SERVICE AND FISCAL YEAR\***

Service:	NEMG (including L&MPA)			
	FY 2016	FY 2017	FY 2018	FY 2019
Behavioral Health	26,900	37,000	37,100	37,200
Cardiology	161,300	193,200	193,900	194,700
Dermatology	5,100	10,300	10,300	10,400
Endocrinology	13,900	20,800	20,800	20,900
Gastroenterology	20,000	20,100	20,100	20,200
General Surgery	80,600	91,900	92,300	92,600
Geriatrics	31,500	31,600	31,800	31,900
Infectious Disease	900	1,800	1,800	1,800
Internal Medicine	178,300	179,100	180,000	180,800
Neonatology	15,200	16,000	16,100	16,200
Neuropsychology	100	300	300	300
Neurology	1,500	2,900	2,900	2,900
Neurosurgery	3,300	6,500	6,500	6,600
Obstetrics and Gynecology	59,100	67,300	67,600	67,900
Oncology	20,900	21,000	21,100	21,200
Orthopedics	4,900	9,900	9,900	9,900
Pain Management	7,300	13,500	13,500	13,500
Palliative Care	3,200	3,200	3,200	3,200
Pediatrics	76,600	78,900	79,200	79,600
Podiatry	7,500	7,500	7,500	7,600
Primary Care	687,400	726,800	730,200	733,100

Psychiatry	4,900	9,700	9,700	9,800
Plastic surgery	-	-	-	-
Rheumatology	10,300	10,300	10,400	10,400
Sleep medicine	9,200	11,600	11,600	11,700
Vascular Surgery	1,600	3,200	3,200	3,200
Wound care	4,900	5,000	5,000	5,000
<b>Total</b>	<b>1,436,400</b>	<b>1,579,400</b>	<b>1,586,000</b>	<b>1,592,600</b>

\*FY 2016-2018 projected to increase as a result of new physician recruitment for primary care, surgical specialties, medical specialists and behavioral health.

Ex. D, p. 221; Late File 1, submitted August 2, 2016

18. Medicaid-covered patients account for 10.5% of NEMG's patient population and 16.1% of L&MPA's patient population. Following the merger, the payer mix with more closely reflect NEMG's due to its significantly higher patient volumes (approximately five times greater):

**TABLE 3  
NEMG AND L&MPA CURRENT AND PROJECTED POPULATION-BASED PAYER MIX**

PAYER	FY 2015 Actual				FY 2016* Projected			
	NEMG		L&MPA		NEMG		L&MPA	
	Volume	%	Volume	%	Volume	%	Volume	%
Medicare**	323,700	24.9%	100,936	37.1%	374,242	26.1%	50,542	37.1%
Medicaid**	137,020	10.5%	43,737	16.1%	158,921	11.1%	21,901	16.1%
CHAMPUS & TriCare	5,330	0.4%	8,340	3.1%	9,506	0.7%	4,176	3.1%
<b>Total Government</b>	<b>466,050</b>	<b>35.9%</b>	<b>153,013</b>	<b>56.2%</b>	<b>542,669</b>	<b>37.8%</b>	<b>76,619</b>	<b>56.2%</b>
Commercial Insurers	720,070	55.4%	111,478	40.9%	775,891	54.0%	55,821	40.9%
Uninsured	111,280	8.6%	3,883	1.4%	113,224	7.9%	1,944	1.4%
Workers Compensation	2,600	0.2%	4,024	1.5%	4,615	0.3%	2,015	1.5%
<b>Total Non-Government</b>	<b>833,950</b>	<b>64.2%</b>	<b>119,386</b>	<b>43.8%</b>	<b>893,731</b>	<b>62.2%</b>	<b>59,781</b>	<b>43.8%</b>
<b>Total Payer Mix</b>	<b>1,300,000</b>	<b>100%</b>	<b>272,399</b>	<b>100%</b>	<b>1,436,400</b>	<b>100%</b>	<b>136,400</b>	<b>100%</b>

\*Based on a merger date of April 1, 2016.

Ex. A. p. 31, 41

**TABLE 4  
NEMG'S PROJECTED POPULATION-BASED PAYER MIX WITH THE PROPOSAL**

PAYER	Projected with Proposal					
	FY 2017		FY 2018		FY 2019	
	Volume	%	Volume	%	Volume	%
Medicare*	426,501	27.0%	428,218	27.0%	429,934	27.0%
Medicaid*	181,550	11.5%	182,279	11.5%	183,007	11.5%
CHAMPUS & TriCare	13,726	0.9%	13,769	0.9%	13,812	0.9%
<b>Total Government</b>	<b>621,777</b>	<b>39.4%</b>	<b>624,265</b>	<b>39.4%</b>	<b>626,753</b>	<b>39.4%</b>
Commercial Insurers	835,281	52.9%	838,850	52.9%	842,419	52.9%
Uninsured	115,691	7.3%	116,213	7.3%	116,735	7.3%
Workers Compensation	6,651	0.4%	6,672	0.4%	6,693	0.4%
<b>Total Non-Government</b>	<b>957,623</b>	<b>60.6%</b>	<b>961,735</b>	<b>60.6%</b>	<b>965,847</b>	<b>60.6%</b>

<b>Total Payer Mix</b>	<b>1,579,400</b>	<b>100%</b>	<b>1,586,000</b>	<b>100%</b>	<b>1,592,600</b>	<b>100%</b>
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Ex. A. p. 31, 41

19. Following the merger, NEMG will continue to administer its existing charity care policies, which are slightly more generous than L&MPA's, to patients requiring financial assistance. Ex. D, p. 218, 219
20. The Applicants do not anticipate any changes to patient health care cost as a direct result of this proposal. Ex. A, p. 31
21. There is no capital expenditure associated with the proposal. Ex. A. p. 32
22. For the most recently completed fiscal year (FY 2015), both group practices experienced operational losses:

**TABLE 5  
APPLICANTS' ACTUAL LOSSES FROM OPERATIONS IN FY 2015\***

	<b>NEMG</b>	<b>L&amp;MPA</b>
Revenues from Operations	\$269,965	\$38,034
Total Operating Expense	\$323,896	\$59,938
<b>Loss from Operations</b>	<b>\$(53,931)</b>	<b>\$(21,903)</b>

\*Amounts are in thousands, rounded  
Ex. D, pp. 225, 226

23. The Applicants project the following operational losses associated with the proposal:

**TABLE 6  
APPLICANTS' PROJECTED LOSSES FROM OPERATIONS WITH THE PROPOSAL\***

	<b>FY 2016</b>	<b>FY 2017</b>	<b>FY 2018</b>	<b>FY 2019</b>
Revenues from Operations	\$307,108	\$335,031	\$342,067	\$349,278
Total Operating Expense	\$371,884	\$408,482	\$415,955	\$423,760
<b>Loss from Operations</b>	<b>\$(64,736)</b>	<b>\$(73,451)</b>	<b>\$(73,888)</b>	<b>\$(74,482)</b>

\*Amounts in thousands, rounded  
Ex. D, pp. 225, 226

24. Despite the losses incurred from NEMG, YNHHS projects operation gains of \$107,829, \$180,433, \$182,377, and \$183,092 in FY 2016, FY 2017, FY 2018 and FY 2019, respectively. Docket number: 15-32033-CON, p. 855
25. YNHHS's financial profile is strong enough to support NEMG and L&MPA and sustain the losses accompanied by its acquisition of L&MPA, as evidenced by its long-term bond ratings: AA- (stable outlook) by Fitch, Aa3 (stable outlook) by Moody's and A+ (positive outlook) by S&P. Ex. G; p 231
26. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1))

27. This CON application is consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2))
28. The Applicants have established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3))
29. The Applicants have demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))
30. The Applicants have satisfactorily demonstrated that the proposal will maintain quality, accessibility and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat. § 19a-639(a)(5))
31. The Applicants have shown that there would be no change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6))
32. The Applicants have satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7))
33. The Applicants' historical provision of treatment in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))
34. The Applicants have satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))
35. The Applicants have demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10))
36. The Applicants have demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the region. (Conn. Gen. Stat. § 19a-639(a)(11))
37. The Applicants have satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or access to care. (Conn. Gen. Stat. § 19a-639(a)(12))

## Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board*, 309 Conn. 727 (2013).

NEMG, an affiliate of YNHHS, is a not-for-profit multispecialty medical foundation that provides physician-related services to Bridgeport, Greenwich, and Yale-New Haven Hospitals and their surrounding communities. *FF1* YNHHS provides support services to YNHHS, a network of affiliated health care providers, the foremost being Yale-New Haven Hospital. *FF2* L&MPA is a not-for-profit multispecialty medical foundation with approximately 70 physicians that provides physician-related services at multiple locations throughout southeastern Connecticut and southwestern Rhode Island. *FF3* L&MPA is a subsidiary of L+M, the parent corporation of L+M Healthcare, whose main providers are L&MPA, L+MH, Westerly Hospital in Rhode Island and the Visiting Nurse Association of Southeastern Connecticut. *FF4*

In conjunction with the proposed request to transfer ownership of L+M to YNHHS (Docket Number 15-32033-CON) and due to Connecticut law<sup>3</sup>, which limits the number of medical foundations allowed by a hospital or health care system to one, the Applicants have requested authorization to transfer ownership of L&MPA to NEMG. Under the proposal current L+MPA physicians will become employees of NEMG. *FF5*

The proposal will improve clinical integration and collaboration among physicians and enhance L&MPA's ability to coordinate care across the region. *FF10* The use of the same electronic medical record software will permit L&MPA physicians access to patient information or clinical and utilization data at any NEMG or YNHHS location. *FF11* L&MPA physicians will be able to view dashboard reports that examine quality indicators such as screenings, preventive care and medication adherence as well as view entire episodes of patient care. *FF12* Additionally, these physicians will share NEMG's clinical pathways and protocols, evidence-based practice information, to help guide them in selecting appropriate tests and interventions. *FF13* NEMG's care coordination services will be extended to L&MPA physicians to address post-acute care needs and to focus on reducing emergency room visits and 30-day hospital readmissions. These services will help patients understand their care plan, gain access to needed services and receive timely and appropriate follow-up. *FF14* YNHHS will support the enhancement of clinical services by adding physicians in L+MH's service area in primary care, surgical specialties (e.g., neurosurgery), medical specialties (e.g., oncology and behavioral health), which will be provided locally at a lower cost over a five-year period. *FF17*

Medicaid-covered patients account for 10.5% of NEMG's patient population and 16.1% of L&MPA's patient population. Following the merger, although the payer mix with more closely

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<sup>3</sup>Connecticut General Statute, section 33-182bb states that a hospital, health system or medical school may organize and become a member of no more than one medical foundation.

reflect NEMG's due to its significantly higher patient volumes (approximately five times greater), Medicaid patients will continue to be served by the physicians. *FF18* After the merger, NEMG will continue to administer its existing charity care policies, which are slightly more generous than L&MPA's, to patients requiring financial assistance. *FF19* The Applicants do not anticipate any changes to patient health care cost as a direct result of this proposal. *FF20*

As a result of these combined factors, the Applicants have satisfactorily demonstrated that quality and access to physician/provider services in the region will be maintained or improved for all relevant patient populations and there will be no changes to patient health care costs.

There is no capital expenditure associated with the proposal. *FF21* For the most recently completed fiscal year (FY 2015), both group practices experienced operational losses and losses are projected in each of the three years following the proposal. *FF22,23* However, despite these losses, YNHHS projects operation gains of \$107,829, \$180,433, \$182,377, and \$183,092 in FY 2016, FY 2017, FY 2018 and FY 2019, respectively, as YNHHS's financial profile is strong enough to support NEMG and L&MPA and sustain the losses accompanied by its acquisition of L&MPA, as evidenced by its long-term bond ratings: AA- (stable outlook) by Fitch, Aa3 (stable outlook) by Moody's and A+ (positive outlook) by S&P. *FF24,25*

The Applicants have satisfactorily demonstrated that the proposal is financially feasible and that the proposal will ensure that access to quality care is maintained or improved for the population currently being served, including the Medicaid population. Accordingly, the Applicants have demonstrated that their proposal is consistent with the Statewide Health Care Facilities and Services Plan.

## Order

Based upon the foregoing Findings of Fact and Discussion, the Applicants' request for Transfer of Ownership of Group Practice by the Merger of L&M Physician Association into Northeast Medical Group, is hereby **Approved** under Conn. Gen. Stat. § 19a-639(a) subject to the enumerated conditions (the "Conditions") set forth below.

Unless expressly provided otherwise, all Conditions of this Order shall, to the extent applicable, be binding on the Applicants, their affiliates, successors and assigns. OHCA and any successor agency shall have the right to enforce the Conditions by all means and remedies available to it under law and equity, including but not limited to, the right to impose and collect a civil penalty under Conn. Gen. Stat. § 19a-653 against any person or health care facility or institution that fails to file required data or information within the prescribed time periods set forth in this Order. All references to days in these Conditions shall mean calendar days.

Given the importance of this affiliation to Eastern Connecticut, the applicants have voluntarily agreed to the following conditions for the purpose of representing its ongoing commitment to the provision of high quality affordable health care services in Eastern Connecticut. To the extent that certain obligations required hereunder are satisfied by L+M and YNHHS pursuant to Docket Number **15-32033-CON**, the obligations herein are not required to be repeated to satisfy the conditions hereunder. Thus, by satisfying the same obligations in Docket Number **15-32033-CON**, the Applicants have satisfied the same condition herein. The following are ways in which L+M and YNHHS shall demonstrate these commitments for a period of not less than five years (except as otherwise noted) following the Closing of the affiliation of L+M with YNHHS:

1. L+M and YNHHS shall maintain the current L+MH and Lawrence & Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017 shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.

Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHS shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation. YNHHS shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut.

For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the

total price per unit of service (as defined below) for L+MH and LMMG shall be subject to a cap determined through the process set forth in Paragraphs 3 and 4 below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L +MH and LMMG.

2. With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):
  - a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph 1 above, i.e. physicians providing services through NEMG to L + M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.
  - b. Physicians who are hired, recruited or contracted by a YNHHS affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 1: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 1.
3. Within ninety days of the Date of Closing, YNHHS shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below:
  - a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined in D. below) for L+MH and LMMG (the "annual CMIR update"). Yale New Haven shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.
  - b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 10a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for

the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.

- c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHS, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHS shall meet and confer for the purpose of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHS is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases.
- d. The independent consultant shall take direction from the Commissioner of the Department of Public Health. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area.
- e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHS and L+M, unless required to do so by law. The confidential information and documents shall not be public records and shall be exempt from disclosure under Connecticut General Statute Section 1-210.

4. For purposes of determining the price per unit of service:
  - a. A “unit of service” for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures.
  - b. A “unit of service” for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state.
  - c. A “unit of service” for physician services shall be a work Relative Value Unit (wRVU).
  - d. The baseline to be established as of the Date of Closing for L+M’s total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service.
  - e. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.
5. L+M and YNHHS shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.
6. Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHS affiliate, such employees’ seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).
7. Every six months (the “six month reports”) until December 1, 2018 and each year thereafter (each an “annual report”), YNHHS shall submit notarized reports to OHCA for the periods of January to June (due July 31<sup>st</sup>) and July through December (due January 31<sup>st</sup>) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:
  - a. Affirmation that L+M and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and

that any new contracts are consistent with the commitments of paragraphs (20), (21) and (22) above.

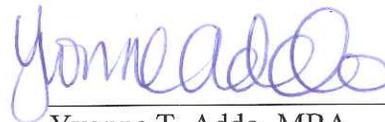
- b. Affirmation that no L+M physician office has been converted to hospital-based status.
  - c. A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSO information technology systems and platforms, YNHHSO's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSO population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSO shall include a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and
8. In addition to the above, L+M and YNHHSO make the following commitment for a period of five years post-Closing:
- a. L+M and YNHHSO shall appoint an independent monitor at their own cost (selected by YNHHSO and L+M and approved by OHCA) to serve as a post-transfer compliance monitor.
  - b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.
  - c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties.
  - d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.
  - e. If the Independent Monitor determines that YNHHSO and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSO and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSO and L+M for the purpose of determining compliance and any appropriate corrective action plan. If

YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653 In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.

By Order of the  
Department of Public Health  
Office of Health Care Access

9/8/16

Date



Yvonne T. Addo, MBA  
Deputy Commissioner

Northeast Medical Group and L&M Physicians Association  
Docket Number: 15-32032-CON

\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
L&M Physician Association Inc.,  
d/b/a L+M Medical Group

Signed by \_\_\_\_\_,  
(Print name)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
Lawrence + Memorial Corporation

Signed by \_\_\_\_\_,  
(Print name)

\_\_\_\_\_  
(Title)

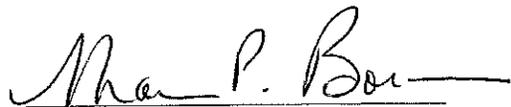
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Date

\_\_\_\_\_  
Duly Authorized Agent for  
Northeast Medical Group, Inc.

Signed by \_\_\_\_\_,  
(Print name)

\_\_\_\_\_  
(Title)

9/7/16  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Duly Authorized Agent for  
Yale New Haven Health Services Corporation

Signed by Marna P. Borgstrom,  
(Print name)

President & CEO  
(Title)

Northeast Medical Group and L&M Physicians Association  
Docket Number: 15-32032-CON

\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Duly Authorized Agent for  
L&M Physician Association Inc.,  
d/b/a L+M Medical Group

Signed by CHRISTOPHER LEINACH, MD  
(Print name)

PRESIDENT L+M MEDICAL GROUP  
(Title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
Lawrence + Memorial Corporation

Signed by \_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
Northeast Medical Group, Inc.

Signed by \_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
Yale New Haven Health Services Corporation

Signed by \_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Title)

Northeast Medical Group and L&M Physicians Association  
Docket Number: 15-32032-CON

\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
L&M Physician Association Inc.,  
d/b/a L+M Medical Group

Signed by \_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Duly Authorized Agent for  
Lawrence + Memorial Corporation

Signed by Bruce Cummings  
(Print name)

President and CEO  
\_\_\_\_\_  
(Title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
Northeast Medical Group, Inc.

Signed by \_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
Yale New Haven Health Services Corporation

Signed by \_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Title)

Northeast Medical Group and L&M Physicians Association  
Docket Number: 15-32032-00N

\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
L&M Physician Association Inc.,  
d/b/a L+M Medical Group

Signed by \_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
Lawrence + Memorial Corporation

Signed by \_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Title)



\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
Northeast Medical Group, Inc.

Signed by Christopher M. O'Connor  
(Print name)

Executive Vice President, COO  
(Title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Duly Authorized Agent for  
Yale New Haven Health Services Corporation

Signed by \_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Title)

## AGENDA

October 11, 2016

- I. Purpose of Meeting: To review conflicting conditions and clarify one set of coordinated conditions.
  - Strategic Plan
  - Financial Reporting
  - Cost and Market Impact Review
  - Independent Monitor
  - Community Benefit
  - Charity Care
  - Employment
  - Governance
  - Licensing, Physician Office Conversion and Cost Savings Attainment
  
- II. Timing and Format of Reporting



**Scheduled Meeting**  
**Lawrence + Memorial and Yale-New Haven Health System**  
**Certificate of Need Transfer of Ownership**  
**Docket Numbers 15-32033-CON and 15-32032-CON**

Date of Meeting: 10/11/2016

Name (Please Print)	Affiliation
Gayle Cappuzzo	YNHHS
May Rosenthal	YNHHS

Present from OHCA were:

Kimberly Martone	Carmen Cotto
Karen Roberts	

Meeting Start Time: 2:00 pm  
 Meeting End Time: 3:30 pm  
 KR

## Greer, Leslie

---

**Subject:** FW: OHCA Conditions Document for Docket Numbers: 15-32033-CON and 15-32032-CON  
**Attachments:** Yale New Haven Summary of Conditions (102116).pptx

---

**From:** Capozzalo, Gayle [<mailto:Gayle.Capozzalo@ynhh.org>]  
**Sent:** Friday, October 21, 2016 2:18 PM  
**To:** Martone, Kim  
**Cc:** Rosenthal, Nancy; Tamaro, Vincent; Willcox, Jennifer; Aseltyne, Bill; O'Connor, Christopher; Perrone, Brett  
**Subject:** OHCA Conditions Document for Docket Numbers: 15-32033-CON and 15-32032-CON

Kim,  
Attached please find the document we discussed yesterday. Nancy and I attempted to document the discussions that we have had regarding integrating the conditions and providing a coordinated way of addressing them. Once you've had time to review it, we look forward to discussing it with you. You will receive Deloitte's qualifications and workplan early next week. Thank you very much for working with us on this.  
Gayle

**Gayle Capozzalo**  
Executive Vice President and  
Chief Strategy Officer

789 Howard Avenue  
New Haven, CT 06519

**Phone:** 203-688-2605  
**Fax:** 203-688-3472

**Email:** [gayle.capozzalo@ynhh.org](mailto:gayle.capozzalo@ynhh.org)

**YaleNewHavenHealth**

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Executive Vice President and  
Chief Strategy Officer

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**Email:** [gayle.capozzalo@ynhh.org](mailto:gayle.capozzalo@ynhh.org)

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# **Review of OHCA Conditions**

Docket Numbers: 15-32033-CON and 15-32032-CON

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October 21, 2016

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H. Employment Conditions	11
I. Governance	12
J. Licensure, Physician Office Conversion, Cost Savings Attainment	13

# Review of OHCA Conditions

## Strategic Plan

### 15-32033-CON CONDITIONS 4 / 19 / 32b

Submit Strategic Plan by 3/7/2017  
and report for 5 years

### 15-32033-CON CONDITION 7

Until Capital Commitment Is Satisfied  
or 5 years

- YNHSC shall submit a strategic plan by March 7<sup>th</sup>, 2017 (180 days after Closing Date) demonstrating how health care services will be provided by L+MH for five years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the “Services Plan”). The strategic plan must include recruiting and retaining eight (8) additional PCPs and other providers to Eastern CT (New London, Windham and Tolland counties). The PCPs are defined as physicians in internal medicine, family practice, pediatrics, OB/GYN and geriatrics. The achievements attained in the strategic plan will be reported semi-annually for the 1<sup>st</sup> year (60 Days after March 31<sup>st</sup> and September 30<sup>th</sup>) and annually thereafter for a total of 5 years (Condition 32f), until March 31, 2021
- YNHSC shall submit to OHCA a narrative report on the resource investments (“Resource Investment Report”) it has made in L+M in semi-annually and its affiliates from the \$300M Commitment Amount. It must include list of expenditures, why the expenditure, and timeframe, and the funding source. The reports shall be signed by L+MH’s or L+M’s Chief Financial Officer. The first reporting period is through March 31<sup>st</sup> 2017 (Report due May 31<sup>st</sup>), the second reporting period is April 1, 2017 – September 30<sup>th</sup>, 2017 (report due November 30<sup>th</sup>, 2017). Semi-Annual reporting shall continue for 3 years ending September 30<sup>th</sup>, 2019 (Report due November 30, 2019).

### 15-32033-CON CONDITION 5

Until Services Plan Submitted

- YNHSC shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for L+MH specific to those services that existed at L+MH as of the Decision Date.

### 15-32033-CON CONDITIONS 18 / 32a

5 Years

- L+M Hospital shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need. Affirmation that these services will continue for 5 years. Reporting periods will be 60 days after March 31, 2017 and September 30, 2017 (Reports due May 31 and November 30<sup>th</sup> 2017) and on an annual basis thereafter (60 days after September 30) each year thereafter for a total of 5 years. (Ending September 30<sup>th</sup> 2021)

# Review of OHCA Conditions

## Financial Reporting

---

### 15-32033-CON CONDITION 6 3 Years

- The Applicants shall file with OHCA the total price ( weighted average price for all government and non-governmental payers) per unit of service for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. This will be reported at the end of each fiscal year for 3 years.

### 15-32033-CON CONDITIONS 8 3 Years

- YNHSC shall submit to OHCA a semi-annual financial measurement report. This report must show current month and year-to-date data and comparable prior year period data for L+MH and L+M. It includes various financial indicators related to margins, liquidity, leverage, and other statistics. The first reporting period is through March 31<sup>st</sup> 2017 (Report due May 31<sup>st</sup>), the second reporting period is April 1, 2017 – September 30<sup>th</sup>, 2017 (report due November 30<sup>th</sup>, 2017). Semi-Annual reporting shall continue for 3 years ending September 30<sup>th</sup>, 2019 (Report due November 30, 2019).

### 15-32033-CON CONDITIONS 32f 15-32032-CON CONDITION 7c 5 Years

- A five year synergy financial plan will be submitted by March 7, 2017. This plan will provide a 5 year projection of synergies expected broken down by fiscal year, resulting from non-clinical shared services opportunities such as L+M's integration of YNHSC Information Technology systems and platforms, supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital and L+M's participation in population health initiatives. Annually, YNHSC shall also submit reports 100,150,175 or successor reports. The first reporting period for all of the reports is through March 31<sup>st</sup> (Report due by May 31<sup>st</sup>). Reporting periods will be 60 days after March 31, 2017 and September 30, 2017 (Report due May 31 and November 30<sup>th</sup> 2017) and on an annual basis thereafter (60 days after September 30) each year thereafter for a total of 5 years. (Ending September 30<sup>th</sup> 2021)

# Review of OHCA Conditions

## Cost and Market Impact Review

Continued

### 15-32033-CON CONDITION 22

### 15-32032-CON CONDITION 3

5 Years,  
Initiate by 12/7/2016

- YNHHS shall initiate a cost and market impact review, within 90 days (12/7/2016) of the Closing date to establish a baseline cost structure and total price per unit of service for L+MH and LMMG, and establish a cap on the annual increase in the total price per unit of service. YNHHS shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline Cost and Market Impact Review ("CMIR") and annual updates and pay all costs associated with the CMIR. The report shall analyze factors relative to L+MH and LMMG and the Eastern CT market including: a) L+MH and LMMG's size and market share within their primary and secondary service areas; b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern CT; c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; d) availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; g) general market conditions for hospitals and medical foundations in the state and in Eastern CT; and h) other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern CT. If the review finds a likelihood of materially increased prices as a result of the affiliation, DPH and YNHHS must meet to create a performance improvement plan to address the conditions and the Commissioner of DPH will determine whether YNHHS is in compliance. Prior to the end of each fiscal year, the consultant will conduct the annual CMIR update and use the results to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. The consultant will report to DPH and provide reports to OHCA within 30 days of completion of the report, which shall be kept confidential. The consultant, in establishing the cap, shall take into consideration the cost reductions resulting from the affiliation and the annual cost of living of the primary service area of Eastern CT.

### 15-32033-CON CONDITION 23

### 15-32032-CON CONDITION 4

5 Years

- For purposes of determining the price per unit of service:
  - (a) A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-IO-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures.
  - (b) A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state.
  - (c) A "unit of service" for physician services shall be a work Relative Value Unit (wRVU).
  - (d) The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service.
  - (e) All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.

# Review of OHCA Conditions

## Cost and Market Impact Review

Continued

### 15-32033-CON CONDITIONS 20a / 32c

15-32032-CON  
CONDITIONS 1 / 7a  
Commercial plan contracts maintained until 12/31/2017, and no rate increase during this period. Rate increase subject to price cap until 9/8/2021 for L+MH

- L+MH shall maintain the current L+M Hospital commercial health plan contracts and rates through 12/31/2017, although scheduled increases previously negotiated prior to the date of Closing (9/8/2016) may be maintained. Any L+MH commercial plan contract that expires prior to 12/31/2016 shall be extended to 12/31/2017 and any contracts without an expiration date shall be continued (as of Closing date 9/8/2016), under their current negotiated term, to 12/31/2017. No negotiations for price increases shall take place between 9/8/2016 and 12/31/2017. After 12/31/2017, L+MH shall negotiate new rates based on L+MH's post-Closing cost structure, taking into account price or cost reductions, i.e. efficiencies, achieved as a result of the affiliation. No single system-wide rates shall be imposed and negotiated rates should be reflective of the market conditions of hospitals in Eastern CT. Any annual increase in the total price per unit of service for L+MH shall be subject to a price cap determined through the process identified in OHCA Condition 22 (CMIR process). An annual price cap will remain in place until 9/8/2021 (5 years). Affirmation that commercial Health Plans are in place as of closing date are maintained new contracts and consistent with Conditions 20a, 21a and 22

### 15-32033-CON CONDITIONS 20b / 32C

15-32032-CON  
CONDITION 1  
Commercial plan contracts maintained until 12/31/2017, and no rate increase during this period. Rate increase subject to price cap until 1/8/2019 for LMMG.

- LMMG shall maintain the current LMMG commercial health plan contracts and rates through 12/31/2017, unless scheduled increases previously negotiated prior to the date of Closing (9/8/2016) shall be maintained. Any LMMG commercial plan contract that expires prior to 12/31/2016 shall be extended to 12/31/2017 and any contracts without an expiration date shall be continued as of 9/8/2016, under their current negotiated term, to 12/31/2017. No negotiations for price increases shall take place between 9/8/2016 and 12/31/2017. After 12/31/2017, LMMG shall negotiate new rates based on LMMG's post-Closing cost structure, taking into account and price or cost reductions, i.e. efficiencies, achieved as a result of the affiliation. Negotiated rates should be reflective of the market conditions of like medical foundations in Eastern CT. Any annual increase in the total price per unit of service for LMMG shall be subject to a price cap determined through the process identified in OHCA Condition 22 (CMIR process). The process to establish annual price cap will remain in effect from 12/31/2017 until 1/8/2019 (28 months). Affirmation that commercial health plans in place as of closing date are maintained and any new plans are consistent with Conditions 20b, 21b, 22

# Review of OHCA Conditions

## Cost and Market Impact Review

Continued

**15-32033-CON  
CONDITION 21a**

**15-32032-CON  
CONDITION 2a**  
After Closing

- LMMG and NEMG will align by 1/1/2017. When NEMG is able to charge site specific prices for LMMG physicians and therefore abide by LMMG commercial health plan contracts and price caps, then LMMG and NEMG may merge. OHCA will be notified when the merger is completed.

**15-32033-CON  
CONDITION 21b**

**15-32032-CON  
CONDITION 2b**  
28 Months until 1/8/2019.

- Physicians who are hired, recruited, or contracted by YNHHS to provide services in the primary service area (East Lyme, Lyme, Old Lyme, Groton, Ledyard, Montville, New London, North Stonington, Preston, Salem, Stonington and Waterford) in the following specialties: family medicine, general medicine, internal medicine, OBGYN, endocrinology, and psychiatry, shall be required to bill at the same rate as LMMG until 1/8/2019 (28 months).

# Review of OHCA Conditions

## Independent Monitor

### 15-32033-CON CONDITION 15 / 33

### 15-32032-CON CONDITION 8 By 11/7/16 and for 5 Years

- Within sixty (60) days after the Closing Date, YNHSC shall contract with an independent Monitor who has experience in hospital administration and regulation to serve as a post-transfer monitor. The Independent Monitor shall be retained at the sole expense of YNHSC. Representatives of OHCA and FLIS will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.
- The monitor shall meet with community representatives six months after the 9/8/2016 Closing date (March 7, 2017) and annually thereafter and shall report to OHCA: a) L+M's compliance with the CON Order and b) the level of community benefits and uncompensated care provided by L+M during the prior period. The Monitor will report to OHCA within 30 days of its on-site reviews and meet with OHCA and FLIS to discuss its written reports. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out his/her duties. L+MH shall hold a public forum in New London 180 days after the Closing date (March 7, 2017) and not less than annually thereafter during the five year monitoring period to provide public review and comment on the monitor's reports and findings. If the monitor determines that YNHHS and L+MH are substantially out of compliance with the CON conditions, the monitor shall issue a notice to YNHHS and L+MH regarding the deficiency(is). Within two weeks of receiving the notice, the monitor will convene a meeting with representatives of YNHHS and L+MH to determine an appropriate corrective plan of action. If the plan is not implemented by YNHHS and L+MH satisfactory to the monitor within thirty (30) days of the meeting, the monitor shall report the noncompliance and its impact on health care costs and accessibility to OHCA. OHCA will determine whether the non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHS and L+MH into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, and the right to impose and collect a civil penalty. In the event OHCA determines that YNHHS and L+MH are in material non-compliance, OHCA may order YNHHS and L+MH to provide additional community benefits as necessary to mitigate the impact.

### 15-32033-CON CONDITION 16 2 Years

- The Independent Monitor will report to both OHCA and FLIS, conduct on-site visits no less than a semi-annual basis, and report to OHCA within 30 days of the on-site review. As necessary, the Independent Monitor will meet with OHCA and FLIS to discuss its written reports. At a minimum, two years duration.

# Review of OHCA Conditions

## Community Benefit

### 15-32033-CON CONDITION 11 3 years

### 15-32033-CON CONDITION 31/32h 5 years

- The Applicants shall apply no less than a 1% increase per year, for the next 3 fiscal years, toward the L+MH's community building activities in terms of dollars spent, consistent with L+M's most recent Scheduled H of IRS Form 990 and its Community Health Needs Assessment (CHNA). . Annually, for 3 years (ending September 30, 2019), YNHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within 30 days of the end of the fiscal year and shall be posted on L+MH's website. Condition 31 – submission to OHCA of the 2016 CHNA and CHIP has been completed.
- After the 3 years, and for the subsequent 2 years of the total 5 year period, L+M and YNHSC will be provide at least the same level of community benefit consistent with L+MH's most recent Schedule H with IRS Form 990 and its CHNA. The narrative should provide a description of L+MH's community benefit commitments in the communities L+M serves and amounts spent.

### 15-32033-CON CONDITION 12 3 Years

- The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. Specifically, the Applicants shall ensure that L+MH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the Applicants shall provide at L+MH, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the Applicants shall ensure that L+MH shall be guided by the National Standards for Culturally and linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, YNHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website.

# Review of OHCA Conditions

## Charity Care Policies

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### 15-32033-CON CONDITION 9 Following Closing

- L+MH will adopt YNHSC's financial assistance (charity and free care) policies or adopt other policies that are at least as generous and benevolent to the community as L+MH's current policies. Any new policies will be provided to OHCA once approved by the L+MH Board. Post to L+MH website.

### 15-32033-CON CONDITION 10 3 years

### 15-32033-CON CONDITION 32e 5 years

- For 3 years, YNHSC shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of L+M Hospital within 30 days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of L+MH simultaneously with their submission to OHCA. All adopted or amended policies are at least as generous as the YNHHS Charity and Free Care policies. Affirmation that L+M has adopted the financial assistance policies to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30<sup>th</sup> 2021 (Report due November 30<sup>th</sup> each year).

# Review of OHCA Conditions

## Employment Conditions

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### 15-32033-CON CONDITIONS 27 / 32g 5 Years

- L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place. Affirmation provided to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30<sup>th</sup> 2021 (Report due November 30<sup>th</sup> each year).

### 15-32033-CON CONDITIONS 28 / 32g 15-32032-CON CONDITION 6 5 Years

- Employees of any L+M affiliate or LMMG shall not be required to reapply for their positions as a result of the affiliation. Affirmation provided to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30<sup>th</sup> 2021 (Report due November 30<sup>th</sup> each year). To the extent that any L+M or LMMG employees leave their employment at L+M or LMMG service sites within ninety days following the Closing Date and obtain employment with a YNHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service). Affidavit will be sent in after 12/7/16

### 15-32033-CON CONDITIONS 29 / 32g 5 Years

- L+MH shall maintain its current wage and salary structures for its non-bargaining or nonrepresented employees based on hospitals of similar scope, size and market conditions in Connecticut. Affirmation provided to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30<sup>th</sup> 2021 (Report due November 30<sup>th</sup> each year).

### 15-32033-CON CONDITIONS 30 / 32g 5 Years

- L+M and YNHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs. Affirmation provided to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30<sup>th</sup> 2021 (Report due November 30<sup>th</sup> each year).

# Review of OHCA Conditions

## Governance

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### 15-32033-CON CONDITION 14 3 Years

- For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as voting members of L+MH's Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. OHCA shall be notified of the Applicant's choice of the community representative to join the L+MH Board and provide background information.

### 15-32033-CON CONDITION 17 3 years

- Joint meeting of YNHHS and L+M Boards to be held at least twice annually for 3 years ending October 7, 2019. Meetings to be followed by a public meeting to which the public is invited in advance and the public is informed of L+MH's activities and may ask questions and comment. Affirmation will be sent to OHCA that these meetings have taken place.

### 15-32033-CON CONDITION 26 5 Years

- L+M Board continues as a fiduciary board composed of members who reside in the communities served by L+MH and an YNHHS representative. Serving as an ex-officio member. Each Director of the L+MH Board shall have an equal vote, and subject to certain reserved powers for YNHHS, will have the right to approve any new programs and clinical services, or the discontinuation or consolidation of programs. The L+M Board shall be empowered and supported to oversee local performance and to create and sustain connections with the community. L&M's bylaws will be submitted to OHCA and any future modifications will be sent to OHCA. Affirmation provided annually for 5 years ending September 30<sup>th</sup>, 2021.

# Review of OHCA Conditions

## Licensure, Physician Office Conversion, Cost Savings Attainment

**15-32033-CON  
CONDITION 13**  
5 Years

- Abide by all requirements of licensure by FLIS and DPH. Affirmation provided annually, ending September 30<sup>th</sup> 2021.

**15-32033-CON  
CONDITION 24 / 32d**  
**15-32033-CON  
CONDITIONS 5 / 7b**  
5 Years

- L+M and YNHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status. Affirmation provided to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30<sup>th</sup> 2021 (Report due November 30<sup>th</sup> each year).

**15-32033-CON  
CONDITION 25**  
5 Years

- L+M shall attain cost savings as a result of the affiliation with YNHSC as described in the CON application. Affirmation provided annually, ending September 30<sup>th</sup> 2021.

## Greer, Leslie

---

**From:** Martone, Kim  
**Sent:** Wednesday, October 26, 2016 12:39 PM  
**To:** Greer, Leslie  
**Subject:** FW: Docket Numbers: 15-32032-CON and 15-32033-CON: Independent Monitor Engagement Letter  
**Attachments:** DT-YNHHS Independent Monitor Eng Letter Draft 102416 FINAL (SENT TO OHCA).docx

### ***Kimberly R. Martone***

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



---

**From:** Capozzalo, Gayle [<mailto:Gayle.Capozzalo@ynhh.org>]  
**Sent:** Tuesday, October 25, 2016 9:07 AM  
**To:** Martone, Kim; Roberts, Karen  
**Cc:** 'Sauders, Kelly (US - New York)'; Tammaro, Vincent; Rosenthal, Nancy; Willcox, Jennifer; O'Connor, Christopher  
**Subject:** Docket Numbers: 15-32032-CON and 15-32033-CON: Independent Monitor Engagement Letter

Kim and Karen,

For your review, attached please find the Engagement Letter between Yale New Haven Health System and Deloitte to act as Independent Monitor. In the Engagement Letter "Appendix A" is the monitoring plan which I sent to you yesterday.

I look forward to hearing from you regarding next steps.

Thank you.  
Gayle

**Gayle Capozzalo**  
Executive Vice President and  
Chief Strategy Officer

789 Howard Avenue  
New Haven, CT 06519

**Phone:** 203-688-2605  
**Fax:** 203-688-3472

Email: [gayle.capozzalo@ynhh.org](mailto:gayle.capozzalo@ynhh.org)

**YaleNewHavenHealth**

This message originates from the Yale New Haven Health System. The information contained in this message may be privileged and confidential. If you are the intended recipient you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you.

October 24, 2016

Bill Aseltyne  
Senior Vice President & General Counsel  
Yale-New Haven Hospital/Yale New Haven Health System  
789 Howard Ave., CB 230  
New Haven, CT 06519

Dear Bill,

This engagement letter is to confirm the engagement of Deloitte & Touche LLP (“D&T” or “we”), effective as of the date hereof, to provide Yale New Haven Health Services Corporation and its subsidiaries (collectively referred to as “YNHHSC” or the “Company”) the services described below (the “Services”).

### **Scope and Approach**

We understand you are seeking an independent monitor related to the agreed settlement (“Agreement” or “Order”) between YNHHSC and State of Connecticut’s Office of Health Care Access (“OHCA”) to monitor the YNHHSC’s compliance with the Conditions of the Order in the transfer of ownership of Lawrence and Memorial Corporation and its subsidiaries to YNHHSC.

Specific anticipated activities we will assist YNHHSC with will include two work streams:

#### *Workstream 1: Assist YNHHSC with the planning and preparing for monitoring reviews*

- Hold kick-off with YNHHSC responsible persons to discuss the monitor requirements
- Meet with the Connecticut Office of Health Care Access (OHCA), as requested
- Review and agree upon with YNHHSC and OHCA, as applicable, the elements of monitor services as documented in the work plan in Appendix A.

#### *Workstream 2: Assist YHHHS with the independent monitoring activities*

- Refer to Appendix A for a detailed monitor work plan which describes the various required activities and activities associated with each condition of the Order.

We anticipate providing our services both off-site and on-site. Where possible we will perform analysis and preparation activities remotely. We anticipate providing these services for a period of approximately two years (as requested by YNHHSC based on requirements of OHCA).

## Engagement Team

Kelly J. Sauders, Partner, Deloitte & Touche LLP, will serve as the lead engagement leader to provide oversight and direction. Ed Sullivan, Principal, Deloitte & Touche LLP will serve as the quality assurance partner, supporting Kelly and the team in the execution of the work. Kaitlin McCarthy, Manager, Deloitte & Touche LLP, will serve as the overall project manager. Additional support will be provided by other professionals from Deloitte & Touche LLP's Regulatory & Compliance practice, as needed, during the course of this engagement.

## Deliverables

The following deliverables will be produced during the course of this engagement:

### *Workstream 1: Assist YNHHS with planning and preparing for monitoring reviews*

1. D&T will create and maintain a written plan for fulfilling the duties set forth in the agreement.

### *Workstream 2: Assist YNHHS with independent monitoring activities*

1. D&T will draft and submit a written report within thirty (30) days of the completion of each (semi-annual) on-site review on YNHHS compliance with the conditions of the Order, totaling two reports per reporting year.

## Professional Fees and Timing

The total fees related to this engagement are estimated as follows:

Year 1: \$180,000 - \$190,000

Years 2 through 5 (as required)\* \$150,000-\$160,000

We will bill for our services based on actual hours incurred at the following billing rates:

<b>Resource Level</b>	<b>Hourly Rate</b>
Partner	\$625
Senior Manager	\$550
Manager	\$510
Senior Consultant	\$445
Consultant	\$380

\* Note that hourly rates will increase approximately 3% per year for years 3, 4 and 5.

This estimated fee and time estimate is based upon our current understanding of the project requirements, our proposed approach, our estimate of the level of effort required, our roles and responsibilities, any assumptions set forth herein, and active participation of Company's management and other personnel. We

plan to meet with you on no less than a quarterly basis to review time incurred and estimates to completion throughout the duration of this engagement.

Based on our experience, issues sometimes arise that require procedures beyond what was initially anticipated. If this should occur, we will discuss it with you promptly and early in the process before we perform any additional work.

We understand that you will reimburse us for all reasonable expenses incurred in performing the Services on this engagement (including, but not limited to, our reasonable travel, meal, lodging, and mileage expenses). Expenses will be noted separately on our invoices and segregated by expense type.

Fees for this engagement will be billed biweekly as the work progresses for fees accrued and expenses incurred by us since our last invoice in performing our Services.

### **Other Matters**

YNHHSC is, among other things, a regulatory/compliance and merger & acquisition services client of D&T and/ or its affiliated and related entities. We do not believe that the proposed services impair the objectivity for D&T to perform the proposed services for YNHHSC. However, we are bringing this to your attention to avoid any misunderstanding.

Should a potential conflict come to the attention of the engagement leader with respect to potential future work being performed or to be performed by D&T or one of its affiliated or related entities for YNHHSC, D&T will advise YNHHSC promptly. YNHHSC will, at its option and in consultation with the Connecticut Office of Health Care Access as appropriate, promptly request, in writing, (1) such entity not to proceed with the proposed services or (2) such entity to proceed with the proposed services, provided that such entity agrees to proceed. If YNHHSC requests such entity to proceed with the proposed services, YNHHSC agrees that D&T and its affiliated and related entities' are able to perform the proposed services objectively. If appropriate, such entity will establish an ethical wall and confidentiality safeguards so that the services will be performed by different personnel on the various engagements.

### **Acknowledgements and Agreements**

The Company specifically acknowledges and agrees to the following:

- Substantial and meaningful involvement of management of the Company is critical to the success of this engagement. The Company shall be responsible for ensuring that the identified Company personnel actively participate in both the planning and execution of this engagement.
- D&T will not make any management decisions, perform any management functions, or assume any management responsibilities.
- The Company agrees that any deliverables provided to the Company hereunder by D&T may be disclosed to the State of Connecticut's Office of Health Care Access ("OHCA") to the extent required by such regulator in connection with an investigation or examination of the Company. To the extent permitted by law, rule, regulation and applicable professional standards, YNHHSC shall be promptly notified in the event such deliverable(s) are provided by D&T to the OHCA.

- Company will limit sensitive information, such as PII, PHI, trade secrets and other information that it considers sensitive or highly confidential, it provides to D&T (or otherwise makes available to D&T to only that which is reasonably necessary to allow D&T to provide the Services. D&T will provide Company with a list of D&T personnel who are authorized to receive or have access to Company sensitive information. Such list may be updated as needed. Any disclosure of sensitive information by Company to D&T will utilize levels of information security and data encryption appropriate to maintain security of Company sensitive information being accessed by or transferred to D&T, and as required by applicable information protection laws.
- The Services will be performed in accordance with the Statement on Standards for Consulting Services that is issued by the American Institute of Certified Public Accountants (“AICPA”). However, the Services will not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body and, therefore, we will not express an opinion or any other form of assurance as a result of performing the Services.
- We will not provide any legal advice regarding our Services nor will we provide any assurance regarding the outcome of any future audit or regulatory examination or other regulatory action; the responsibility for all legal issues with respect to these matters, such as reviewing all deliverables and work product for any legal implications to the Company, will be the Company’s.
- The Services may include advice and recommendations, but all decisions in connection with the implementation of such advice and recommendations shall be the responsibility of, and made by, the Company.

\*\*\*\*\*

During the term of this engagement, the Company may request that D&T perform additional services that are not encompassed by this engagement letter. D&T may perform such additional services upon receipt of a separate signed engagement letter with terms and conditions that are acceptable to D&T and the Company. Our observations and recommendations will be based solely on the results of the assessment performed.

This engagement letter, together with the General Business Terms attached hereto as Appendix B and the Business Associate Addendum attached hereto as Appendix C and made a part hereof constitute the entire agreement between the Company and D&T with respect to this engagement, supersede all other oral and written representations, understandings, or agreements relating to this engagement, and may not be amended except by the mutual written agreement of the Company and D&T.

Please indicate your acceptance of this agreement by signing in the space below and returning a fully executed copy of this engagement letter to us. A duplicate of this engagement letter is provided for your records. We look forward to serving you. If you have any questions please contact Kelly Saunders at (212) 436-3180.

Very truly yours,

Deloitte & Touche LLP

By: Kelly J. Saunders  
Partner

**Accepted and Agreed to by:**

Yale New Haven Health Services Corporation on behalf of itself and its subsidiaries

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

## Greer, Leslie

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**Subject:** FW: Independent Monitoring Plan for Docket Numbers: 15-32032-CON and 15-32033-CON  
**Attachments:** YNHHS Monitor Quals and Bios draft 10-22-16.pptx; DT-YNHHS Independent Monitor Draft Procedures (102416).pdf

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**From:** Capozzalo, Gayle  
**Sent:** Monday, October 24, 2016 2:52 PM  
**To:** 'kimberly.martone@ct.gov'  
**Cc:** Willcox, Jennifer; Rosenthal, Nancy; O'Connor, Christopher; 'Sauders, Kelly (US - New York)'; Tammaro, Vincent  
**Subject:** Independent Monitoring Plan for Docket Numbers: 15-32032-CON and 15-32033-CON

Attached please find Deloitte's credentials and experience in providing independent monitoring services to other organizations. The second attachment is the Draft Workplan Deloitte would use as the Independent Monitor. We are still working on the Engagement Letter, which should be submitted to you to ty tomorrow. I look forward to speaking with you at your earliest convenience in order to allow us to have the Independent Monitor in place by November 8. Thank you.  
Gayle

**Gayle Capozzalo**  
Executive Vice President and  
Chief Strategy Officer

789 Howard Avenue  
New Haven, CT 06519

**Phone:** 203-688-2605  
**Fax:** 203-688-3472

**Email:** [gayle.capozzalo@ynhh.org](mailto:gayle.capozzalo@ynhh.org)

**YaleNewHavenHealth**

This message originates from the Yale New Haven Health System. The information contained in this message may be privileged and confidential. If you are the intended recipient you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you.



# Yale New Haven Health System and Lawrence + Memorial Corporation Independent Monitor Qualifications

October 22, 2016



# Qualifications

# Related experience

## Independent Review Organization (IRO) and Monitor Qualifications

- Deloitte is currently serving as an IRO for a large health care system that entered into a 5 year CIA that requires the IRO to perform claim reviews at various facilities that provide hospital services. Deloitte's specialists are working with key stakeholders, including the OIG, to design a risk-based approach to the facility selection and claims review that will bring value above and beyond that of a simple random review selection.
- Deloitte served as the IRO for a stand-alone hospital in California that entered into a 3 year CIA that required the IRO to perform Claims Reviews, Cost Report Reviews and an Unallowable Cost Review. Deloitte specialists with deep experience in coding and billing were utilized to perform the claims reviews, while specialists with cost reporting and reimbursement experience were utilized to perform the cost report and unallowable cost reviews. The Claims Review included a sample of claims from the population of claims that had been submitted and reimbursed by the Medicare Program during the Reporting Period.
- Deloitte served as the IRO for a hospital that was part of a larger health system that had entered into a 3 year CIA that required the IRO to perform Claims Reviews and an Unallowable Cost Review. Specialists with certifications in inpatient medical record coding performed reviews of inpatient claims that had been billed to and paid by the Medicare Program that were included in the Discovery Samples as required by the CIA. Our work involved also included an Unallowable Cost Review performed by reimbursement and cost reporting specialists.

# Related experience

## Independent Review Organization (IRO) and Monitor Qualifications (continued)

- Deloitte is currently working with outside legal counsel for a physician-owned hospital in the southern United States and pursuant to a non-prosecution agreement after an investigation by the United States Department of Justice (DOJ) related to alleged violations of the Physician Self-Referral Law (Stark Law), federal and State anti-kickback laws and other anti-bribery anti-corruption (ABAC) laws and regulations. Deloitte was selected to be the ethics and compliance monitor to assess the operation of the compliance program, to conduct proactive monitoring of risk areas, and to make recommendations for improvement. To initiate the project, the Deloitte team conducted a comprehensive assessment of the existing compliance program, including the review of policies and procedures, hotline operations, training programs, and organizational structure. A detailed report was prepared and presented to the executive leadership, the governing board, and the Department of Justice. This report compared the existing compliance program to best practices for hospital compliance programs, and provided a roadmap on where the program met standards or required improvements.
- Deloitte has acted as the Independent Consultant for a Top 5 Bank as required by Consent Orders from both the Federal Reserve Board and the Office of the Comptroller of the Currency in multiple complex areas of mortgage servicing and foreclosure related activities. Activities for this engagement included: performed detailed review of loans with a foreclosure action taken over a five-year period, including reviewing millions of individual mortgage loan files; maintained high quality of work across multiple work streams with diverse U.S. and U.S. India teams; stood up a quality assurance process for the project in line with the expectations and practices required by the regulatory bodies; established a strong PMO for status reporting, metrics, and analysis as part of oversight by the regulatory bodies as well as the Bank; and, developed electronic tools/accelerators for capturing and documenting the results of the individual file reviews.

# Related experience

## Independent Review Organization (IRO) and Monitor Qualifications (continued)

- Deloitte has acted as the Independent Consultant for a Top 5 Student Loan Servicer as required by Consent Orders from both the Federal Deposit Insurance Corporation and the United States Department of Justice(DOJ). Engagement activities included the following: Performed predictive analytics as part of a multiple year lookback to estimate remediation related to multiple sections within the Servicemembers Civil Relief Act (SCRA); Performed detailed reviews of loans and related documents as well as court documents over multiple years related to multiple SCRA sections; stood up a quality assurance process; established a strong PMO; provided a detailed report as required within the consent order with the results of both the estimated remediation as well as the results of the detailed loan review based on regulatory criteria and direction.
- Deloitte Acted as the Independent Consultant for a Top 5 Bank as required by Consent Order and Judgement from the US Department of Justice (DOJ). Engagement activities included the following: Executed a retrospective review on qualifying military personnel in accordance with § 3937 of the federal SCRA; developed tools which utilized financial data at the transactional level to assess loan attributes, including payment and fees data, to calculate preliminary remediation amounts resulting from misapplied or missing benefits payable to borrowers under the SCRA; performed manual document assessment for select sub-set of loans identified through a data driven waterfall approach to reduce the number of manual touches; designed and executed quality assurance procedures; facilitated monthly meetings between Bank and US DOJ; provided a detailed report as required by the consent order along with full loan information used in the assessment using custom built databases; trained Bank and DOJ on how to utilize the custom built databases.

# Project Leadership

# Proposed engagement team

We have a core team ready to work with you

## Engagement Leadership

### Kelly Sauders

*Partner  
Advisory*



### Lead Engagement Partner

Kelly is a Partner with Deloitte & Touche LLP who has over 20 years of experience in the health care industry. She specializes in providing regulatory compliance and risk services in the health care industry. Kelly has led numerous regulatory compliance program assessments, implementation projects and responses to government investigations. She has also been involved in many enterprise-wide risk assessment and ERM program development projects. In these roles she works frequently with boards of directors and executive teams. She has assisted numerous clients with CIA-readiness, government investigations, OIG audits, and self-disclosures regarding documentation, coding and billing matters and has led a number of Independent Review Organization (IRO) engagements and other projects with health care regulators.

### Ed Sullivan

*Principal  
Advisory*



### Quality Assurance Advisor

Ed is a Principal within the Governance & Regulatory Risk Services group of the Advisory Practice. He has over 19 years' experience providing regulatory, internal control, risk services and enforcement action oversight to our largest banking clients. He has lead a numerous of engagements assisting top 5 US banks deal with regulatory matters as both an advisor and independent consultant. Additionally, he has assisted clients in preparation for regulatory examinations, conducted independent testing, provided training and developed policies and procedures directly related to regulatory matters. He routinely serves as an independent consultant related to regulatory matters for Federal Reserve Bank, Office of the Comptroller of Currency, FDIC, Consumer Financial Protection Bureau and the Department of Justice.

# Proposed engagement team

We have a core team ready to work with you

## Engagement Leadership

Kaitlin McCarthy

*Manger  
Advisory*



### Monitor Engagement Lead

Kaitlin has over 8 years of experience in the life science and health care industry, with a specialization in health care compliance and regulatory matters. She has conducted compliance program assessments, enterprise risk assessments, and been engaged by clients for compliance program enhancement and implementation in preparations for pending CIAs. Kaitlin has provided interim compliance program assistance to clients, serving as interim Chief Privacy Officer for a large academic medical center. Kaitlin has participated in OIG investigation responses and remediation. She has also provided litigation support surrounding billing and coding compliance matters.

Ryan DeMerlis

*Manger  
Advisory*



### Subject Matter Expert

Ryan is a certified Project Management Professional (PMP) with more than 9 years of experience in commercial health care and Federal government consulting and management. Ryan principally consults with clients on issues related to regulatory impacts to strategy and operations, including the establishment of effective corporate compliance programs, physician contract compliance related to Stark and anti-kickback regulations, general billing compliance, and organizational responses to Federal regulators. A focus of his work relates to Federal health payment regulations, leading him to manage several engagements related to voluntary refunds, self-disclosures, and organizational monitoring, including managing an Independent Review Organization engagement.

# Proposed engagement team (continued)

We have a core team ready to work with you

## Engagement Leadership

Mark Giguere

*Consultant  
Advisory*



### Subject Matter Expert

Mark has over 3 years of experience in the life sciences and health care industry, specifically in the areas of regulatory compliance and risk management. Mark is currently working on an IRO engagement with a large health system. Mark also supports Deloitte's Health Care Regulatory Leader advising clients on emerging health care policy. Prior to joining Deloitte, Mark consulted provider organizations on regulatory matters related to Medicare payments.

# Deloitte.

The Services will not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body and, therefore, we will not express an opinion or any other form of assurance as a result of performing the Services.

DRAFT  
10/24/16

## INDEPENDENT MONITORING PROCEDURES (per Docket Numbers 15-32032-CON and 15-32033-CON)

Condition	D&T Procedure
<p><b>Strategic Plan</b></p> <p><u>15-32033-CON Condition 4:</u> Within one hundred and eighty (180) days following the Closing Date of 9/8/16, YNHHS shall submit a plan demonstrating how health care services will be provided by L+MH for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and YNHHS. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p> <p>NOTE 1: This applies only to Eastern Connecticut which has been defined in the Affiliation Agreement as Tolland, Windham and New London counties.</p> <p>Note 2: Refer to Condition #19 which addresses the same/similar requirements</p>	<p>D&amp;T will obtain a copy of the Services Plan, verify timely submission, verify that it incorporates the required elements and that it meets the 3-5 year requirement.</p>
<p><u>15-32033-CON Condition 19:</u> L+M and YNHHS shall develop a strategic plan to focus on the retention and enhancement of healthcare services in the primary service area, i.e. towns served by L+M, which assures patient affordability and is consistent with appropriate standards of care, quality, and accessibility. Such plan shall seek to minimize travel for patients requiring clinical services that can be provided appropriately at L+M service sites, and to support the return of patients back to L+M and its medical staff for care should patients be referred to other YNHHS affiliated facilities for specialized care not available locally. The strategic plan shall include but not be limited to the following components:</p> <ol style="list-style-type: none"> <li>a. L+M shall enhance access to primary care physician services in the Eastern Connecticut region by recruiting and retaining eight additional primary care providers and other providers required to respond to local community need, in accordance with the community needs assessment in paragraph 31 herein and shall accommodate improvements to delivery models including value based care during such</li> </ol>	<p>D&amp;T will obtain the Plan and review the plan for inclusion of these required elements.</p>

Condition	D&T Procedure
<p>period. L+M shall demonstrate annual progress toward achieving these goals.</p> <p>b. YNHHS C and L+M shall abide by the resource commitments for clinical service programming as set forth in the Affiliation Agreement.</p> <p>NOTE 1: Refer to Condition #4 which addresses the same/similar requirements.</p>	
<p><u>15-32033-CON Condition 32b</u>: A narrative description of the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by L+M, including with respect to physician recruitment and resource commitments for clinical service programming, whether the commitments described in the Affiliation Agreement were achieved, as well as the purposes, dates and amounts for which expenditures were made.</p>	<p>For 15-32033-CON Condition 32 requirements a through e and g, D&amp;T will obtain a copy of YNHHS C’s Management Representation to OHCA that Condition 32 requirements a through e and g have been met.</p>
<p><u>15-32033-CON Condition 7</u>: Within one hundred and eighty (180) days following the Closing Date and thereafter until the capital commitment <sup>1</sup>is satisfied, YNHHS C shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in L+M and its affiliates from the \$300M Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:</p> <p>a. A list of the capital expenditures <sup>2</sup>that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and</p> <p>b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and</p>	<p>D&amp;T will obtain the Plan (per 15-32033-CON Conditions #4 and #19). We will read the plan and verify that expenditures/investments made are in accordance with the Plan. D&amp;T will confirm timely submissions of all required reports.</p>

<sup>1</sup> Per discussion with OHCA, we understand that “capital requirement” per this Order is intended to mean “resource commitment”. YNHHS C will describe the plan/resource commitment per Conditions #4 and #19 of this Order.

<sup>2</sup> See footnote 4.

Condition	D&T Procedure
<p>c. The funding source of the capital investment<sup>3</sup> indicating whether it was drawn from operating revenue, capital contributions from YNHHS or another source and, if funding was drawn from another source, indicating the source.</p> <p>For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th beginning, November 30, 2016. The reports shall be signed by L+MH's or L+M's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project.</p>	
<p><u>15-32033-CON Condition 5</u>: Until such time as the Services Plan is submitted<sup>4</sup>, YNHHS shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for L+MH specific to those services that existed at L+MH as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: Cross-reference to Condition #18</p>	<p>D&amp;T will confirm that notices of reallocation or relocation were submitted in a timely manner and published on the L+MH website within ten days.</p> <p>Per related 15-32033-CON Condition #18, D&amp;T will confirm that any changes or reallocation of services are not in conflict with the requirements of 15-32033-CON Condition #18.</p>

<sup>3</sup> Per discussion with OHCA, we understand that “capital investment” per this Order is intended to mean expenditures/investment made”.

<sup>4</sup> The Services Plan is due 180 days after the closing date of September 8, 2016. Therefore this provision only applies until the Services Plan per Condition #4 is submitted.

Condition	D&T Procedure
<p><u>15-32033-CON Condition 18:</u> L+MH shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need.</p> <p>NOTE 1: See related Condition #1 which applies to the first 180 dates post-closing. Following that time, YNHHS is bound by Condition #4 and the Services Plan created per Condition #4</p>	<p>D&amp;T will confirm that these services are properly maintained by conducting site visits, and ongoing data analysis of unit and patient data.</p> <p>YNHHS will provide a Management Attestation/Representation to OHCA that it is in compliance with 15-32033-CON Condition #18. D&amp;T will obtain a copy of that Management Representation.</p>
<p><u>15-32033-CON Condition 32a:</u> Every six months ( the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHHS shall submit notarized reports to OHCA for the periods of January to June (due July 31") and July through December (due January 31' certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <p>a. Affirmation of the continuation of all L+MH services as described herein.</p>	<p>For 15-32033-CON Condition 32 requirements a through e and g, D&amp;T will obtain a copy of YNHHS's Management Representation to OHCA that 15-32033-CON Condition 32 requirements a through e and g have been met.</p>
<b>Financial Reporting</b>	
<p><u>15-32033-CON Condition 8:</u> For three (3) years following the Closing Date, YNHHS shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30<sup>th</sup>, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report: (i) <b>Operating performance</b> to include operating margin, non-operating margin, and total margin; (ii) <b>Liquidity</b> to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) <b>Leverage and capital structure</b> to include long-term debt to equity, long-term debt to capitalization, unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and equity financing ratio; and (iv) <b>Additional Statistics</b> to include income from operations, revenue over (under) expense, cash from operation, cash and cash equivalents, net working capital, free cash flow (and the elements</p>	<p>D&amp;T will obtain the financial measurement report and read to confirm that the required elements are addressed in the report; we will confirm the timely submission of each report.</p>

Condition	D&T Procedure
<p>used in the calculation, unrestricted net assets/retained earnings, bad debt as a percentage of gross revenue, and credit ratings.</p>	
<p><u>15-32033-CON Condition 32f</u>: A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHS's information technology systems and platforms, YNHHS's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHS population health initiatives. Subsequent to submission of the plan in its six month report, YNHHS shall include the following additional information in its annual report.</p> <ol style="list-style-type: none"> <li data-bbox="321 835 951 1003">i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M of YNHHS non-clinical shared services opportunities;</li> <li data-bbox="321 1037 951 1604">ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHS shall also file a narrative describing the specifics of the cost savings for each of these major expense categories;</li> <li data-bbox="321 1638 951 1869">iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and</li> </ol>	<p>For 15-32033-CON Condition #32F, D&amp;T will obtain the Five-Year Plan prepared by YNHHS and the ongoing six month reports. We will verify that the required elements are included in the report. We will confirm timely submission to OHCA.</p>

Condition	D&T Procedure
<p>iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.</p>	
<p><u>15-32032-CON Condition 7c</u>: Every six months (the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHHS shall submit notarized reports to OHCA for the periods of January to June (due July 31<sup>st</sup>) and July through December (due January 31<sup>st</sup>) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <p>A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHS information technology systems and platforms, YNHHS's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHS population health initiatives. Subsequent to submission of the plan in its six month report, YNHHS shall include a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and</p>	<p>Refer to procedures for 15-32033-CON Condition #32f in the work plan above.</p>
<p><u>15-32033-CON Condition 6</u>: Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price<sup>5</sup> per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period September 1, 2015-August 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the</p>	<p>D&amp;T will obtain YNHHS's analysis of the top 25 most frequent MS-DRGs and CPT codes and related weighted average price information.</p> <p>D&amp;T will confirm the timely submission of YNHHS's filings as required by this Order.</p> <p>* 1<sup>st</sup> filing is due within 180 days (March 2017); 2<sup>nd</sup> filing is due 60 days after the close of FY2017</p>

<sup>5</sup> Per guidance from OHCA, "total prices per unit of service" is meant to be the weighted average price across all payers per unit of service.

Condition	D&T Procedure
<p>proposed transfer of ownership does not adversely affect health care costs.</p>	<p>which is 11/30/17 and the 3<sup>rd</sup> filing is due 60 dates after the close of FY2018 which is 11/30/18.</p>
Cost and Market Impact Review	
<p><u>15-32033-CON Condition 22</u>: Within ninety days of the Date of Closing, YNHHS shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below:</p> <ol style="list-style-type: none"> <li>a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHS shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.</li> <li>b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low</li> </ol>	<p>D&amp;T will confirm that YNHHS initiated this review within 90 days of closing. D&amp;T will also confirm that the analysis addresses the required elements.</p> <p>D&amp;T will obtain a copy of the CMIR performed by the Independent Consultant.</p> <p>D&amp;T will meet annually with the Independent Consultant.</p>

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- margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.
- c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purposes of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases.
  - d. The independent consultant shall report to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area.
  - e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR

Condition	D&T Procedure
<p>and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHS and L+M, unless required to do by law.</p>	
<p><u>15-32032-CON Condition 3</u>: Within ninety days of the Date of Closing, YNHHS shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below:</p> <ol style="list-style-type: none"> <li>a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined in D. below) for L+MH and LMMG (the "annual CMIR update"). Yale New Haven shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.</li> <li>b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 10a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant</li> </ol>	<p>Refer to procedures for 15-32033-CON Condition #22 above.</p>

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to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.

- c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHS, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHS shall meet and confer for the purpose of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHS is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases.
- d. The independent consultant shall take direction from the Commissioner of the Department of Public Health. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area.
- e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHS and L+M, unless required to do so by law. The confidential information and documents shall not be public records and shall be exempt from disclosure under Connecticut General Statute Section 1-210.

Condition	D&T Procedure
<p><u>15-32033-CON Condition 23:</u> For purposes of determining the price per unit of service:</p> <ul style="list-style-type: none"> <li>f. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures.</li> <li>g. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state.</li> <li>h. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU).</li> <li>i. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service.</li> <li>j. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.</li> </ul>	<p>D&amp;T will obtain a copy of the CMIR performed by the Independent Consultant.</p> <p>D&amp;T will meet annual with the Independent Consultant.</p> <p>D&amp;T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.</p>
<p><u>15-32032-CON Condition 4:</u> For purposes of determining the price per unit of service:</p> <ul style="list-style-type: none"> <li>a. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of</li> </ul>	

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insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures.

- b. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state.
- c. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU).
- d. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service.
- e. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.

Condition	D&T Procedure
<p><u>15-32033-CON Condition 20a</u>: L+M and YNHHSC shall maintain the current L+MH and Lawrence &amp; Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017 shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.</p>	<p>D&amp;T will evaluate and verify that contracts are maintained in accordance with this condition.</p>
<p><u>15-32033-CON Condition 32c</u>: Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of paragraphs (20), (21) and (22) above.</p>	<p>For 15-32033-CON Condition 32c, D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32c requirements have been met.</p>
<p><u>15-32032-CON Condition 1</u>: Lawrence &amp; Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017 shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.</p> <p>Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHSC shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation. YNHHSC shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut.</p>	<p>Refer to procedures for 15-32033-CON Condition #20 above.</p>

Condition	D&T Procedure
<p>For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to a cap determined through the process set forth in Paragraphs 3 and 4 below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.</p>	
<p><u>15-32032-CON Condition 7a</u>: Every six months (the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHHS shall submit notarized reports to OHCA for the periods of January to June (due July 31<sup>st</sup>) and July through December (due January 31<sup>st</sup>) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <ol style="list-style-type: none"> <li>a. Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of paragraphs (20), (21) and (22) above.</li> </ol>	<p>Refer to procedures for 15-32033-CON Condition #32f.</p>
<p><u>15-32033-CON Condition 20b</u>: Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHS shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation and in addition as set forth in paragraph 25 herein. YNHHS shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut.</p>	<p>D&amp;T will obtain the Independent Consultant/CMIR Report which should address/provide analysis to confirm paragraphs 2 and 3 of 15-32033-CON Condition #20. D&amp;T as the Monitor will not independently perform additional/separate procedures related to paragraphs 2 and 3 of 15-32033-CON Condition #20.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 21a:</u> With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph 20 above, i.e. physicians providing services through NEMG to L + M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.</p>	<p>Refer to procedures related to 15-32033-CON Conditions #4 and #19 (the Services Plan). D&amp;T will obtain YNHHS's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21a.</p>
<p><u>15-32032-CON Condition 2a:</u> With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph I above, i.e. physicians providing services through NEMG to L+M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.</p>	<p>Refer to procedures for 15-32033-CON Condition #21a above.</p>
<p><u>15-32033-CON Condition 21b:</u> With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>Physicians who are hired, recruited or contracted by a YNHHS affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 20: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 20.</p>	<p>D&amp;T will obtain YNHHS's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21b.</p>

Condition	D&T Procedure
<p><u>15-32032-CON Condition 2b:</u> With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>b. Physicians who are hired, recruited or contracted by a YNHHS affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 1: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 1.</p>	<p>Refer to procedures for 15-32033-CON Condition #21 above.</p>
<b>Independent Monitor</b>	
<p><u>15-32033-CON Condition 15:</u> Within sixty (60) days after the Closing Date, YNHHS shall contract with an Independent Monitor who has experience in hospital administration and regulation. The Independent Monitor shall be retained at the sole expense of YNHHS. Representatives of OHCA and FLIS will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years<sup>6</sup> following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the conditions set forth herein.</p>	<p>D&amp;T and YNHHS will execute an Engagement Letter by the required date. A copy of this Engagement Letter will be provided to OHCA.</p>

<sup>6</sup> The Monitor may be required for only 1 (one) year or up to five (5) years as determined in writing by OHCA.

Condition	D&T Procedure
<p>NOTE: See Condition #33a (appointment of Monitor requirement)</p>	
<p><u>15-32033-CON Condition 33</u>: In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing:</p> <ol style="list-style-type: none"> <li>a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor.</li> <li>b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.</li> <li>c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties.</li> <li>d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.</li> <li>e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate connective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material</li> </ol>	<p>For 15-32033-CON Condition #33a, refer to 15-32033-CON Condition #15.</p> <p>15-32033-CON Condition #33b – D&amp;T will meet with CHNA/CHIP Steering Committee in March 2017 for an initial introduction and will meet with this group annually thereafter to present the annual Monitor report. Relative to (ii), Refer to the procedures performed per Conditions #11 and #31. Minutes will be maintained by D&amp;T of these meetings and provided to OHCA upon request.</p> <p>With respect to 15-32033-CON #33d, D&amp;T will confirm that YNHHSC has held a public forum including members of the CHIP (Community Health Improvement Program) group.</p> <p>With respect to 15-32033-CON #33e, D&amp;T agrees to provide written notice of any deficiencies as required.</p>

Condition	D&T Procedure
<p>negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653. In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.</p>	
<p><u>15-32032-CON Condition 8</u>: In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing:</p> <ol style="list-style-type: none"> <li>a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor.</li> <li>b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.</li> <li>c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties.</li> <li>d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.</li> <li>e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing</li> </ol>	<p>Refer to procedures for 15-32033-CON Condition #33 a through e above.</p>

Condition	D&T Procedure
<p>regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHS and L+M for the purpose of determining compliance and any appropriate corrective action plan. If YNHHS and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHS and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653 In addition, in the event OHCA determines YNHHS and L+M are in material non-compliance, OHCA may order YNHHS and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.</p>	
<p><u>15-32033-CON Condition 16</u>: The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis<sup>7</sup> to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHS will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall di with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.</p>	<p>D&amp;T will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration/Leadership. D&amp;T will provide a report that summarizes the activities from the prior six month period along with any recommendations or observations to YNHHS, OHCA, and FLIS.</p> <p>Procedures associated with 15-32033-CON Condition #16 are expected to coincide/satisfy 15-32033-CON Conditions 33b and 33d as well.</p>

<sup>7</sup> The semi-annual basis will be defined as six months post-closing and on the anniversary of the closing date to coincide with meetings with the community representatives per Conditions # 33b and 33d

Condition	D&T Procedure
<p data-bbox="180 352 428 386"><b>Community Benefit</b></p> <p data-bbox="180 443 935 772"><u>15-32033-CON Condition 11:</u> The Applicants shall maintain community benefit programs and community building activities for L+MH for three (3) years after the Closing Date consistent with L+MH's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as L+MH's current programs, and the Applicants shall apply no less than a 1% increase per year for the next three (3) years toward the L+MH's community building activities in terms of dollars spent.</p> <p data-bbox="180 810 932 1010">In determining L+MH's participation and investment in both community benefits and community building activities, the Applicants shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.</p> <p data-bbox="228 1047 948 1413">a. On an annual basis, YNHHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing for three years and shall be posted on L+MH's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p data-bbox="967 443 1369 705">D&amp;T will obtain L+MH's most recent Schedule H of IRS Form 990 to act as a baseline. We will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase requirement has been met.</p> <p data-bbox="967 726 1369 1056">D&amp;T will also obtain the YNHHSC report/summary on the amounts and uses related to community benefits and community building per the categories identified in the CHNA. D&amp;T will confirm that these documents are filed in a timely manner and posted to the L+MH website.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 31:</u> L+M and YNHHSC have agreed to maintain at least the same level of community benefit consistent with L+M's most recent Schedule H of IRS Form 990 and its Community Health Needs Assessment (CHNA). L+M and YNHHSC agree to conduct an updated Community Health Needs Assessment by no later than December 31, 2016, and provide services in accordance with implementation plan adopted as part of the updated CHNA process and provide OHCA with its updated CHNA within thirty days of its approval.</p>	<p>After obtaining L+M's baseline Schedule H of IRS Form 990, D&amp;T will obtain and confirm that L+M and YNHHSC have increased community benefit by 1% per year for the first three (3) years of this agreement. Thereafter for years 4 and 5, we will confirm that the level of community benefit provided in year 3 was at least maintained (not required to increase in years 4 and 5).</p> <p>Cross-reference to 15-32033-CON Condition #11.</p>
<p><u>15-32033-CON Condition 32h:</u> A narrative description of L+M's community benefit commitments described herein, including without limitation the amounts spent and a description of such spending to support and invest in the communities that L+M serves.</p>	<p>Relative to 15-32033-CON Condition #32h, see procedures performed for 15-32033-CON Conditions #11 and #31.</p>
<p><u>15-32033-CON Condition 12:</u> The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. Specifically, the Applicants shall ensure that L+MH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the Applicants shall provide at L+MH, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the Applicants shall ensure that L+MH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, YNHHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population.</p>	<p>D&amp;T will obtain and review interpreter services policies and contracts as applicable. Additionally, our team will obtain a cultural competency plan, training, as well as related policies. We will also obtain YNHHSC's report and supporting documents and confirm the timely filing of these materials.</p>

Condition	D&T Procedure
<b>Charity Care Policies</b>	
<p><u>15-32033-CON Condition 9</u>: Following the Closing Date, L+MH will adopt YNHHS's financial assistance (charity and free care) policies or adopt other policies that are at least as generous and benevolent to the community as L+MH's current policies, consistent with state and federal law. These policies shall be posted on the website pages of L+MH and as additionally required by applicable law, OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>Deloitte will obtain copies of the relevant financial assistance policies and confirm that L+MH has adopted YNHHS's financial assistance policies (or policies at least as generous as these policies) using management approval of the policies as evidence. After verifying that this step has been properly completed, we will confirm that these policies are properly posted on L+MH's website.</p>
<p><u>15-32033-CON Condition 10</u>: For three (3) years following the Closing Date, YNHHS shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of L+MH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of L+MH simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>After obtaining original L+MH policies on charity care, indigent care, and community volunteer services, D&amp;T will read and assess these policies on an annual basis for changes. When changes are made to these policies, we will confirm OHCA is notified (as required) and revised policies are posted to the L+MH website.</p>
<p><u>15-32033-CON Condition 32e</u>: Affirmation that L+M has adopted the YNHHS Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHS Financial Assistance Program Policies currently in effect as of the date hereof.</p>	<p>For 15-32033-CON Condition 32 requirements a through e and g, D&amp;T will obtain a copy of YNHHS's Management Representation to OHCA that Condition 32 requirements a through e and g have been met.</p>
<b>Employment Conditions</b>	
<p><u>15-32033-CON Condition 27</u>: L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.</p>	<p>D&amp;T will obtain a copy of YNHHS's Management Representation to OHCA that 15-32033-CON Condition #27 has been met.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 32g</u>: Affirmation of the labor and employment commitments described herein, including but not limited to L+M's service sites continued honoring of collective bargaining agreements in place as of the date hereof.</p>	<p>See others below</p>
<p><u>15-32033-CON Condition 28</u>: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).</p>	<p>D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #28 has been met.</p>
<p><u>15-32032-CON Condition 6</u>: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).</p>	<p>Refer to procedures for 15-32033-CON Condition #28.</p>
<p><u>15-32033-CON Condition 29</u>: L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.</p>	<p>D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #29 has been met.</p>
<p><u>15-32033-CON Condition 30</u>: L+M and YNHHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.</p>	<p>D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #30 has been met.</p>
<p><b>Governance</b></p>	

Condition	D&T Procedure
<p><u>15-32033-CON Condition 14</u>: For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as voting members of L+MH' s Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>Verify that the designated Board member(s) meet this condition, as confirmed by OHCA.</p>
<p><u>15-32033-CON Condition 17</u>: For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHS Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>To confirm compliance with this provision, D&amp;T will obtain minutes from these Joint Board Meetings and confirm that notice of the public meetings is posted with proper notice.</p> <p>D&amp;T will attend the public meetings as part of the Monitor role.</p>
<p><u>15-32033-CON Condition 26</u>: As described in the Affiliation Agreement, YNHHS is committed to maintaining local governance at L+M. The L+M Board of Directors shall continue as a fiduciary board composed of a majority of members who reside in the communities served by L+M with the only change in composition being the addition of the President/CEO of YNHHS (or his or her designee) serving as an ex-officio member. Each director of the L+M Board of Directors shall have an equal vote. The L+M Board shall be empowered and supported to oversee local performance and to create and sustain connections with the community. Subject to certain reserved powers for YNHHS, the L+M Board of directors will have the right to approve any major new programs and clinical services, or the discontinuation or consolidation of any such programs.</p>	<p>D&amp;T will obtain and evaluate the Board of Directors bylaws to confirm that L+M Board maintains rights and powers specified in the Order.</p>
<p><b>Licensure, Physician Office Conversion, Cost Savings Attainment</b></p>	
<p><u>15-32033-CON Condition 13</u>: The Applicants shall abide by all requirements of licensure that may be imposed by the Facility Licensing and Investigations Section ("FLIS") of the Department of Public Health ("DPH") in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA</p>	<p>D&amp;T will obtain the survey/certification results as applicable (if surveys occur). We will confirm licensure via an</p>

Condition	D&T Procedure
is imposing this Condition to ensure that quality health care services are provided to the patient population.	annual YNHHSC Management Representation.
<u>15-32033-CON Condition 24</u> : L+M and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #24 has been met.
<u>15-32033-CON Condition 32d</u> : Affirmation that no L+M physician office has been converted to hospital-based status.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #32d has been met.
<u>15-32032-CON Condition 5</u> : L+MH and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.	Refer to procedures for 15-32033-CON Condition #24 above.
<p><u>15-32032-CON Condition 7b</u>: Every six months (the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of January to June (due July 31st) and July through December (due January 31st) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <p>Affirmation that no L+M physician office has been converted to hospital-based status.</p>	Refer to procedures for 15-32033-CON Condition #32f above.
<u>15-32033-CON Condition 25</u> : L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application.	D&T will obtain and read YNHHSC's reporting created per 15-32033-CON condition #32f.

**Reference documents:**

Name	title	Organization	email	comments
<b>Participants in the CHA/CHIP process:</b>				
Megan Brown	Senior Director of Marketing and Development	TVCCA	<a href="mailto:megan.brown@tvcca.org">megan.brown@tvcca.org</a>	neutral on affiliation allied with intervenors; connected to NAAACP and NL Housing Authority
Stephanye Clarke	Communications Coordinator	Universal Health Foundation	<a href="mailto:stephanyclarke@gmail.com">stephanyclarke@gmail.com</a>	pro on affiliation
Nancy Cowser	Senior VP of Strategy	United Community and Family Services	<a href="mailto:ncowser@ucfs.org">ncowser@ucfs.org</a>	neutral; attorney
Jim Haslam	Chair	NL County Food Policy Council	<a href="mailto:jhaslam@connlegalservices.org">jhaslam@connlegalservices.org</a>	neutral to pro
Jerry Lokken	Recreation Services Manager	Groton Parks and Recreation	<a href="mailto:jlokken@town.groton.ct.us">jlokken@town.groton.ct.us</a>	pro
Alejandro Melendez-Cooper	President	Hispanic Alliance	<a href="mailto:pacopeco48@gmail.com">pacopeco48@gmail.com</a>	neutral; co-leader of the CHA and CHIP
Russ Melmed	Epidemiologist	Ledge Light Health District	<a href="mailto:rmmelmed@lhd.org">rmmelmed@lhd.org</a>	
Pat McCormack	Director of Health	Uncas Health District	<a href="mailto:doh@uncashd.org">doh@uncashd.org</a>	I'm not sure his stance but may be somewhat cautious due to Norwich experience with Hartford HC
Jeanne Milstein	Director, Human Services	City of New London	<a href="mailto:jmilstein@ci.New-London.ct.us">jmilstein@ci.New-London.ct.us</a>	neutral
Jennifer O'Brien	Program Director	Community Foundation of Eastern CT	<a href="mailto:jennob@cfect.org">jennob@cfect.org</a>	neutral
Tracee Reiser	Associate Dean for Community Learning, Associate Director Holleran Center	Connecticut College	<a href="mailto:tirei@conncoll.edu">tirei@conncoll.edu</a>	neutral to cautious; long-time community partner
Dianna Rodriguez	Behavioral health provider	Community Health Center, Inc.	<a href="mailto:rodridgd@chc1.com">rodridgd@chc1.com</a>	likely neutral
Chris Soto	Director	Higher Edge	<a href="mailto:chris@higheredget.org">chris@higheredget.org</a>	likely neutral; also likely to be elected State Rep
Victor Villagra, MD	Director	UCONN Health Disparities Institute	<a href="mailto:victor.villagra@gmail.com">victor.villagra@gmail.com</a>	neutral
<b>Hospital Corporators offered by Bill Stanley</b>				
Jane Lassen Bobruff	volunteer	n/a	<a href="mailto:nealane@aol.com">nealane@aol.com</a>	pro
Ann Burdick	volunteer	n/a	860-443-4236	pro
Karen Hatcher		Mashantucket Pequots	<a href="mailto:khatcher@prxn.com">khatcher@prxn.com</a>	pro
Dan O'Shea	retired Pfizer exec.		<a href="mailto:danooshea@snet.net">danooshea@snet.net</a>	pro
Ricardo Ochoa	retired Pfizer exec., former board planning committee		860-235-5459	pro
Verna Swann	volunteer, retired L+M employee		<a href="mailto:vswann@yahoo.com">vswann@yahoo.com</a>	pro

## Greer, Leslie

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**From:** Roberts, Karen  
**Sent:** Monday, November 07, 2016 9:41 AM  
**To:** Capozzalo, Gayle; Nancy.Rosenthal@greenwichhospital.org  
**Cc:** Furniss, Wendy; Ortelle, Donna; Cass, Barbara; Martone, Kim; Cotto, Carmen; ksauders@deloitte.com  
**Subject:** Re: Independent Monitor for Certificate of Need Docket #s 15-32032-CON and 15-32033-CON

Dear Gayle and Nancy

Below please find two emails regarding the Yale-New Haven Hospital selection for Independent Monitor for the above noted Docket Numbers. With these two emails, both the Office of Health Care Access (OHCA) and the Health Care Quality and Safety/Facility Licensing and Inspections (FLIS) section of the Department of Public Health provide their approval of the Independent Monitor chosen by YNHSC, as required by the CON orders for these two CON orders. YNHSC may now proceed to finalize this contractual arrangement and should provide OHCA with a copy of documents for the CON public records. Thank you for your cooperation in this matter.

Sincerely,

*Karen Roberts*

Principal Health Care Analyst  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308  
P: (860) 418-7041 / F: (860) 418-7053 / E: [karen.roberts@ct.gov](mailto:karen.roberts@ct.gov)



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**From:** Martone, Kim  
**Sent:** Monday, November 07, 2016 7:58 AM  
**To:** Cass, Barbara  
**Cc:** Roberts, Karen; Furniss, Wendy; Ortelle, Donna  
**Subject:** RE: Deloitte

Thank you Barbara. OHCA approves Deloitte as well to serve as the Independent Monitor for the Yale L&M acquisition.

Kim

**Kimberly R. Martone**

Director of Operations, Office of Health Care Access

Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



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**From:** Cass, Barbara  
**Sent:** Friday, November 04, 2016 5:50 PM  
**To:** Martone, Kim  
**Cc:** Roberts, Karen; Furniss, Wendy; Ortelle, Donna  
**Subject:** Deloitte

Dear Kim:

Thank you very much for including the Department of Public Health Facility Licensing and Investigations Section (FLIS) in the conference call with Deloitte to assess their ability to act as the Independent Monitor (IM) for the Yale New Haven Hospital/Lawrence and Memorial Hospital acquisition. Pursuant to the information Deloitte provided regarding capacity to assess hospital systems and their availability to access clinicians, FLIS approves Deloitte as capable of serving in the capacity of the IM if the Office of Health Care Access is also in agreement.

Best,

Barbara

Barbara S. Cass, R.N.  
Section Chief  
Facility Licensing and Investigations Section  
State of Connecticut, Department of Public Health  
410 Capitol Avenue  
Hartford, CT 06134  
Telephone: 860-509-7609  
[Barbara.cass@ct.gov](mailto:Barbara.cass@ct.gov)

## Greer, Leslie

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**From:** Roberts, Karen  
**Sent:** Tuesday, November 08, 2016 8:15 AM  
**To:** Greer, Leslie; Cotto, Carmen  
**Cc:** Martone, Kim; Hansted, Kevin  
**Subject:** FW: Independent Monitor for Docket Numbers 15-32032-CON and 15-32033-CON  
**Attachments:** DT-YNHHS Engagement Letter and Workplan.pdf

FYI for Yale's two CON docket #s. Karen

*Karen Roberts*

Principal Health Care Analyst  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308  
P: (860) 418-7041 / F: (860) 418-7053 / E: [karen.roberts@ct.gov](mailto:karen.roberts@ct.gov)



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**From:** Capozzalo, Gayle [<mailto:Gayle.Capozzalo@ynhh.org>]  
**Sent:** Monday, November 07, 2016 5:03 PM  
**To:** Martone, Kim; Roberts, Karen  
**Cc:** Rosenthal, Nancy; 'Sauders, Kelly (US - New York)'; Willcox, Jennifer; Anderson, Maureen (LMHOSP); Aseltyne, Bill; Borgstrom, Marna; Cummings, Bruce (L and M); Tammaro, Vincent; O'Connor, Christopher  
**Subject:** Independent Monitor for Docket Numbers 15-32032-CON and 15-32033-CON

Per OHCAs approval of Deloitte as the Independent Monitor for Docket numbers 15-32032-CON and 15-32033-CON, attached please find an executed engagement letter between Yale New Haven Health Services Corporation and Deloitte. Thank you.

Gayle

Gayle Capozzalo, FACHE  
Chief Strategy Officer  
789 Howard Avenue  
New Haven, CT 06519  
**Phone:** 203-688-2605  
**Fax:** 203-688-3472  
[gayle.capozzalo@ynhh.org](mailto:gayle.capozzalo@ynhh.org)

**YaleNewHavenHealth**



Deloitte & Touche LLP  
30 Rockefeller Plaza  
New York, New York 10112  
Tel: 212-436-3180  
Fax: 212-653-7033  
www.us.deloitte.com

November 7, 2016

Bill Aselyne  
Senior Vice President & General Counsel  
Yale-New Haven Hospital/Yale New Haven Health System  
789 Howard Ave., CB 230  
New Haven, CT 06519

Dear Bill,

This engagement letter is to confirm the engagement of Deloitte & Touche LLP ("D&T" or "we"), effective as of the date hereof, to provide Yale New Haven Health Services Corporation and its subsidiaries (collectively referred to as "YNHHSC" or the "Company") the services described below (the "Services").

### Scope and Approach

We understand you are seeking an independent monitor related to the agreed settlement ("Agreement" or "Order") between YNHHSC and State of Connecticut's Office of Health Care Access ("OHCA") to monitor the YNHHSC's compliance with the Conditions of the Order in the transfer of ownership of Lawrence + Memorial Corporation and its subsidiaries to YNHHSC.

Specific anticipated activities we will assist YNHHSC with will include two work streams:

#### *Workstream 1: Assist YNHHSC with the planning and preparing for monitoring reviews*

- Hold kick-off with YNHHSC responsible persons to discuss the monitor requirements
- Meet with the Connecticut Office of Health Care Access (OHCA), as requested
- Review and agree upon with YNHHSC and OHCA, as applicable, the elements of monitor services as documented in the work plan in Appendix A.

#### *Workstream 2: Assist YNHHSC with the independent monitoring activities*

- Refer to Appendix A for a detailed monitor work plan which describes the various required activities and activities associated with each condition of the Order.

We anticipate providing our services both off-site and on-site. Where possible we will perform analysis and preparation activities remotely. We anticipate providing these services for a period of two to five years (as requested by YNHHSC based on requirements of OHCA).

### Engagement Team

Kelly J. Saunders, Partner, Deloitte & Touche LLP, will serve as the lead engagement leader to provide oversight and direction. Ed Sullivan, Principal, Deloitte & Touche LLP will serve as the quality assurance partner, supporting Kelly and the team in the execution of the work. Kaitlin McCarthy, Manager, Deloitte & Touche LLP, will serve as the overall project manager. Additional support will be provided by other professionals from Deloitte & Touche LLP's Regulatory & Compliance practice, as needed, during the course of this engagement.

### Deliverables

The following deliverables will be produced during the course of this engagement:

#### *Workstream 1: Assist YNHHS with planning and preparing for monitoring reviews*

1. D&T will create and maintain a written plan for fulfilling the duties set forth in the agreement.

#### *Workstream 2: Assist YNHHS with independent monitoring activities*

1. D&T will draft and submit a written report within thirty (30) days of the completion of each (semi-annual) on-site review on YNHHS compliance with the conditions of the Order, totaling two reports per reporting year.

### Professional Fees and Timing

The total fees related to this engagement are estimated as follows:

Year 1: \$180,000 - \$190,000

Years 2 through 5 (as required)\* \$150,000-\$160,000

We will bill for our services based on actual hours incurred at the following billing rates:

Resource Level	Hourly Rate
Partner	\$625
Senior Manager	\$550
Manager	\$510
Senior Consultant	\$445
Consultant	\$380

\* Note that hourly rates will increase approximately 3% per year for years 3, 4 and 5.

This estimated fee and time estimate is based upon our current understanding of the project requirements, our proposed approach, our estimate of the level of effort required, our roles and responsibilities, any assumptions set forth herein, and active participation of Company's management and other personnel. We

plan to meet with you on no less than a quarterly basis to review time incurred and estimates to completion throughout the duration of this engagement.

Based on our experience, issues sometimes arise that require procedures beyond what was initially anticipated. If this should occur, we will discuss it with you promptly and early in the process before we perform any additional work.

We understand that you will reimburse us for all reasonable expenses incurred in performing the Services on this engagement (including, but not limited to, our reasonable travel, meal, lodging, and mileage expenses). Expenses will be noted separately on our invoices and segregated by expense type.

Fees for this engagement will be billed biweekly as the work progresses for fees accrued and expenses incurred by us since our last invoice in performing our Services.

#### **Other Matters**

YNHHSC is, among other things, a regulatory/compliance and merger & acquisition services client of D&T and/ or its affiliated and related entities. We do not believe that the proposed services impair the objectivity for D&T to perform the proposed services for YNHHSC. However, we are bringing this to your attention to avoid any misunderstanding.

Should a potential conflict come to the attention of the engagement leader with respect to potential future work being performed or to be performed by D&T or one of its affiliated or related entities for YNHHSC, D&T will advise YNHHSC promptly. YNHHSC will, at its option and in consultation with the Connecticut Office of Health Care Access as appropriate, promptly request, in writing, (1) such entity not to proceed with the proposed services or (2) such entity to proceed with the proposed services, provided that such entity agrees to proceed. If YNHHSC requests such entity to proceed with the proposed services, YNHHSC agrees that D&T and its affiliated and related entities' are able to perform the proposed services objectively. If appropriate, such entity will establish an ethical wall and confidentiality safeguards so that the services will be performed by different personnel on the various engagements.

#### **Acknowledgements and Agreements**

The Company specifically acknowledges and agrees to the following:

- Substantial and meaningful involvement of management of the Company is critical to the success of this engagement. The Company shall be responsible for ensuring that the identified Company personnel actively participate in both the planning and execution of this engagement.
- D&T will not make any management decisions, perform any management functions, or assume any management responsibilities.
- The Company agrees that any deliverables provided to the Company hereunder by D&T may be disclosed to the State of Connecticut's Office of Health Care Access ("OHCA") to the extent required by such regulator in connection with an investigation or examination of the Company. To the extent permitted by law, rule, regulation and applicable professional standards, YNHHSC shall be promptly notified in the event such deliverable(s) are provided by D&T to the OHCA.

- Company will limit sensitive information, such as PII, PHI, trade secrets and other information that it considers sensitive or highly confidential, it provides to D&T (or otherwise makes available to D&T) to only that which is reasonably necessary to allow D&T to provide the Services. D&T will provide Company with a list of D&T personnel who are authorized to receive or have access to Company sensitive information. Such list may be updated as needed. Any disclosure of sensitive information by Company to D&T will utilize levels of information security and data encryption appropriate to maintain security of Company sensitive information being accessed by or transferred to D&T, and as required by applicable information protection laws.
- The Services will be performed in accordance with the Statement on Standards for Consulting Services that is issued by the American Institute of Certified Public Accountants ("AICPA"). However, the Services will not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body and, therefore, we will not express an opinion or any other form of assurance as a result of performing the Services.
- We will not provide any legal advice regarding our Services nor will we provide any assurance regarding the outcome of any future audit or regulatory examination or other regulatory action; the responsibility for all legal issues with respect to these matters, such as reviewing all deliverables and work product for any legal implications to the Company, will be the Company's.
- The Services may include advice and recommendations, but all decisions in connection with the implementation of such advice and recommendations shall be the responsibility of, and made by, the Company.

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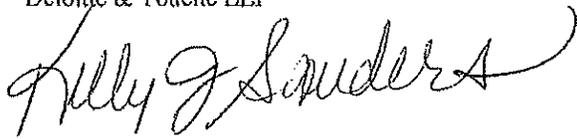
During the term of this engagement, the Company may request that D&T perform additional services that are not encompassed by this engagement letter. D&T may perform such additional services upon receipt of a separate signed engagement letter with terms and conditions that are acceptable to D&T and the Company. Our observations and recommendations will be based solely on the results of the assessment performed.

This engagement letter, together with the General Business Terms attached hereto as Appendix B and the Business Associate Addendum attached hereto as Appendix C and made a part hereof constitute the entire agreement between the Company and D&T with respect to this engagement, supersede all other oral and written representations, understandings, or agreements relating to this engagement, and may not be amended except by the mutual written agreement of the Company and D&T.

Please indicate your acceptance of this agreement by signing in the space below and returning a fully executed copy of this engagement letter to us. A duplicate of this engagement letter is provided for your records. We look forward to serving you. If you have any questions please contact Kelly Saunders at (212) 436-3180.

Very truly yours,

Deloitte & Touche LLP

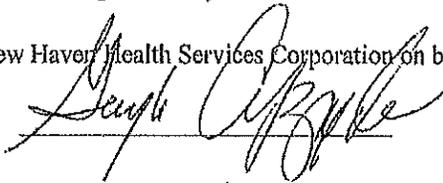


By: Kelly J. Saunders  
Partner

Accepted and Agreed to by:

Yale New Haven Health Services Corporation on behalf of itself and its subsidiaries

By:



Title: Executive VP / chief strategy officer

Date:

11/7/16

**APPENDIX A. MONITORING PROCEDURES (per Docket Numbers 15-32032-CON and 15-32033-CON)**

Condition	D&T Procedure
<p><b>Strategic Plan</b></p>	
<p><u>15-32033-CON Condition 4:</u> Within one hundred and eighty (180) days following the Closing Date of 9/8/16, YNHHS shall submit a plan demonstrating how health care services will be provided by L+MH for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and YNHHS. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.            NOTE 1: This applies only to Eastern Connecticut which has been defined in the Affiliation Agreement as Tolland, Windham and New London counties.            Note 2: Refer to Condition #19 which addresses the same/similar requirements</p>	<p>D&amp;T will obtain a copy of the Services Plan/Strategic Plan submitted for Condition #4 and #19, verify timely submission, verify that it incorporates the required elements (e.g. describing any planned consolidation, reduction, or elimination of existing services or introduction of new services) and that it meets the 3 year requirement.</p>
<p><u>15-32033-CON Condition 19:</u> L+M and YNHHS shall develop a strategic plan to focus on the retention and enhancement of healthcare services in the primary service area, i.e. towns served by L+M, which assures patient affordability and is consistent with appropriate standards of care, quality, and accessibility. Such plan shall seek to minimize travel for patients requiring clinical services that can be provided appropriately at L+M service sites, and to support the return of patients back to L+M and its medical staff for care should patients be referred to other YNHHS affiliated facilities for specialized care not available locally. The strategic plan shall include but not be limited to the following components:</p> <p>a. L+M shall enhance access to primary care physician services in the Eastern Connecticut region by recruiting and retaining eight additional primary care providers and other providers required to respond to local community need, in accordance with the community needs assessment in paragraph 31 herein and shall accommodate improvements to delivery models including value based care during such period. L+M shall demonstrate annual progress toward achieving these goals.</p>	<p>D&amp;T will obtain the Services Plan/Strategic Plan submitted for Condition #4 and #19 and review the plan for inclusion of these required components (as compared to the needs described within the Community Needs Assessment and the resource commitments within the Affiliation Agreement).</p>

Condition	D&T Procedure
<p>b. YNHHC and L+M shall abide by the resource commitments for clinical service programming as set forth in the Affiliation Agreement.</p> <p>NOTE 1: Refer to Condition #4 which addresses the same requirements.</p>	
<p><u>15-32033-CON Condition 32b</u>: A narrative description of the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by L+M, including with respect to physician recruitment and resource commitments for clinical service programming, whether the commitments described in the Affiliation Agreement were achieved, as well as the purposes, dates and amounts for which expenditures were made.</p>	<p>For 15-32033-CON Condition 32 requirements a through e and g, D&amp;T will obtain a copy of YNHHC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met including referencing specific locations of primary care physicians.</p>
<p><u>15-32033-CON Condition 7</u>: Within one hundred and eighty (180) days following the Closing Date and thereafter until the capital commitment <sup>1</sup>is satisfied, YNHHC shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in L+M and its affiliates from the \$300M Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:</p> <p>a. A list of the capital expenditures <sup>2</sup>that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and</p> <p>b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including</p>	<p>D&amp;T will obtain the Plan (per 15-32033-CON Conditions #4 and #19). We will read the plan and verify that expenditures/investments made are in accordance with the Plan. We will discuss any questions/need for clarification with Management to ensure the expenditures are verified.</p> <p>D&amp;T will confirm detailed, full and timely submissions, with appropriate signatures of all required reports.</p>

<sup>1</sup> Per discussion with OHCA, we understand that "capital requirement" per this Order is intended to mean "resource commitment". YNHHC will describe the plan/resource commitment per Conditions #4 and #19 of this Order.

<sup>2</sup> See footnote 4.

Condition	D&T Procedure
<p>estimated beginning, ending all startup/operation dates); and</p> <p>c. The funding source of the capital investment<sup>3</sup> indicating whether it was drawn from operating revenue, capital contributions from YNHHSO or another source and, if funding was drawn from another source, indicating the source.</p> <p>For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th beginning May 31, 2017. The reports shall be signed by L+MH's or L+M's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project.</p>	
<p><u>15-32033-CON Condition 5</u>: Until such time as the Services Plan is submitted<sup>4</sup>, YNHHSO shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for L+MH specific to those services that existed at L+MH as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p> <p>NOTE 1: Cross-reference to Condition #18</p>	<p>D&amp;T will confirm that notices of reallocation or relocation were submitted in a timely manner and published on the L+MH website within ten days.</p> <p>Per related 15-32033-CON Condition #18, D&amp;T will confirm that any changes or reallocation of services are not in conflict with the requirements of 15-32033-CON Condition #18.</p>

<sup>3</sup> Per discussion with OHCA, we understand that "capital investment" per this Order is intended to mean expenditures/investment made".

<sup>4</sup> The Services Plan is due 180 days after the closing date of September 8, 2016. Therefore this provision only applies until the Services Plan per Condition #4 is submitted.

Condition	D&T Procedure
<p><u>15-32033-CON Condition 18</u>: L+MH shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need.</p> <p>NOTE 1: See related Condition #1 which applies to the first 180 dates post-closing. Following that time, YNHHS is bound by Condition #4 and the Services Plan created per Condition #4</p>	<p>D&amp;T will confirm that these services are properly maintained by conducting site visits, and ongoing data analysis of unit and patient data (e.g. to see continuing patient volume/services).</p> <p>YNHHS will provide a Management Attestation/Representation to OHCA that it is in compliance with 15-32033-CON Condition #18. D&amp;T will obtain a copy of that Management Representation.</p>
<p><u>15-32033-CON Condition 32a</u>: Every six months ( the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHS shall submit notarized reports to OHCA for the periods of October 1 – September 30 with reports due November and May certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <p>a. Affirmation of the continuation of all L+MH services as described herein.</p>	<p>For 15-32033-CON Condition 32 requirements a through e and g, D&amp;T will obtain a copy of YNHHS's notarized Management Representation to OHCA that 15-32033-CON Condition 32 requirements a through e and g have been met.</p>
<p><b>Financial Reporting</b></p>	
<p><u>15-32033-CON Condition 8</u>: For three (3) years following the Closing Date, YNHHS shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than two (2) months after the end of each semi-annual period (fiscal year). Due dates are May 31st and November 30<sup>th</sup>, beginning May 2017. The following financial measurements/indicators should be addressed in the report: (i) <b>Operating performance</b> to include operating margin, non-operating margin, and total margin; (ii) <b>Liquidity</b> to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) <b>Leverage and capital structure</b> to include long-term debt to equity, long-term debt to capitalization,</p>	<p>D&amp;T will obtain the financial measurement report and review work papers to ensure that they are consistent with financial reports being submitted to L+M Hospital Board and that the required elements and financial measurements are appropriately recorded in the report; we will confirm the timely submission of each report.</p>

Condition	D&T Procedure
<p>unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and equity financing ratio; and (iv) <b>Additional Statistics</b> to include income from operations, revenue over (under) expense, cash from operation, cash and cash equivalents, net working capital, free cash flow (and the elements used in the calculation, unrestricted net assets/retained earnings, bad debt as a percentage of gross revenue, and credit ratings.</p>	
<p><u>15-32033-CON Condition 32f</u>: A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHS information technology systems and platforms, YNHHS's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHS population health initiatives. Subsequent to submission of the plan in its six month report, YNHHS shall include the following additional information in its annual report.</p> <ul style="list-style-type: none"> <li>i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M of YNHHS non-clinical shared services opportunities;</li> <li>ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHS shall also file a narrative describing the</li> </ul>	<p>For 15-32033-CON Condition #32F, D&amp;T will obtain the Five-Year Plan prepared by YNHHS and the ongoing six month reports based on fiscal year. We will verify that the required elements are included in the report and are documented and supported by underlying information. We will confirm timely submission of all reports (OHCA's, HRS, Report 100, Report 150 and Report 175 and succession reports to OHCA.</p>

Condition	D&T Procedure
<p>specifics of the cost savings for each of these major expense categories;</p> <p>iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and</p> <p>iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.</p>	
<p><u>15-32032-CON Condition 7c</u>: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHS shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31) and April 1 through September 30 (due November 30) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <p>A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHS information technology systems and platforms, YNHHS's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHS population health initiatives. Subsequent to submission of the plan in its six month report, YNHHS shall include a completed Balance Sheet, Statement of Operations, and Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and</p>	<p>Refer to procedures for 15-32033-CON Condition #32f in the work plan above.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 6:</u> Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price<sup>5</sup> per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period October 1, 2015 – September 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the proposed transfer of ownership does not adversely affect health care costs.</p>	<p>D&amp;T will obtain YNHHSCT's analysis of the top 25 most frequent MS-DRGs and CPT codes and related weighted average price information.</p> <p>D&amp;T will review work papers to confirm information and timely filing.</p> <p>* 1<sup>st</sup> filing is due within 180 days (March 2017); 2<sup>nd</sup> filing is due 60 days after the close of FY2017 which is 11/30/17 and the 3<sup>rd</sup> filing is due 60 dates after the close of FY2018 which is 11/30/18.</p>
<b>Cost and Market Impact Review</b>	
<p><u>15-32033-CON Condition 22:</u> Within ninety days of the Date of Closing, YNHHSCT shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below:</p> <p>a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHSCT shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.</p>	<p>D&amp;T will confirm that YNHHSCT initiated this review within 90 days of closing by obtaining a copy of the relevant contract/engagement letter as evidence. D&amp;T will also confirm that the analysis addresses the required elements.</p> <p>D&amp;T will obtain a copy of the CMIR performed by the Independent Consultant.</p> <p>D&amp;T will meet annually with the Independent Consultant.</p>

<sup>5</sup>For purposes of this calculation, "total prices per unit of service" will be the weighted average price across all payers per unit of service.

Condition	D&T Procedure
<p>b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.</p>	
<p>c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHS, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHS shall meet and confer for the purposes of determining further conditions as necessary to</p>	

Condition	D&T Procedure
<p>correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHS is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases.</p> <p>d. The independent consultant shall report to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area.</p> <p>e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHS and L+M, unless required to do by law.</p>	
<p><u>15-32032-CON Condition 3:</u> Within ninety days of the Date of Closing, YNHHS shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below:</p> <p>a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined in d. below)</p>	<p>Refer to procedures for 15-32033-CON Condition #22 above.</p>

Condition	D&F Procedure
<p>for L+MH and LMMG (the "annual CMIR update"). Yale New Haven shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.</p> <p>b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 10a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.</p> <p>c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in</p>	

Condition	D&T Procedure
<p>the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHS, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHS shall meet and confer for the purpose of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHS is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases.</p> <p>d. The independent consultant shall take direction from the Commissioner of the Department of Public Health. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area.</p> <p>e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHS and L+M, unless required to do so by law. The confidential information and documents shall not be public records and shall be exempt from disclosure under Connecticut General Statute Section 1-210.</p>	

Condition	D&T Procedure
<p><u>15-32033-CON Condition 23:</u> For purposes of determining the price per unit of service:</p> <ul style="list-style-type: none"> <li>f. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures.</li> <li>g. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state.</li> <li>h. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU).</li> <li>i. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service.</li> <li>j. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.</li> </ul>	<p>D&amp;T will obtain a copy of the CMIR performed by the Independent Consultant. D&amp;T will meet annually with the Independent Consultant.</p> <p>D&amp;T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.</p>
<p><u>15-32032-CON Condition 4:</u> For purposes of determining the price per unit of service:</p> <ul style="list-style-type: none"> <li>a. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-</li> </ul>	<p>D&amp;T will obtain a copy of the CMIR performed by the Independent Consultant.</p>

Condition	D&T Procedure
<p>10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures.</p> <p>b. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state.</p> <p>c. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU).</p> <p>d. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service.</p> <p>e. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.</p>	<p>D&amp;T will meet annually with the Independent Consultant.</p> <p>D&amp;T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 20 Paragraph 1:</u> L+M and YNHHSC shall maintain the current L+MH and Lawrence + Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017 shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.</p>	<p>D&amp;T will evaluate and verify that contracts are maintained in accordance with this condition. We will meet with YNHHSC Management to read the contracts and confirm that this condition is met.</p>
<p><u>15-32033-CON Condition 32c:</u> Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of Conditions (20), (21) and (22) above.</p>	<p>For 15-32033-CON Condition 32c, D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32c requirements have been met. We will meet with YNHHSC Management to read the contracts and confirm that this condition is met.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 20 Paragraphs 2/3</u>: Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHS shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation and in addition as set forth in paragraph 25 herein. YNHHS shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut.</p> <p>For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to cap determined through the process set forth below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.</p>	<p>D&amp;T will obtain the Independent Consultant/CMIR Report which should address/provide analysis to confirm paragraphs 2 and 3 of 15-32033-CON Condition #20. D&amp;T as the Monitor will not independently perform additional/separate procedures related to paragraphs 2 and 3 of 15-32033-CON Condition #20.</p>

Condition	D&T Procedure
<p><u>15-32032-CON Condition 1:</u> Lawrence &amp; Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017 shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.</p> <p>Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHS shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation. YNHHS shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut.</p> <p>For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to a cap determined through the process set forth in Paragraphs 3 and 4 below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.</p>	<p>Refer to procedures for 15-32033-CON Condition #20 outlined here and 1532033-CON Condition 20a, 20b and 20c.</p>

Condition	D&T Procedure
<p><u>15-32032-CON Condition 7a</u>: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHS shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31) and April 1 through September 30 (due November 30) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <p>a. Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of paragraphs (20), (21) and (22) above.</p>	<p>Refer to procedures for 15-32033-CON Condition #32c.</p>
<p><u>15-32033-CON Condition 21a</u>: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph 20 above, i.e. physicians providing services through NEMG to L + M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.</p>	<p>D&amp;T will receive samples of payer submissions for LMMG physicians and obtain YNHHS's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21a.</p>

Condition	D&T Procedure
<p><u>15-32032-CON Condition 2a:</u> With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph I above, i.e. physicians providing services through NEMG to L+M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.</p>	<p>Refer to procedures for 15-32033-CON Condition #21a above.</p>
<p><u>15-32033-CON Condition 21b:</u> With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>Physicians who are hired, recruited or contracted by a YNHHS affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 20: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 20.</p>	<p>D&amp;T will obtain YNHHS's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21b.</p>

Condition	D&T Procedure
<p><u>15-32032-CON Condition 2b:</u> With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>b. Physicians who are hired, recruited or contracted by a YNHHS affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 1: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 1.</p>	<p>Refer to procedures for 15-32033-CON Condition #21b above.</p>
<b>Independent Monitor</b>	
<p><u>15-32033-CON Condition 15:</u> Within sixty (60) days after the Closing Date, YNHHS shall contract with an Independent Monitor who has experience in hospital administration and regulation. The Independent Monitor shall be retained at the sole expense of YNHHS. Representatives of OHCA and FLIS will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years<sup>6</sup> following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the</p>	<p>D&amp;T and YNHHS will execute an Engagement Letter by the required date. A copy of this Engagement Letter will be provided to OHCA.</p>

<sup>6</sup> The Monitor may be required for only 1 (one) year or up to five (5) years as determined in writing by OHCA.

Condition	D&T Procedure
<p>Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the conditions set forth herein.</p> <p>NOTE: See Condition #33a (appointment of Monitor requirement)</p>	
<p><u>15-32033-CON Condition 16:</u> The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis<sup>7</sup> to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHSO will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.</p>	<p>D&amp;T will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration/Leadership and review of any documentation requested by D&amp;T. D&amp;T will provide a report that summarizes the activities from the prior six month period along with any recommendations or observations to YNHHSO, OHCA, and FLIS.</p> <p>Procedures associated with 15-32033-CON Condition #16 are expected to coincide/satisfy 15-32033-CON Conditions 33b and 33d as well.</p>
<p><u>15-32033-CON Condition 33:</u> In addition to the above, L+M and YNHHSO make the following commitment for a period of five years post-Closing:</p> <p>a. L+M and YNHHSO shall appoint an independent monitor at their own cost (selected by YNHHSO and L+M and approved by OHCA) to serve as a post-transfer compliance monitor.</p>	<p>For 15-32033-CON Condition #33a, refer to 15-32033-CON Condition #15.</p> <p>15-32033-CON Condition #33b – D&amp;T will meet with CHNA/CHIP “participation</p>

<sup>7</sup> The semi-annual basis will be defined as six months post-closing and on the anniversary of the closing date to coincide with meetings with the community representatives per Conditions # 33b and 33d

Condition	D&T Procedure
<p>b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.</p>	<p>group<sup>8</sup> in March 2017 for an initial introduction and will meet with this group annually thereafter to present the annual Monitor report. Relative to (ii), Refer to the procedures performed per Conditions #11 and #31. Minutes will be maintained by D&amp;T of these meetings and provided to OHCA upon request.</p>
<p>c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties.</p>	<p>With respect to 15-32033-CON #33d, D&amp;T will review the public notice and attend the public forum held by YNHHSC and confirm that it includes members of the CHIP (Community Health Improvement Program) group.</p>
<p>d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.</p>	<p>With respect to 15-32033-CON #33e, D&amp;T agrees to provide written notice of any deficiencies as required.</p>
<p>e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate connective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce</p>	<p>With respect to 15-32033-CON #33e, D&amp;T agrees to provide written notice of any deficiencies as required.</p>

<sup>8</sup> See attached list.

Condition	D&T Procedure
<p>these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653. In addition, in the event OHCA determines YNHHS and L+M are in material non-compliance, OHCA may order YNHHS and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.</p>	
<p><u>15-32032-CON Condition 8</u>: In addition to the above, L+M and YNHHS make the following commitment for a period of five years post-Closing:</p> <ol style="list-style-type: none"> <li>a. L+M and YNHHS shall appoint an independent monitor at their own cost (selected by YNHHS and L+M and approved by OHCA) to serve as a post-transfer compliance monitor.</li> <li>b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.</li> <li>c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties.</li> <li>d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.</li> </ol>	<p>Refer to procedures for 15-32033-CON Condition #33 a through e above.</p>

Condition	D&T Procedure
<p>e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate corrective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653 In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.</p>	
<p><b>Community Benefit</b></p>	
<p><u>15-32033-CON Condition 11:</u> The Applicants shall maintain community benefit programs and community building activities for L+MH for three (3) years after the Closing Date consistent with L+MH's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as L+MH's current programs, and the Applicants shall apply no less than a 1% increase per year for the next three (3) years toward the L+MH's community building activities in terms of dollars spent.</p>	<p>D&amp;T will obtain L+MH's most recent Schedule H of IRS Form 990 to act as a baseline. We will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase requirement has been met.</p> <p>D&amp;T will also obtain the YNHHSC report/summary on</p>

Condition	D&T Procedure
<p>In determining L+MH' s participation and investment in both community benefits and community building activities, the Applicants shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.</p> <p>a. On an annual basis, YNHHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing for three years and shall be posted on L+MH's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>the amounts and uses related to community benefits and community building per the categories identified in the CHNA. D&amp;T will evaluate these reports/summaries as compared to the CHNA and defined population health management objectives and will discuss any questions with YNHHSC Management. D&amp;T will confirm that these documents are filed in a timely manner and posted to the L+MH website.</p>
<p><u>15-32033-CON Condition 31</u>: L+M and YNHHSC have agreed to maintain at least the same level of community benefit consistent with L+M's most recent Schedule H of IRS Form 990 and its Community Health Needs Assessment (CHNA). L+M and YNHHSC agree to conduct an updated Community Health Needs Assessment by no later than December 31, 2016, and provide services in accordance with implementation plan adopted as part of the updated CHNA process and provide OHCA with its updated CHNA within thirty days of its approval.</p>	<p>After obtaining L+M's baseline Schedule H of IRS Form 990, D&amp;T will obtain and confirm that L+M and YNHHSC have increased community benefit by 1% per year for the first three (3) years of this agreement. Thereafter for years 4 and 5, we will confirm that the level of community benefit provided in year 3 was at least maintained (not required to increase in years 4 and 5).</p> <p>Cross-reference to 15-32033-CON Condition #11.</p>
<p><u>15-32033-CON Condition 32h</u>: A narrative description of L+M's community benefit commitments described herein, including without limitation the amounts spent and a description of such spending to support and invest in the communities that L+M serves.</p>	<p>Relative to 15-32033-CON Condition #32h, see procedures performed for 15-32033-CON Conditions #11 and #31.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 12</u>: The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. Specifically, the Applicants shall ensure that L+MH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the Applicants shall provide at L+MH, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the Applicants shall ensure that L+MH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, YNHHSOC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population.</p>	<p>D&amp;T will obtain and review interpreter services policies and contracts as applicable. Additionally, our team will obtain the cultural competency plan, training and related policies. We will also obtain YNHHSOC's report and supporting documents and confirm the timely filing of these materials.</p>
<b>Charity Care Policies</b>	
<p><u>15-32033-CON Condition 9</u>: Following the Closing Date, L+MH will adopt YNHHSOC's financial assistance (charity and free care) policies or adopt other policies that are at least as generous and benevolent to the community as L+MH's current policies, consistent with state and federal law. These policies shall be posted on the website pages of L+MH and as additionally required by applicable law, OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>D&amp;T will obtain copies of the relevant financial assistance policies and confirm that L+MH has adopted YNHHSOC's financial assistance policies (or policies at least as generous as these policies) using L+M Hospital board resolutions. After verifying that this step has been properly completed, we will confirm that these policies are properly posted on L+MH's website.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 10</u>: For three (3) years following the Closing Date, YNHHSC shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of L+MH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of L+MH simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>After obtaining original L+MH policies on charity care, indigent care, and community volunteer services, D&amp;T will read and assess these policies on an annual basis for changes. When changes are made to these policies, we will confirm OHCA is notified (as required) and revised policies are posted to the L+MH website.</p>
<p><u>15-32033-CON Condition 32e</u>: Affirmation that L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.</p>	<p>For 15-32033-CON Condition 32 requirements a through e and g, D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met.</p>
<p><b>Employment Conditions</b></p>	
<p><u>15-32033-CON Condition 27</u>: L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.</p>	<p>D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #27 has been met.</p>
<p><u>15-32033-CON Condition 32g</u>: Affirmation of the labor and employment commitments described herein, including but not limited to L+M's service sites continued honoring of collective bargaining agreements in place as of the date hereof.</p>	<p>See others below</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 28</u>: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHS affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).</p>	<p>D&amp;T will obtain a copy of YNHHS's Management Representation to OHCA that 15-32033-CON Condition #28 has been met.</p>
<p><u>15-32032-CON Condition 6</u>: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHS affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).</p>	<p>Refer to procedures for 15-32033-CON Condition #28.</p>
<p><u>15-32033-CON Condition 29</u>: L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.</p>	<p>D&amp;T will obtain a copy of YNHHS's Management Representation to OHCA that 15-32033-CON Condition #29 has been met.</p>
<p><u>15-32033-CON Condition 30</u>: L+M and YNHHS shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.</p>	<p>D&amp;T will obtain a copy of YNHHS's Management Representation to OHCA that 15-32033-CON Condition #30 has been met.</p>

Condition	D&T Procedure
<b>Governance</b>	
<p><u>15-32033-CON Condition 14:</u> For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as voting members of L+MH's Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>D&amp;T will confirm the appointment of this individual (community representative) to the L+MH Board as evidenced by Board minutes. We will discuss the selection process with Management and document our understanding of the selection process/qualifications of the individual.</p>
<p><u>15-32033-CON Condition 17:</u> For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>To confirm compliance with this provision, D&amp;T will obtain minutes from these Joint Board Meetings and confirm that notice of the public meetings is posted with proper notice.</p> <p>D&amp;T will attend the public meetings as part of the Monitor role.</p>
<p><u>15-32033-CON Condition 26:</u> As described in the Affiliation Agreement, YNHHSC is committed to maintaining local governance at L+M. The L+M Board of Directors shall continue as a fiduciary board composed of a majority of members who reside in the communities served by L+M with the only change in composition being the addition of the President/CEO of YNHHSC (or his or her designee) serving as an ex-officio member. Each director of the L+M Board of Directors shall have an equal vote. The L+M Board shall be empowered and supported to oversee local performance and to create and sustain connections with the community. Subject to certain reserved powers for YNHHSC, the L+M Board of directors will have the right to approve any major new programs and clinical services, or the discontinuation or consolidation of any such programs.</p>	<p>D&amp;T will obtain and evaluate the Board of Directors bylaws to confirm that L+M Board maintains rights and powers specified in the Order.</p>

Condition	D&T Procedure
<p align="center"><b>Licensure, Physician Office Conversion, Cost Savings Attainment</b></p>	
<p><u>15-32033-CON Condition 13:</u> The Applicants shall abide by all requirements of licensure that may be imposed by the Facility Licensing and Investigations Section ("FLIS") of the Department of Public Health ("DPH") in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA is imposing this Condition to ensure that quality health care services are provided to the patient population.</p>	<p>D&amp;T will, if necessary, work with DPH to ensure compliance with this Condition.</p>
<p><u>15-32033-CON Condition 24:</u> L+M and YNHHS shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.</p>	<p>D&amp;T will obtain a copy of YNHHS's Management Representation to OHCA that 15-32033-CON Condition #24 has been met.</p>
<p><u>15-32033-CON Condition 32d:</u> Affirmation that no L+M physician office has been converted to hospital-based status.</p>	<p>D&amp;T will obtain a copy of YNHHS's Management Representation to OHCA that 15-32033-CON Condition #32d has been met.</p>
<p><u>15-32032-CON Condition 5:</u> L+MH and YNHHS shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.</p>	<p>Refer to procedures for 15-32033-CON Condition #24 above.</p>
<p><u>15-32032-CON Condition 7b:</u> Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHS shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31st) and April 1 through September 30 (due November 30th) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <p>Affirmation that no L+M physician office has been converted to hospital-based status.</p>	<p>Refer to procedures for 15-32033-CON Condition #32f above.</p>
<p><u>15-32033-CON Condition 25:</u> L+M shall attain cost savings as a result of the affiliation with YNHHS as described in the CON application.</p>	<p>D&amp;T will obtain and read YNHHS's reporting created per 15-32033-CON condition #32f.</p>

**Footnote 8 Attachment**

Representative	Thames Valley Council of Community Action
Representative	Universal Health Foundation
Representative	United Community and Family Services
Representative	NL County Food Policy Council
Representative	Groton Parks and Recreation
Representative	Hispanic Alliance
Representative	Ledge Light Health District
Representative	Uncas Health District
Representative	City of New London
Representative	Community Foundation of Eastern CT
Representative	Connecticut College
Representative	Community Health Center, Inc.
Representative	Higher Edge
Representative	UCONN Health Disparities Institute

## APPENDIX B: GENERAL BUSINESS TERMS

**Client: Yale New Haven Health Services Corporation (“Yale New Haven Health” or the “System”)**

**1. Services.** It is understood and agreed that the services provided by Deloitte & Touche LLP (Deloitte & Touche) (as defined in paragraph 13) (the “Services”) under the engagement letter to which these terms are attached (the “Engagement Letter”) may include advice and recommendations, but all decisions in connection with the implementation of such advice and recommendations shall be the responsibility of, and made by, the System. For purposes of these terms and the Engagement Letter, the “System” shall mean Yale New Haven Health Services Corporation and its subsidiaries. Yale New Haven Health Services Corporation represents and warrants that it has the power and authority to execute this agreement on behalf of, and to bind, itself and its subsidiaries.

**2. Exclusion.** Deloitte & Touche represents and warrants that neither Deloitte & Touche nor any of its employees providing the Services: (1) has ever been (A) convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) excluded or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) otherwise sanctioned by the federal government, including being listed on the General Services Administration’s Excluded Party Listing System and (2) shall notify System immediately in the event that the Consultant (A) is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) is excluded or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) is otherwise sanctioned by the federal government, including being listed on the General Services Administration’s Excluded Party Listing System. System may terminate this Agreement immediately in the event that Deloitte & Touche or any of its employees (A) is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) is excluded from or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) is otherwise sanctioned by the federal government, including being listed on the General Services Administration’s Excluded Party Listing System.

**3. Payment of Invoices.** Deloitte & Touche’s invoices are due upon presentation. Without limiting its rights or remedies, Deloitte & Touche shall have the right to halt or terminate the Services entirely if payment is not received within sixty (60) days of the invoice date. The System shall be responsible for all taxes imposed on the Services or on the transaction, other than Deloitte & Touche’s income taxes or tax imposed by employment withholding, and other than taxes imposed on Deloitte & Touche's property.

**4. Term.** Unless terminated sooner in accordance with its terms, this engagement shall terminate on the completion of the Services. This engagement may be terminated by either party at any time, with or without cause, by giving written notice to the other party not less than sixty (60) days before the effective date of termination, provided that, in the event of a termination for cause, the breaching party shall have the right to cure the breach within the notice period. Deloitte & Touche may terminate this engagement upon written notice to the System if it determines that (a) a governmental, regulatory, or professional entity (including, without limitation, the American Institute of Certified Public Accountants, the Public Company Accounting Oversight Board, or the Securities and Exchange Commission), or an entity having the force of law, has introduced a new, or modified an existing, law, rule, regulation, interpretation, or decision, the result of

which would render Deloitte & Touche's performance of any part of the engagement illegal or otherwise unlawful or in conflict with independence or professional rules; or (b) circumstances change (including, without limitation, changes in ownership of the System or any of its affiliates) such that Deloitte & Touche's performance of any part of the engagement would be illegal or otherwise unlawful or in conflict with independence or professional rules. Upon termination of the engagement, the System will compensate Deloitte & Touche under the terms of the Engagement Letter for the Services performed and expenses incurred through the effective date of termination.

## **5. Deliverables.**

- a) Deloitte & Touche has created, acquired, or otherwise has rights in, and may, in connection with the performance of the Services, employ, provide, modify, create, acquire, or otherwise obtain rights in, works of authorship, materials, information, and other intellectual property (collectively, the "Deloitte & Touche Technology").
- b) Except as provided below, upon full and final payment to Deloitte & Touche hereunder, the tangible items specified as deliverables or work product in the Engagement Letter (the "Deliverables") shall become the property of the System. To the extent that any Deloitte & Touche Technology is contained in any of the Deliverables, Deloitte & Touche hereby grants the System, upon full and final payment to Deloitte & Touche hereunder, a royalty-free, fully paid-up, worldwide, nonexclusive license to use such Deloitte & Touche Technology in connection with the Deliverables.
- c) To the extent that Deloitte & Touche utilizes any of its property (including, without limitation, the Deloitte & Touche Technology or any hardware or software of Deloitte & Touche) in connection with the performance of the Services, such property shall remain the property of Deloitte & Touche and, except for the license expressly granted in the preceding paragraph, the System shall acquire no right or interest in such property. Notwithstanding anything herein to the contrary, the parties acknowledge and agree that (1) Deloitte & Touche shall own all right, title, and interest, including, without limitation, all rights under all copyright, patent, and other intellectual property laws, in and to the Deloitte & Touche Technology and (2) Deloitte & Touche may employ, modify, disclose, and otherwise exploit the Deloitte & Touche Technology (including, without limitation, providing services or creating programming or materials for other clients). Deloitte & Touche does not agree to any terms that may be construed as precluding or limiting in any way its right to (1) provide consulting or other services of any kind or nature whatsoever to any person or entity as Deloitte & Touche in its sole discretion deems appropriate or (2) develop for itself, or for others, materials that are competitive with or similar to those produced as a result of the Services, irrespective of their similarity to the Deliverables.
- d) To the extent any Deloitte & Touche Technology provided to the System hereunder is a product (to the extent it constitutes merchandise within the meaning of section 471 of the Internal Revenue Code), such Deloitte & Touche Technology is licensed to the System by Deloitte & Touche as agent for Deloitte & Touche Products Company LLC on the terms and conditions herein. The assignment and license grant in this paragraph 5 do not apply to any works of authorship, materials, information, or other intellectual property (including any modifications or enhancements thereto or derivative works based thereon) that is subject to a separate license agreement between the System and a third party, including without limitation, Deloitte & Touche Products Company LLC.

**6. Limitation on Warranties. THIS IS A SERVICES ENGAGEMENT. DELOITTE & TOUCHE WARRANTS THAT IT SHALL PERFORM THE SERVICES IN GOOD FAITH AND WITH DUE PROFESSIONAL CARE. DELOITTE & TOUCHE DISCLAIMS ALL OTHER WARRANTIES, EITHER EXPRESS OR IMPLIED, INCLUDING, WITHOUT LIMITATION, WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.**

**7. Limitation on Damages and Indemnification.**

a) The System agrees that Deloitte & Touche, its subcontractors, and their respective personnel shall not be liable to the System for any claims, liabilities, or expenses relating to this engagement (“Claims”) for an aggregate amount in excess of two (2) times the fees paid by the System to Deloitte & Touche pursuant to this engagement, except to the extent finally judicially determined to have resulted primarily from the bad faith, or intentional misconduct of Deloitte & Touche or its subcontractors.

b) Except with respect to Claims for which a party has an indemnification obligation hereunder, in no event shall either party, its subcontractors, or their respective personnel be liable for any loss of use, data, goodwill, revenues, or profits (whether or not deemed to constitute a direct Claim), or any consequential, special, indirect, incidental, punitive, or exemplary loss, damage, or expense relating to this engagement.

c) Except for those claims for which Deloitte & Touche has agreed to indemnify the System pursuant to paragraph 7(d) and, 7(e), the System shall indemnify and hold harmless Deloitte & Touche, its subcontractors, and their respective personnel from all Claims of third parties arising from the use or disclosure of the Services or the Deliverables, except to the extent finally judicially determined to have resulted primarily from the recklessness, bad faith, or intentional misconduct of Deloitte & Touche or its subcontractors.

d) Deloitte & Touche shall indemnify, defend and hold harmless the System, its directors, officers, employees and agents from and against any and all Claims, including reasonable attorneys' fees, in each case solely for bodily injury, death or physical damage to real or tangible personal property, to the extent such Claims are caused by Deloitte & Touche's negligent acts, negligent errors or negligent omissions. In the event such Claims are caused by the joint or concurrent negligence of the parties, they shall be borne by each party in proportion to such party's negligence.

e) Deloitte & Touche agrees to defend the System, its officers and employees from and against any and all claims and pay any settlement costs or any final judgments, including reasonable defense costs and reasonable legal fees, arising out of infringement by the Deliverables of any U.S. patent known to Deloitte & Touche or copyright or any unauthorized use of any trade secret or trademark, except to the extent that such infringement or unauthorized use arises from (i) the System's modification of the Deliverables or use thereof in a manner not contemplated by this engagement, (ii) the failure of the System to use any corrections or modifications made available by Deloitte & Touche, (iii) information, materials, instructions or specifications provided by or on behalf of the System, (iv) the System's distribution, marketing or use for the benefit of third parties of the Deliverables, or (v) the use of the Deliverable in combination with any product or data not provided by Deloitte & Touche whether or not with Deloitte & Touche's consent. If any such Deliverable, or any portion thereof, becomes, or in Deloitte & Touche's reasonable judgment, is likely to become the subject of a claim based upon infringement or unauthorized use, or if any such Deliverable or

any portion thereof, is found by final, non-appealable order of a court of competent jurisdiction to be such an infringement or unauthorized use, Deloitte & Touche, at its option and expense, shall have the right to (x) procure for the System the continued use of such Deliverable, (y) replace or modify such Deliverable provided that the replacement or modified Deliverable is reasonably capable of performing substantially the same function, or (z) require the System to cease use of such Deliverable and refund an appropriate portion of the fee paid with respect to the affected Deliverable. The foregoing provisions of this Paragraph constitute the sole and exclusive remedy of the System, and the sole and exclusive obligation of Deloitte & Touche, relating to a claim that a Deliverable infringes any patent, copyright or other intellectual property right of a third party.

**8. Client Responsibilities.** The System shall cooperate with Deloitte & Touche in the performance by Deloitte & Touche of the Services, including, without limitation, providing Deloitte & Touche with reasonable facilities and timely access to data, information, and personnel of the System. The System shall be responsible for the performance of its personnel and agents and for the accuracy and completeness of all data and information provided to Deloitte & Touche for purposes of the performance by Deloitte & Touche of the Services. The System acknowledges and agrees that Deloitte & Touche's performance is dependent upon the timely and effective satisfaction of the System's responsibilities hereunder and timely decisions and approvals of the System in connection with the Services. Deloitte & Touche shall be entitled to rely on all decisions and approvals of the System. The System shall be solely responsible for, among other things (a) making all management decisions and performing all management functions, (b) designating a competent management member to oversee the Services, (c) evaluating the adequacy and results of the Services, (d) accepting responsibility for the results of the Services, and (e) establishing and maintaining internal controls, including, without limitation, monitoring ongoing activities.

**9. Force Majeure.** Neither party shall be liable for any delays or nonperformance directly or indirectly resulting from circumstances or causes beyond its reasonable control, including, without limitation, acts or omissions or the failure to cooperate by the other party (including, without limitation, entities or individuals under its control, or any of their respective officers, directors, employees, other personnel and agents), acts or omissions or the failure to cooperate by any third party, fire, epidemic or other casualty, act of God, strike or labor dispute, war or other violence, or any law, order, or requirement of any governmental agency or authority.

**10. [Reserved]**

**11. Independent Contractor.**

(a) Deloitte & Touche and System acknowledge and agree that Deloitte & Touche is being retained as an independent contractor, and that Deloitte & Touche shall be responsible for determining the manner and means by which Deloitte & Touche performs the Services. Nothing herein shall be construed to make Deloitte & Touche an employee or agent of System, to entitle Deloitte & Touche to receive the benefits of any employee benefit plan of System, or to create a joint venture or partnership or fiduciary relationship between the parties. Neither party shall not make an unauthorized representation or warranty concerning the products or services of the other party or commit the other party to any agreement or obligation.

(b) No payroll or employment taxes of any kind shall be withheld or paid with respect to payments to Deloitte & Touche hereunder. Deloitte & Touche agrees to indemnify System against, and to defend and hold System harmless from, any liabilities, claims, costs or expenses (including reasonable attorneys' fees) which may be made against System, or incurred by System, in respect of any such payroll or employment taxes.

(c) No workers' compensation insurance has been or will be obtained by System on account of Deloitte & Touche.

## **12. Confidentiality and Internal Use.**

a) The System agrees that all Services and Deliverables shall be solely for the System's informational purposes and internal use, and are not intended to be, and should not be, used by any person or entity other than the System. Except as otherwise specifically provided in the Engagement Letter, the System further agrees that such Services and Deliverables shall not be circulated, quoted, disclosed, or distributed to, nor shall reference to such Services or Deliverables be made to, any person or entity other than the System and other contractors of the System to whom the System may disclose the Deliverables solely for the purpose of such contractors providing services to the System relating to the subject matter of this engagement, provided that the System shall ensure that such contractors do not further circulate, quote, disclose, or distribute such Deliverables, or make reference to such Deliverables, to any person or entity other than the System. Notwithstanding the foregoing, the System shall not be prohibited from creating its own materials based on the content of such Services and Deliverables and using and disclosing such System-created materials for external purposes, provided that the System does not, expressly or by implication, in any manner whatsoever, attribute such materials to Deloitte & Touche or otherwise refer to or identify Deloitte & Touche in connection with such materials.

b) To the extent that, in connection with this engagement, either party (each, the "receiving party") comes into possession of any trade secrets or other proprietary or confidential information of the other (the "disclosing party"), it will not disclose such information to any third party without the disclosing party's consent. The disclosing party hereby consents to the receiving party disclosing such information (1) to subcontractors, whether located within or outside of the United States, that are providing services in connection with this engagement and that have agreed to be bound by confidentiality obligations similar to those in this paragraph 12(b); (2) as may be required by law, regulation, judicial or administrative process, or in accordance with applicable professional standards or rules, or in connection with litigation or arbitration pertaining hereto; or (3) to the extent such information (i) shall have otherwise become publicly available (including, without limitation, any information filed with any governmental agency and available to the public) other than as the result of a disclosure in breach hereof, (ii) becomes available to the receiving party on a nonconfidential basis from a source other than the disclosing party that the receiving party believes is not prohibited from disclosing such information to the receiving party by obligation to the disclosing party, (iii) is known by the receiving party prior to its receipt from the disclosing party without any obligation of confidentiality with respect thereto, or (iv) is developed by the receiving party independently of any disclosures made by the disclosing party to the receiving party of such information. In satisfying its obligations under this paragraph 12(b), each party shall maintain the other's trade secrets and proprietary or

confidential information in confidence using at least the same degree of care as it employs in maintaining in confidence its own trade secrets and proprietary or confidential information, but in no event less than a reasonable degree of care. Nothing in this paragraph 12(b) shall alter the System's obligations under paragraph 12(a). Notwithstanding anything to the contrary herein, the System acknowledges that Deloitte & Touche, in connection with performing the Services, may develop or acquire experience, skills, knowledge, and ideas that are retained in the unaided memory of its personnel. The System acknowledges and agrees that Deloitte & Touche may use and disclose such experience, skills, knowledge, and ideas.

**13. Survival and Interpretation.** All paragraphs herein relating to payment of invoices, deliverables, limitation on warranties, limitation on damages and indemnification, limitation on actions, confidentiality and internal use, survival and interpretation, assignment, nonexclusivity, waiver of jury trial and governing law shall survive the expiration or termination of this engagement. For purposes of these terms, "Deloitte & Touche" shall mean Deloitte & Touche LLP and, for purposes of paragraph 7, shall also mean Deloitte & Touche Products Company LLC, one of its subsidiaries. The System acknowledges and agrees that no affiliated or related entity of Deloitte & Touche, whether or not acting as a subcontractor, or such entity's personnel shall have any liability hereunder to the System or any other person and the System will not bring any action against any such affiliated or related entity or such entity's personnel in connection with this engagement. Without limiting the foregoing, affiliated and related entities of Deloitte & Touche are intended third-party beneficiaries of these terms, including, without limitation, the limitation on liability and indemnification provisions of paragraph 7, and the agreements and undertakings of the System contained in the Engagement Letter. Any affiliated or related entity of Deloitte & Touche may in its own right enforce such terms, agreements, and undertakings. **The provisions of paragraphs 7, 13, 15, and 18 hereof shall apply to the fullest extent of the law, whether in contract, statute, tort (such as negligence), or otherwise, notwithstanding the failure of the essential purpose of any remedy.**

**14. Assignment and Subcontracting.** Except as provided below, neither party may assign, transfer, or delegate any of its rights or obligations hereunder (including, without limitation, interests or Claims) without the prior written consent of the other party. The System hereby consents to Deloitte & Touche subcontracting any of Deloitte & Touche's rights or obligations hereunder to (a) any affiliate or related entity, whether located within or outside of the United States. Services performed hereunder by Deloitte & Touche's subcontractors shall be invoiced as professional fees on the same basis as Services performed by Deloitte & Touche's personnel, unless otherwise agreed.

**15. Waiver of Jury Trial. THE PARTIES HEREBY IRREVOCABLY WAIVE, TO THE FULLEST EXTENT PERMITTED BY LAW, ALL RIGHTS TO TRIAL BY JURY IN ANY ACTION, PROCEEDING, OR COUNTERCLAIM RELATING TO THIS ENGAGEMENT.**

**16. Nonsolicitation.** During the term of this engagement and for a period of one (1) year thereafter, each party agrees that its personnel (in their capacity as such) who had direct and substantive contact in the course of this engagement with personnel of the other party shall not, without the other party's consent, directly or indirectly employ, solicit, engage, or retain the services of such personnel of the other party. In the event a party breaches this provision, the breaching party shall be liable to the aggrieved party for an amount equal to thirty percent (30%) of the annual base compensation of the relevant personnel in his or her new position. Although such payment shall be the aggrieved party's exclusive means of monetary recovery from the breaching party for breach of this provision, the aggrieved party shall be entitled to seek injunctive or other

equitable relief. This provision shall not restrict the right of either party to solicit or recruit generally in the media.

**17. Entire Agreement, Amendment, and Notices.** These terms, and the Engagement Letter, including exhibits, constitute the entire agreement between the parties with respect to this engagement; supersede all other oral and written representations, understandings, or agreements relating to this engagement; and may not be amended except by written agreement signed by the parties. In the event of any conflict, ambiguity, or inconsistency between these terms and the Engagement Letter, these terms shall govern and control. All notices, requests, demands and other communications hereunder shall be in writing and shall be deemed to have been duly given when either personally served or mailed by certified or registered mail, return receipt requested to the addresses first set forth above.

**18. Governing Law, Jurisdiction and Venue, and Severability.** These terms, the Engagement Letter, including exhibits and all matters relating to this engagement shall be governed by, and construed in accordance with, the laws of the State of Connecticut (without giving effect to the choice of law principles thereof). Any action based on or arising out of this engagement or the Services provided or to be provided hereunder shall be brought and maintained exclusively in any court of the State of Connecticut or any federal court of the United States, in each case located in the State of Connecticut. Each of the parties hereby expressly and irrevocably submits to the jurisdiction of such courts for the purposes of any such action and expressly and irrevocably waives, to the fullest extent permitted by law, any objection which it may have or hereafter may have to the laying of venue of any such action brought in any such court and any claim that any such action has been brought in an inconvenient forum. If any provision of these terms or the Engagement Letter is found by a court of competent jurisdiction to be unenforceable, such provision shall not affect the other provisions, but such unenforceable provision shall be deemed modified to the extent necessary to render it enforceable, preserving to the fullest extent permissible the intent of the parties set forth herein.

**19. Non-Use of YNHHS Name.** Deloitte & Touche shall not use YNHHS name or logo, or the name of any YNHHS facility, in any way other than in connection with the Services, including in any advertising or promotional media as a customer or client of Deloitte & Touche, without obtaining the prior written consent of System.

**20. False Claims.** Deloitte & Touche acknowledges that System has provided it with access to its policy on False Claims and Payment Fraud Prevention (the "Policy") located on its internet site at [www.ynhhs.org/FalseClaims.pdf](http://www.ynhhs.org/FalseClaims.pdf). The False Claims Act imposes civil penalties on people and companies who knowingly submit a false claim or statement to a federally funded program, or otherwise conspire to defraud the government, in order to receive payment. It also protects people who report suspected fraud.

**21. Personal Inducements.** Deloitte & Touche represents and warrants that no cash, equity interest, merchandise, equipment, services or other forms of remuneration have been offered, shall be offered or will be paid or distributed by or on behalf of Deloitte & Touche to YNHHS and/or the employees, officers, or directors of YNHHS or its member hospitals, or to any other person, party or entity affiliated with YNHHS or its member hospitals, as an inducement to purchase or to influence the purchase of services by YNHHS or its member hospitals from Deloitte & Touche.

**22. No Undisclosed Relationships.** Deloitte & Touche represents and warrants to the System that, except for those relationships (if any) Deloitte & Touche has disclosed to the System in writing, as of the date of this Agreement the Deloitte & Touche and Deloitte FAS personnel that provide services under this Agreement: (i) do not have a financial relationship with any of the System's trustees, officers, employees, or medical staff members, (ii) will not establish or otherwise create any such relationship after the Effective Date without disclosing such relationship to the System in writing, and (iii) Deloitte & Touche will promptly notify the System in writing if its Engagement Partner for the Services becomes aware of the existence of any such relationship during the course of the services provided under this Agreement. Notwithstanding any other provision of this Agreement or any other agreement between the System and Deloitte & Touche, the System may terminate this Agreement upon written notice to Deloitte & Touche in the event the System becomes aware of any such relationship (through disclosure by Deloitte & Touche or otherwise).

**23. General Compliance.** Deloitte & Touche shall comply with all applicable standards, statutes, rules, regulations, acts and orders of the United States, its departments, agencies, and bureaus, and of any applicable state or political subdivision thereof, including without limitation, laws and regulations pertaining to labor, wages, hours, conditions of employment, environmental protection, hazardous and infectious materials, identity theft, as applicable to Deloitte & Touche in its performance of the Services hereunder.

**24. Equal Employment Opportunities.** Deloitte LLP (the parent company of Deloitte & Touche) and its subsidiaries (together, referred to as "Deloitte" for purposes of this Section 24) are equal opportunity employers. Deloitte recruits, employs, trains, compensates, and promotes without regard to race, religion, creed, color, citizenship, national origin, age, gender, gender identity/expression, sexual orientation, marital status, disability, veteran status, or any other legally protected basis, in accordance with applicable federal, state, or local law. Deloitte makes reasonable attempts to accommodate the expression of religious beliefs, as long as that expression does not harass or intimidate coworkers or place an undue hardship on its business.

As a federal contractor, Deloitte also provides an affirmative action program for minorities, women, disabled and Vietnam-era veterans, and persons with disabilities.

In response to a request from a qualified individual with a disability, Deloitte will make a reasonable accommodation that would allow that individual to perform the essential functions of his or her job, unless doing so would create undue hardship on its business.

**25. Access to Records.** In the event that the Engagement Letter provides for services to be performed by Vendor worth \$10,000 or more over a 12-month period, Deloitte & Touche agrees, until the expiration of four years after the termination of the Arrangement, to make available to the Secretary, U.S. Department of Health and Human Services, and the U.S. Comptroller General and their representatives, pursuant to a proper request, the Agreement, if any, and all books, documents and records necessary to certify the nature and extent of the cost of those services. If Deloitte & Touche carries out any of the duties described herein through a subcontract worth \$10,000 or more over a 12-month period with a related organization, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General and their representatives pursuant to a proper request to the related organization's books, documents and records necessary to certify the nature and extent of the cost of those services. In the event Deloitte & Touche receives a request for access, Deloitte & Touche agrees to notify YNHHS immediately and to consult with YNHHS regarding the response to the request.

**26. Security and Access.** Deloitte & Touche shall comply with all YNHHS policies and procedures pertaining to visitation, confidentiality, security and vendor identification as are provided to it in writing prior to execution of the Engagement Letter. YNHHS may issue non-employee identification badges under certain conditions; in the event that any non-employee identification badge is issued to an employee of Deloitte & Touche, Deloitte & Touche agrees to cause such employee to prominently display such badge at all times while on YNHHS premises. All badges must be surrendered by Deloitte & Touche when requested by YNHHS. Non-compliance with any of the above policies shall be deemed a breach of the Engagement Letter.

## **APPENDIX C: Business Associate Addendum**

This Appendix (“Appendix C”) is part of the attached engagement letter dated November 7, 2016 between Deloitte & Touche LLP (“D&T”), Yale-New Haven Health System (“YNHH”). If and to the extent, and so long as, required by HIPAA or HITECH (each as defined below), and not otherwise, D&T and YNHH hereby agree to the following in connection with D&T’s performance of services under the engagement letter to which this Business Associate Appendix is attached (such engagement letter, the “Engagement Letter,” together with this Business Associate Appendix and all other attachments, appendices, and exhibits to the Engagement Letter, this “Agreement”). D&T agrees that for purposes of this Appendix C, D&T is a business associate of YNHH to the extent that, in performance of the Services, D&T qualifies as a “business associate” as that term is defined at 45 C.F.R §160.103.

(A) Unless otherwise specified in this Business Associate Appendix, all capitalized terms used in this Business Associate Appendix shall have the meanings established for purposes of HIPAA or HITECH, as applicable. Specific statutory or regulatory citations used in this Business Associate Appendix shall mean such citations as amended and in effect from time to time.

1. “Compliance Date” shall mean, with respect to any applicable provision in this Business Associate Appendix, the later of the date by which compliance with such provision is required under HITECH and the effective date of this Agreement.
2. “Electronic Protected Health Information” shall mean Protected Health Information that is transmitted or maintained in electronic media.
3. “HIPAA” shall mean the Health Insurance Portability and Accountability Act, 42 U.S.C. §§ 1320d through 1320d-8, as amended from time to time, and all associated existing and future implementing regulations, when effective and as amended from time to time.
4. “HITECH” shall mean Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§ 17921-17954, as amended from time to time, and all associated existing and future implementing regulations, when effective and as amended from time to time.
5. “Protected Health Information” shall mean the term as defined in 45 C.F.R. § 160.103, and is limited to the Protected Health Information received from, or received or created on behalf of, the Client by D&T pursuant to performance of the Services.
6. “Privacy Rule” shall mean the federal privacy regulations issued pursuant to HIPAA, as amended from time to time, codified at 45 C.F.R. Part 164 (Subparts A and E).
7. “Security Rule” shall mean the federal security regulations issued pursuant to HIPAA, as amended from time to time, codified at 45 C.F.R. Part 164 (Subparts A and C).
8. “Services” shall have the meaning set forth in the attached engagement letter, and, if not therein defined, shall mean the services described in the Engagement Letter to be performed by D&T for the Client.
9. “Unsecured Protected Health Information” shall mean Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a

technology or methodology specified by the Secretary in the regulations or guidance issued pursuant to 42 U.S.C. § 17932(h)(2).

(B) With regard to D&T's use and disclosure of Protected Health Information:

1. D&T may use and disclose Protected Health Information as reasonably required or contemplated in connection with the performance of the Services, excluding the use or further disclosure of Protected Health Information in a manner that would violate the requirements of the Privacy Rule, if done by the Client. Notwithstanding the foregoing, D&T may use and disclose Protected Health Information for the proper management and administration of D&T as provided in 45 C.F.R. § 164.504(e)(4).
2. D&T will not use or further disclose Protected Health Information other than as permitted or required by this Business Associate Appendix, and in compliance with each applicable requirement of 45 C.F.R. § 164.504(e), or as otherwise Required by Law.
3. D&T will implement and use appropriate administrative, physical, and technical safeguards to (1) prevent use or disclosure of Protected Health Information other than as permitted or required by this Business Associate Appendix; (2) reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that D&T creates, receives, maintains, or transmits on behalf of the Client; and (3) as of the Compliance Date of 42 U.S.C. § 17931, comply with the Security Rule requirements set forth in 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316.
4. D&T will, without unreasonable delay report to the Client (1) any use or disclosure of Protected Health Information not provided for by this Business Associate Appendix of which it becomes aware in accordance with 45 C.F.R. § 164.504(e) (2) (ii) (C); and/or (2) any Security Incident affecting Electronic Protected Health Information of which D&T becomes aware in accordance with 45 C.F.R. § 164.314(a) (2) (C).
5. D&T will, without unreasonable delay, and in any event no later than ten (10) business days after Discovery, notify the Client of any Breach of Unsecured Protected Health Information. The notification shall include, to the extent possible (and subsequently as the information becomes available), the identification of all individuals whose Unsecured Protected Health Information is reasonably believed by D&T to have been Breached along with any other available information that is required to be included in the notification to the Individual, the Secretary, and/or the media, all in accordance with the data breach notification requirements set forth in 42 U.S.C. § 17932 and 45 C.F.R. Parts 160 and 164 (Subparts A, D, and E), as of their respective Compliance Dates.
6. D&T will ensure that any subcontractors or agents to whom D&T provides Protected Health Information agree to the same restrictions and conditions that apply to D&T with respect to such Protected Health Information. To the extent that D&T provides Electronic Protected Health Information to a subcontractor or agent, it will require the subcontractor or agent to implement reasonable and appropriate safeguards to protect the Electronic Protected Health Information consistent with the requirements of this Business Associate Appendix.

7. D&T will, to the extent that Protected Health Information in D&T's possession constitutes a Designated Record Set, make available such Protected Health Information in accordance with 45 C.F.R. § 164.524.
8. In the event that D&T, in connection with the Services, uses or maintains an Electronic Health Record of Protected Health Information of or about an Individual, D&T will provide an electronic copy of such Protected Health Information in accordance with 42 U.S.C. § 17935(e) as of its Compliance Date.
9. D&T will, to the extent that Protected Health Information in D&T's possession constitutes a Designated Record Set, make available such Protected Health Information for amendment and incorporate any amendments to such information as directed by the Client, all in accordance with 45 C.F.R. § 164.526.
10. D&T will document and make available the information required to provide an accounting of disclosures of Protected Health Information, in accordance with 45 C.F.R. § 164.528.
11. In the event that D&T, in connection with the Services, uses or maintains an Electronic Health Record of Protected Health Information of or about an Individual, D&T will make an accounting of disclosures of such Protected Health Information in accordance with the requirements for accounting of disclosures made through an Electronic Health Record in 42 U.S.C. § 17935(c), as of its Compliance Date.
12. D&T will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary for purposes of determining the Client's compliance with the Privacy Rule.
13. D&T will, as of the Compliance Date of 42 U.S.C. § 17935(b), limit any request, use, or disclosure by D&T of Protected Health Information, to the extent practicable, to the Limited Data Set of such Protected Health Information (as defined in 45 C.F.R. § 164.514(e)(2)), or, if the request, use, or disclosure by D&T of Protected Health Information, not in a Limited Data Set, is necessary for D&T's performance of the Services, D&T will limit the amount of such Protected Health Information requested, used, or disclosed by D&T to the minimum necessary to accomplish the intended purpose of such request, use, or disclosure, respectively; provided, however, that the requirements set forth above in this subsection (13) shall be superseded and replaced by the requirements of the "minimum necessary" regulations or guidance to be issued by the Secretary (pursuant to 42 U.S.C. § 17935(b)(1)(B)) on and after its Compliance Date.
14. D&T will not directly or indirectly receive remuneration in exchange for any Protected Health Information as prohibited by 42 U.S.C. § 17935(d) as of its Compliance Date.
15. D&T will not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. § 17936(a) as of its Compliance Date.
16. D&T will not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. § 17936(b) as of its Compliance Date.

(C) In addition to any other obligation set forth in this Agreement, including this Business Associate Appendix, the Client agrees that it will: (1) not make any disclosure of Protected Health Information to

D&T if such disclosure would violate HIPAA, HITECH, or any applicable federal or state law or regulation; (2) not request D&T to use or make any disclosure of Protected Health Information in any manner that would not be permissible under HIPAA, HITECH, or any applicable federal or state law or regulation if such use or disclosure were done by the Client; and (3) limit any disclosure of Protected Health Information to D&T, to the extent practicable, to the Limited Data Set of such Protected Health Information, or, if the disclosure of Protected Health Information that is not in a Limited Data Set is necessary for D&T's performance of the Services, to limit the disclosure of such Protected Health Information to the minimum necessary to accomplish the intended purpose of such disclosure, provided, however, that the requirements set forth above in this part (3) shall be superseded and replaced by the requirements of the "minimum necessary" regulations or guidance to be issued by the Secretary (pursuant to 42 U.S.C. § 17935(b)(1)(B)) on and after its Compliance Date.

(D) If either the Client or D&T knows of either a violation of a material term of this Business Associate Appendix by the other party or a pattern of activity or practice of the other party that constitutes a material breach or violation of this Business Associate Appendix, the non-breaching party will provide written notice of the breach or violation to the other party that specifies the nature of the breach or violation. In the event that the breaching party does not cure the breach or end the violation on or before thirty (30) days after receipt of the written notice, the non-breaching party may do the following:

- (i) if feasible, terminate this Agreement; or
- (ii) if termination of this Agreement is infeasible, report the issue to the Secretary.

(E) D&T will, at termination of this Agreement, if feasible, return or destroy all Protected Health Information that D&T still maintains in any form and retain no copies of Protected Health Information or, if such return or destruction is not feasible (such as in the event that the retention of Protected Health Information is required for archival purposes to evidence the Services), D&T may retain such Protected Health Information and shall thereupon extend the protections of this Business Associate Appendix to such Protected Health Information and limit further uses and disclosures to those purposes that make the return or destruction of such Protected Health Information infeasible.

(F) Any other provision of this Agreement that is directly contradictory to one or more terms of this Business Associate Appendix shall be superseded by the terms of this Business Associate Appendix to the extent and only to the extent of the contradiction and only for the purpose of the Client's and D&T's compliance with HIPAA and HITECH. The terms of this Business Associate Appendix, to the extent they are unclear, shall be construed to allow for compliance by the Client and D&T with HIPAA and HITECH.

In addition, the Client agrees to compensate D&T for any time and expenses that we may incur in responding to requests for documents or information under HIPAA, HITECH, or any regulations promulgated under HIPAA or HITECH.

Nothing contained in this Business Associate Appendix is intended to confer upon any person (other than the parties hereto) any rights, benefits, or remedies of any kind or character whatsoever, whether in contract, statute, tort (such as negligence), or otherwise, and no person shall be deemed a third-party beneficiary under or by reason of this Business Associate Appendix.

**Greer, Leslie**

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**Subject:** FW: CMIR Independent Consultant: CON Docket #s 15-32032-CON and 15-32033-CON

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**From:** Martone, Kim [<mailto:Kimberly.Martone@ct.gov>]  
**Sent:** Thursday, November 17, 2016 11:08 AM  
**To:** Capozzalo, Gayle  
**Cc:** Rosenthal, Nancy; Roberts, Karen; Cotto, Carmen  
**Subject:** RE: CMIR Independent Consultant: CON Docket #s 15-32032-CON and 15-32033-CON

Hi Gayle, it was a pleasure as well. It was very informative and comprehensive. The presentation and discussion with Milliman regarding their expertise in this field and approach to conducting the CMIR is acceptable to OHCA therefore their engagement is approved.

Kim

***Kimberly R. Martone***

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



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**From:** Capozzalo, Gayle [<mailto:Gayle.Capozzalo@ynhh.org>]  
**Sent:** Thursday, November 17, 2016 10:02 AM  
**To:** Martone, Kim  
**Cc:** Rosenthal, Nancy  
**Subject:** CMIR Independent Consultant: CON Docket #s 15-32032-CON and 15-32033-CON

Dear Kim,

It was a pleasure meeting with you on Tuesday. We would like to request your approval to engage Milliman to complete the initial CMIR and appropriate updates.

Sincerely,

Gayle

**Gayle Capozzalo**  
Executive Vice President and  
Chief Strategy Officer

789 Howard Avenue  
New Haven, CT 06519

**Phone:** 203-688-2605

**Fax:** 203-688-3472

**Email:** [gayle.capozzalo@ynhh.org](mailto:gayle.capozzalo@ynhh.org)

YaleNewHavenHealth

This message originates from the Yale New Haven Health System. The information contained in this message may be privileged and confidential. If you are the intended recipient you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you.

## Greer, Leslie

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**From:** Martone, Kim  
**Sent:** Friday, November 18, 2016 2:44 PM  
**To:** Roberts, Karen; Cotto, Carmen  
**Cc:** Greer, Leslie  
**Subject:** FW: DT-YNHHS Independent Monitor - slightly updated contract for your records  
**Attachments:** DT-YNHHS Independent Monitor Eng Ltr REVISED FINAL 111816.pdf

### ***Kimberly R. Martone***

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



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**From:** Sauders, Kelly (US - New York) [<mailto:ksauders@deloitte.com>]  
**Sent:** Friday, November 18, 2016 2:43 PM  
**To:** Martone, Kim  
**Cc:** Capozzalo, Gayle; Rosenthal, Nancy  
**Subject:** RE: DT-YNHHS Independent Monitor - slightly updated contract for your records

Dear Kim - per OHCA's approval of Deloitte as the Independent Monitor for Docket numbers 15-32032-CON and 15-32033-CON, please see the attached updated engagement letter which corrects for a few minor edits (to correct the parties to the BAA and update the Appendix of community groups to reflect the appropriate parties/groups). There are no other changes – just wanted to make sure OHCA has the latest/final copy.

Please feel free to call me directly with any questions.

Thanks,  
Kelly

### **Kelly J. Sauders**

Partner  
Deloitte Advisory  
30 Rockefeller Plaza  
New York, NY 10112  
Office: 212 436 3180  
Fax: 212 653 7033  
Mobile: 518 469 0890  
Email: [ksauders@deloitte.com](mailto:ksauders@deloitte.com)

November 7, 2016

Bill Aseltyne  
Senior Vice President & General Counsel  
Yale-New Haven Hospital/Yale New Haven Health System  
789 Howard Ave., CB 230  
New Haven, CT 06519

Dear Bill,

This engagement letter is to confirm the engagement of Deloitte & Touche LLP (“D&T” or “we”), effective as of the date hereof, to provide Yale New Haven Health Services Corporation and its subsidiaries (collectively referred to as “YNHHSC” or the “Company”) the services described below (the “Services”).

### **Scope and Approach**

We understand you are seeking an independent monitor related to the agreed settlement (“Agreement” or “Order”) between YNHHSC and State of Connecticut’s Office of Health Care Access (“OHCA”) to monitor the YNHHSC’s compliance with the Conditions of the Order in the transfer of ownership of Lawrence + Memorial Corporation and its subsidiaries to YNHHSC.

Specific anticipated activities we will assist YNHHSC with will include two work streams:

#### *Workstream 1: Assist YNHHSC with the planning and preparing for monitoring reviews*

- Hold kick-off with YNHHSC responsible persons to discuss the monitor requirements
- Meet with the Connecticut Office of Health Care Access (OHCA), as requested
- Review and agree upon with YNHHSC and OHCA, as applicable, the elements of monitor services as documented in the work plan in Appendix A.

#### *Workstream 2: Assist YHHHS with the independent monitoring activities*

- Refer to Appendix A for a detailed monitor work plan which describes the various required activities and activities associated with each condition of the Order.

We anticipate providing our services both off-site and on-site. Where possible we will perform analysis and preparation activities remotely. We anticipate providing these services for a period of two to five years (as requested by YNHHSC based on requirements of OHCA).

## Engagement Team

Kelly J. Sauders, Partner, Deloitte & Touche LLP, will serve as the lead engagement leader to provide oversight and direction. Ed Sullivan, Principal, Deloitte & Touche LLP will serve as the quality assurance partner, supporting Kelly and the team in the execution of the work. Kaitlin McCarthy, Manager, Deloitte & Touche LLP, will serve as the overall project manager. Additional support will be provided by other professionals from Deloitte & Touche LLP's Regulatory & Compliance practice, as needed, during the course of this engagement.

## Deliverables

The following deliverables will be produced during the course of this engagement:

### *Workstream 1: Assist YNHHS with planning and preparing for monitoring reviews*

1. D&T will create and maintain a written plan for fulfilling the duties set forth in the agreement.

### *Workstream 2: Assist YNHHS with independent monitoring activities*

1. D&T will draft and submit a written report within thirty (30) days of the completion of each (semi-annual) on-site review on YNHHS compliance with the conditions of the Order, totaling two reports per reporting year.

## Professional Fees and Timing

The total fees related to this engagement are estimated as follows:

Year 1: \$180,000 - \$190,000

Years 2 through 5 (as required)\* \$150,000-\$160,000

We will bill for our services based on actual hours incurred at the following billing rates:

<b>Resource Level</b>	<b>Hourly Rate</b>
Partner	\$625
Senior Manager	\$550
Manager	\$510
Senior Consultant	\$445
Consultant	\$380

\* Note that hourly rates will increase approximately 3% per year for years 3, 4 and 5.

This estimated fee and time estimate is based upon our current understanding of the project requirements, our proposed approach, our estimate of the level of effort required, our roles and responsibilities, any assumptions set forth herein, and active participation of Company's management and other personnel. We

plan to meet with you on no less than a quarterly basis to review time incurred and estimates to completion throughout the duration of this engagement.

Based on our experience, issues sometimes arise that require procedures beyond what was initially anticipated. If this should occur, we will discuss it with you promptly and early in the process before we perform any additional work.

We understand that you will reimburse us for all reasonable expenses incurred in performing the Services on this engagement (including, but not limited to, our reasonable travel, meal, lodging, and mileage expenses). Expenses will be noted separately on our invoices and segregated by expense type.

Fees for this engagement will be billed biweekly as the work progresses for fees accrued and expenses incurred by us since our last invoice in performing our Services.

### **Other Matters**

YNHHSC is, among other things, a regulatory/compliance and merger & acquisition services client of D&T and/ or its affiliated and related entities. We do not believe that the proposed services impair the objectivity for D&T to perform the proposed services for YNHHSC. However, we are bringing this to your attention to avoid any misunderstanding.

Should a potential conflict come to the attention of the engagement leader with respect to potential future work being performed or to be performed by D&T or one of its affiliated or related entities for YNHHSC, D&T will advise YNHHSC promptly. YNHHSC will, at its option and in consultation with the Connecticut Office of Health Care Access as appropriate, promptly request, in writing, (1) such entity not to proceed with the proposed services or (2) such entity to proceed with the proposed services, provided that such entity agrees to proceed. If YNHHSC requests such entity to proceed with the proposed services, YNHHSC agrees that D&T and its affiliated and related entities' are able to perform the proposed services objectively. If appropriate, such entity will establish an ethical wall and confidentiality safeguards so that the services will be performed by different personnel on the various engagements.

### **Acknowledgements and Agreements**

The Company specifically acknowledges and agrees to the following:

- Substantial and meaningful involvement of management of the Company is critical to the success of this engagement. The Company shall be responsible for ensuring that the identified Company personnel actively participate in both the planning and execution of this engagement.
- D&T will not make any management decisions, perform any management functions, or assume any management responsibilities.
- The Company agrees that any deliverables provided to the Company hereunder by D&T may be disclosed to the State of Connecticut's Office of Health Care Access ("OHCA") to the extent required by such regulator in connection with an investigation or examination of the Company. To the extent permitted by law, rule, regulation and applicable professional standards, YNHHSC shall be promptly notified in the event such deliverable(s) are provided by D&T to the OHCA.

- Company will limit sensitive information, such as PII, PHI, trade secrets and other information that it considers sensitive or highly confidential, it provides to D&T (or otherwise makes available to D&T) to only that which is reasonably necessary to allow D&T to provide the Services. D&T will provide Company with a list of D&T personnel who are authorized to receive or have access to Company sensitive information. Such list may be updated as needed. Any disclosure of sensitive information by Company to D&T will utilize levels of information security and data encryption appropriate to maintain security of Company sensitive information being accessed by or transferred to D&T, and as required by applicable information protection laws.
- The Services will be performed in accordance with the Statement on Standards for Consulting Services that is issued by the American Institute of Certified Public Accountants (“AICPA”). However, the Services will not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body and, therefore, we will not express an opinion or any other form of assurance as a result of performing the Services.
- We will not provide any legal advice regarding our Services nor will we provide any assurance regarding the outcome of any future audit or regulatory examination or other regulatory action; the responsibility for all legal issues with respect to these matters, such as reviewing all deliverables and work product for any legal implications to the Company, will be the Company’s.
- The Services may include advice and recommendations, but all decisions in connection with the implementation of such advice and recommendations shall be the responsibility of, and made by, the Company.

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During the term of this engagement, the Company may request that D&T perform additional services that are not encompassed by this engagement letter. D&T may perform such additional services upon receipt of a separate signed engagement letter with terms and conditions that are acceptable to D&T and the Company. Our observations and recommendations will be based solely on the results of the assessment performed.

This engagement letter, together with the General Business Terms attached hereto as Appendix B and the Business Associate Addendum attached hereto as Appendix C and made a part hereof constitute the entire agreement between the Company and D&T with respect to this engagement, supersede all other oral and written representations, understandings, or agreements relating to this engagement, and may not be amended except by the mutual written agreement of the Company and D&T.

Please indicate your acceptance of this agreement by signing in the space below and returning a fully executed copy of this engagement letter to us. A duplicate of this engagement letter is provided for your records. We look forward to serving you. If you have any questions please contact Kelly Saunders at (212) 436-3180.

Very truly yours,

Deloitte & Touche LLP



By: Kelly J. Saunders  
Partner

**Accepted and Agreed to by:**

Yale New Haven Health Services Corporation on behalf of itself and its subsidiaries

By:



Title:

Executive VP / Chief Strategy Officer

Date:

11/7/16

**APPENDIX A. MONITORING PROCEDURES (per Docket Numbers 15-32032-CON and 15-32033-CON)**

Condition	D&T Procedure
<p><b>Strategic Plan</b></p> <p><u>15-32033-CON Condition 4:</u> Within one hundred and eighty (180) days following the Closing Date of 9/8/16, YNHHS shall submit a plan demonstrating how health care services will be provided by L+MH for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and YNHHS. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p> <p>NOTE 1: This applies only to Eastern Connecticut which has been defined in the Affiliation Agreement as Tolland, Windham and New London counties.</p> <p>Note 2: Refer to Condition #19 which addresses the same/similar requirements</p>	<p>D&amp;T will obtain a copy of the Services Plan/Strategic Plan submitted for Condition #4 and #19, verify timely submission, verify that it incorporates the required elements (e.g. describing any planned consolidation, reduction, or elimination of existing services or introduction of new services) and that it meets the 3 year requirement.</p>
<p><u>15-32033-CON Condition 19:</u> L+M and YNHHS shall develop a strategic plan to focus on the retention and enhancement of healthcare services in the primary service area, i.e. towns served by L+M, which assures patient affordability and is consistent with appropriate standards of care, quality, and accessibility. Such plan shall seek to minimize travel for patients requiring clinical services that can be provided appropriately at L+M service sites, and to support the return of patients back to L+M and its medical staff for care should patients be referred to other YNHHS affiliated facilities for specialized care not available locally. The strategic plan shall include but not be limited to the following components:</p> <p>a. L+M shall enhance access to primary care physician services in the Eastern Connecticut region by recruiting and retaining eight additional primary care providers and other providers required to respond to local community need, in accordance with the community needs assessment in paragraph 31 herein and shall accommodate improvements to delivery models including value based care during such period. L+M shall demonstrate annual progress toward achieving these goals.</p>	<p>D&amp;T will obtain the Services Plan/Strategic Plan submitted for Condition #4 and #19 and review the plan for inclusion of these required components (as compared to the needs described within the Community Needs Assessment and the resource commitments within the Affiliation Agreement).</p>

Condition	D&T Procedure
<p>b. YNHHC and L+M shall abide by the resource commitments for clinical service programming as set forth in the Affiliation Agreement.</p> <p>NOTE 1: Refer to Condition #4 which addresses the same requirements.</p>	
<p><u>15-32033-CON Condition 32b</u>: A narrative description of the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by L+M, including with respect to physician recruitment and resource commitments for clinical service programming, whether the commitments described in the Affiliation Agreement were achieved, as well as the purposes, dates and amounts for which expenditures were made.</p>	<p>For 15-32033-CON Condition 32 requirements a through e and g, D&amp;T will obtain a copy of YNHHC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met including referencing specific locations of primary care physicians.</p>
<p><u>15-32033-CON Condition 7</u>: Within one hundred and eighty (180) days following the Closing Date and thereafter until the capital commitment <sup>1</sup>is satisfied, YNHHC shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in L+M and its affiliates from the \$300M Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:</p> <p>a. A list of the capital expenditures <sup>2</sup>that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and</p> <p>b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including</p>	<p>D&amp;T will obtain the Plan (per 15-32033-CON Conditions #4 and #19). We will read the plan and verify that expenditures/investments made are in accordance with the Plan. We will discuss any questions/need for clarification with Management to ensure the expenditures are verified. D&amp;T will confirm detailed, full and timely submissions, with appropriate signatures of all required reports.</p>

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<sup>1</sup> Per discussion with OHCA, we understand that “capital requirement” per this Order is intended to mean “resource commitment”. YNHHC will describe the plan/resource commitment per Conditions #4 and #19 of this Order.

<sup>2</sup> See footnote 4.

Condition	D&T Procedure
<p>estimated beginning, ending a 11d startup/operation dates); and</p> <p>c. The funding source of the capital investment<sup>3</sup> indicating whether it was drawn from operating revenue, capital contributions from YNHHSO or another source and, if funding was drawn from another source, indicating the source.</p> <p>For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th beginning May 31, 2017. The reports shall be signed by L+MH's or L+M's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project.</p>	
<p><u>15-32033-CON Condition 5</u>: Until such time as the Services Plan is submitted<sup>4</sup>, YNHHSO shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for L+MH specific to those services that existed at L+MH as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: Cross-reference to Condition #18</p>	<p>D&amp;T will confirm that notices of reallocation or relocation were submitted in a timely manner and published on the L+MH website within ten days. Per related 15-32033-CON Condition #18, D&amp;T will confirm that any changes or reallocation of services are not in conflict with the requirements of 15-32033-CON Condition #18.</p>

<sup>3</sup> Per discussion with OHCA, we understand that “capital investment” per this Order is intended to mean expenditures/investment made”.

<sup>4</sup> The Services Plan is due 180 days after the closing date of September 8, 2016. Therefore this provision only applies until the Services Plan per Condition #4 is submitted.

Condition	D&T Procedure
<p><u>15-32033-CON Condition 18</u>: L+MH shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need.</p> <p>NOTE 1: See related Condition #1 which applies to the first 180 dates post-closing. Following that time, YNHHS is bound by Condition #4 and the Services Plan created per Condition #4</p>	<p>D&amp;T will confirm that these services are properly maintained by conducting site visits, and ongoing data analysis of unit and patient data (e.g. to see continuing patient volume/services).</p> <p>YNHHS will provide a Management Attestation/Representation to OHCA that it is in compliance with 15-32033-CON Condition #18. D&amp;T will obtain a copy of that Management Representation.</p>
<p><u>15-32033-CON Condition 32a</u>: Every six months ( the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHS shall submit notarized reports to OHCA for the periods of October 1 – September 30 with reports due November and May certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <p>a. Affirmation of the continuation of all L+MH services as described herein.</p>	<p>For 15-32033-CON Condition 32 requirements a through e and g, D&amp;T will obtain a copy of YNHHS's notarized Management Representation to OHCA that 15-32033-CON Condition 32 requirements a through e and g have been met.</p>
<p><b>Financial Reporting</b></p>	
<p><u>15-32033-CON Condition 8</u>: For three (3) years following the Closing Date, YNHHS shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than two (2) months after the end of each semi-annual period (fiscal year). Due dates are May 31st and November 30<sup>th</sup>, beginning May 2017. The following financial measurements/indicators should be addressed in the report: (i) <b>Operating performance</b> to include operating margin, non-operating margin, and total margin; (ii) <b>Liquidity</b> to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) <b>Leverage and capital structure</b> to include long-term debt to equity, long-term debt to capitalization,</p>	<p>D&amp;T will obtain the financial measurement report and review work papers to ensure that they are consistent with financial reports being submitted to L+M Hospital Board and that the required elements and financial measurements are appropriately recorded in the report; we will confirm the timely submission of each report.</p>

Condition	D&T Procedure
<p>unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and equity financing ratio; and (iv) <b>Additional Statistics</b> to include income from operations, revenue over (under) expense, cash from operation, cash and cash equivalents, net working capital, free cash flow (and the elements used in the calculation, unrestricted net assets/retained earnings, bad debt as a percentage of gross revenue, and credit ratings.</p>	
<p><u>15-32033-CON Condition 32f</u>: A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHS information technology systems and platforms, YNHHS's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHS population health initiatives. Subsequent to submission of the plan in its six month report, YNHHS shall include the following additional information in its annual report.</p> <ol style="list-style-type: none"> <li data-bbox="375 1104 922 1304">i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M of YNHHS non-clinical shared services opportunities;</li> <li data-bbox="375 1339 922 1902">ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHS shall also file a narrative describing the</li> </ol>	<p>For 15-32033-CON Condition #32F, D&amp;T will obtain the Five-Year Plan prepared by YNHHS and the ongoing six month reports based on fiscal year. We will verify that the required elements are included in the report and are documented and supported by underlying information. We will confirm timely submission of all reports (OHCA's, HRS, Report 100, Report 150 and Report 175 and succession reports to OHCA.</p>

Condition	D&T Procedure
<p>specifics of the cost savings for each of these major expense categories;</p> <p>iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and</p> <p>iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.</p>	
<p><u>15-32032-CON Condition 7c</u>: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHS shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31) and April 1 through September 30 (due November 30) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <p>A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHS information technology systems and platforms, YNHHS's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHS population health initiatives. Subsequent to submission of the plan in its six month report, YNHHS shall include a completed Balance Sheet, Statement of Operations, and Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and</p>	<p>Refer to procedures for 15-32033-CON Condition #32f in the work plan above.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 6:</u> Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price<sup>5</sup> per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period October 1, 2015 – September 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the proposed transfer of ownership does not adversely affect health care costs.</p>	<p>D&amp;T will obtain YNHHSC’s analysis of the top 25 most frequent MS-DRGs and CPT codes and related weighted average price information.</p> <p>D&amp;T will review work papers to confirm information and timely filing.</p> <p>* 1<sup>st</sup> filing is due within 180 days (March 2017); 2<sup>nd</sup> filing is due 60 days after the close of FY2017 which is 11/30/17 and the 3<sup>rd</sup> filing is due 60 dates after the close of FY2018 which is 11/30/18.</p>
<b>Cost and Market Impact Review</b>	
<p><u>15-32033-CON Condition 22:</u> Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below:</p> <p>a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHSC shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.</p>	<p>D&amp;T will confirm that YNHHSC initiated this review within 90 days of closing by obtaining a copy of the relevant contract/engagement letter as evidence. D&amp;T will also confirm that the analysis addresses the required elements.</p> <p>D&amp;T will obtain a copy of the CMIR performed by the Independent Consultant.</p> <p>D&amp;T will meet annually with the Independent Consultant.</p>

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<sup>5</sup>For purposes of this calculation, “total prices per unit of service” will be the weighted average price across all payers per unit of service.

Condition	D&T Procedure
<p>b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.</p>	
<p>c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purposes of determining further conditions as necessary to</p>	

Condition	D&T Procedure
<p>correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHS is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases.</p> <p>d. The independent consultant shall report to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area.</p> <p>e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHS and L+M, unless required to do by law.</p>	
<p><u>15-32032-CON Condition 3:</u> Within ninety days of the Date of Closing, YNHHS shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below:</p> <p>a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined in d. below)</p>	<p>Refer to procedures for 15-32033-CON Condition #22 above.</p>

Condition	D&T Procedure
<p>for L+MH and LMMG (the "annual CMIR update"). Yale New Haven shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.</p> <p>b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 10a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.</p> <p>c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in</p>	

Condition	D&T Procedure
<p>the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purpose of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases.</p> <p>d. The independent consultant shall take direction from the Commissioner of the Department of Public Health. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area.</p> <p>e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do so by law. The confidential information and documents shall not be public records and shall be exempt from disclosure under Connecticut General Statute Section 1-210.</p>	

Condition	D&T Procedure
<p><u>15-32033-CON Condition 23:</u> For purposes of determining the price per unit of service:</p> <ul style="list-style-type: none"> <li>f. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures.</li> <li>g. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state.</li> <li>h. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU).</li> <li>i. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service.</li> <li>j. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.</li> </ul>	<p>D&amp;T will obtain a copy of the CMIR performed by the Independent Consultant. D&amp;T will meet annually with the Independent Consultant.</p> <p>D&amp;T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.</p>
<p><u>15-32032-CON Condition 4:</u> For purposes of determining the price per unit of service:</p> <ul style="list-style-type: none"> <li>a. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-</li> </ul>	<p>D&amp;T will obtain a copy of the CMIR performed by the Independent Consultant.</p>

Condition	D&T Procedure
<p>10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures.</p> <p>b. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state.</p> <p>c. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU).</p> <p>d. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service.</p> <p>e. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.</p>	<p>D&amp;T will meet annually with the Independent Consultant.</p> <p>D&amp;T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 20 Paragraph 1</u>: L+M and YNHHSC shall maintain the current L+MH and Lawrence + Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017 shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.</p>	<p>D&amp;T will evaluate and verify that contracts are maintained in accordance with this condition. We will meet with YNHHSC Management to read the contracts and confirm that this condition is met.</p>
<p><u>15-32033-CON Condition 32c</u>: Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of Conditions (20), (21) and (22) above.</p>	<p>For 15-32033-CON Condition 32c, D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32c requirements have been met. We will meet with YNHHSC Management to read the contracts and confirm that this condition is met.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 20 Paragraphs 2/3</u>: Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHS shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation and in addition as set forth in paragraph 25 herein. YNHHS shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut.</p> <p>For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to cap determined through the process set forth below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.</p>	<p>D&amp;T will obtain the Independent Consultant/CMIR Report which should address/provide analysis to confirm paragraphs 2 and 3 of 15-32033-CON Condition #20. D&amp;T as the Monitor will not independently perform additional/separate procedures related to paragraphs 2 and 3 of 15-32033-CON Condition #20.</p>

Condition	D&T Procedure
<p><u>15-32032-CON Condition 1</u>: Lawrence &amp; Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017 shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.</p> <p>Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHS shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation. YNHHS shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut.</p> <p>For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to a cap determined through the process set forth in Paragraphs 3 and 4 below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.</p>	<p>Refer to procedures for 15-32033-CON Condition #20 outlined here and 1532033-CON Condition 20a, 20b and 20c.</p>

Condition	D&T Procedure
<p><u>15-32032-CON Condition 7a</u>: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHS shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31) and April 1 through September 30 (due November 30) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <p>a. Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of paragraphs (20), (21) and (22) above.</p>	<p>Refer to procedures for 15-32033-CON Condition #32c.</p>
<p><u>15-32033-CON Condition 21a</u>: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph 20 above, i.e. physicians providing services through NEMG to L + M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.</p>	<p>D&amp;T will receive samples of payer submissions for LMMG physicians and obtain YNHHS's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21a.</p>

Condition	D&T Procedure
<p><u>15-32032-CON Condition 2a:</u> With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph I above, i.e. physicians providing services through NEMG to L+M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.</p>	<p>Refer to procedures for 15-32033-CON Condition #21a above.</p>
<p><u>15-32033-CON Condition 21b:</u> With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>Physicians who are hired, recruited or contracted by a YNHHS affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 20: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 20.</p>	<p>D&amp;T will obtain YNHHS's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21b.</p>

Condition	D&T Procedure
<p><u>15-32032-CON Condition 2b:</u> With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):</p> <p>b. Physicians who are hired, recruited or contracted by a YNHHS affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 1: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 1.</p>	<p>Refer to procedures for 15-32033-CON Condition #21b above.</p>
<b>Independent Monitor</b>	
<p><u>15-32033-CON Condition 15:</u> Within sixty (60) days after the Closing Date, YNHHS shall contract with an Independent Monitor who has experience in hospital administration and regulation. The Independent Monitor shall be retained at the sole expense of YNHHS. Representatives of OHCA and FLIS will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years<sup>6</sup> following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the</p>	<p>D&amp;T and YNHHS will execute an Engagement Letter by the required date. A copy of this Engagement Letter will be provided to OHCA.</p>

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<sup>6</sup> The Monitor may be required for only 1 (one) year or up to five (5) years as determined in writing by OHCA.

Condition	D&T Procedure
<p>Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the conditions set forth herein.</p> <p>NOTE: See Condition #33a (appointment of Monitor requirement)</p>	
<p><u>15-32033-CON Condition 16:</u> The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis<sup>7</sup> to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHSOC will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.</p>	<p>D&amp;T will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration/Leadership and review of any documentation requested by D&amp;T. D&amp;T will provide a report that summarizes the activities from the prior six month period along with any recommendations or observations to YNHHSOC, OHCA, and FLIS.</p> <p>Procedures associated with 15-32033-CON Condition #16 are expected to coincide/satisfy 15-32033-CON Conditions 33b and 33d as well.</p>
<p><u>15-32033-CON Condition 33:</u> In addition to the above, L+M and YNHHSOC make the following commitment for a period of five years post-Closing:</p> <p>a. L+M and YNHHSOC shall appoint an independent monitor at their own cost (selected by YNHHSOC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor.</p>	<p>For 15-32033-CON Condition #33a, refer to 15-32033-CON Condition #15.</p> <p>15-32033-CON Condition #33b – D&amp;T will meet with CHNA/CHIP “participation</p>

<sup>7</sup> The semi-annual basis will be defined as six months post-closing and on the anniversary of the closing date to coincide with meetings with the community representatives per Conditions # 33b and 33d

Condition	D&T Procedure
<p>b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.</p>	<p>group<sup>8</sup> in March 2017 for an initial introduction and will meet with this group annually thereafter to present the annual Monitor report. Relative to (ii), Refer to the procedures performed per Conditions #11 and #31. Minutes will be maintained by D&amp;T of these meetings and provided to OHCA upon request.</p>
<p>c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties.</p>	<p>With respect to 15-32033-CON #33d, D&amp;T will review the public notice and attend the public forum held by YNHHSC and confirm that it includes members of the CHIP (Community Health Improvement Program) group.</p>
<p>d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.</p>	<p>With respect to 15-32033-CON #33e, D&amp;T agrees to provide written notice of any deficiencies as required.</p>
<p>e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate connective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce</p>	

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<sup>8</sup> See attached list.

Condition	D&T Procedure
<p>these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653. In addition, in the event OHCA determines YNHHS and L+M are in material non-compliance, OHCA may order YNHHS and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.</p>	
<p><u>15-32032-CON Condition 8</u>: In addition to the above, L+M and YNHHS make the following commitment for a period of five years post-Closing:</p> <ol style="list-style-type: none"> <li>a. L+M and YNHHS shall appoint an independent monitor at their own cost (selected by YNHHS and L+M and approved by OHCA) to serve as a post-transfer compliance monitor.</li> <li>b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.</li> <li>c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties.</li> <li>d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.</li> </ol>	<p>Refer to procedures for 15-32033-CON Condition #33 a through e above.</p>

Condition	D&T Procedure
<p>e. If the Independent Monitor determines that YNHHS and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHS and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHS and L+M for the purpose of determining compliance and any appropriate corrective action plan. If YNHHS and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHS and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653 In addition, in the event OHCA determines YNHHS and L+M are in material non-compliance, OHCA may order YNHHS and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.</p>	
<p><b>Community Benefit</b></p>	
<p><u>15-32033-CON Condition 11:</u> The Applicants shall maintain community benefit programs and community building activities for L+MH for three (3) years after the Closing Date consistent with L+MH's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as L+MH's current programs, and the Applicants shall apply no less than a 1% increase per year for the next three (3) years toward the L+MH's community building activities in terms of dollars spent.</p>	<p>D&amp;T will obtain L+MH's most recent Schedule H of IRS Form 990 to act as a baseline. We will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase requirement has been met.</p> <p>D&amp;T will also obtain the YNHHS report/summary on</p>

Condition	D&T Procedure
<p>In determining L+MH' s participation and investment in both community benefits and community building activities, the Applicants shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.</p> <p>a. On an annual basis, YNHHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing for three years and shall be posted on L+MH's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>the amounts and uses related to community benefits and community building per the categories identified in the CHNA. D&amp;T will evaluate these reports/summaries as compared to the CHNA and defined population health management objectives and will discuss any questions with YNHHSC Management. D&amp;T will confirm that these documents are filed in a timely manner and posted to the L+MH website.</p>
<p><u>15-32033-CON Condition 31</u>: L+M and YNHHSC have agreed to maintain at least the same level of community benefit consistent with L+M's most recent Schedule H of IRS Form 990 and its Community Health Needs Assessment (CHNA). L+M and YNHHSC agree to conduct an updated Community Health Needs Assessment by no later than December 31, 2016, and provide services in accordance with implementation plan adopted as part of the updated CHNA process and provide OHCA with its updated CHNA within thirty days of its approval.</p>	<p>After obtaining L+M's baseline Schedule H of IRS Form 990, D&amp;T will obtain and confirm that L+M and YNHHSC have increased community benefit by 1% per year for the first three (3) years of this agreement. Thereafter for years 4 and 5, we will confirm that the level of community benefit provided in year 3 was at least maintained (not required to increase in years 4 and 5).</p> <p>Cross-reference to 15-32033-CON Condition #11.</p>
<p><u>15-32033-CON Condition 32h</u>: A narrative description of L+M's community benefit commitments described herein, including without limitation the amounts spent and a description of such spending to support and invest in the communities that L+M serves.</p>	<p>Relative to 15-32033-CON Condition #32h, see procedures performed for 15-32033-CON Conditions #11 and #31.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 12</u>: The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. Specifically, the Applicants shall ensure that L+MH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the Applicants shall provide at L+MH, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the Applicants shall ensure that L+MH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, YNHHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population.</p>	<p>D&amp;T will obtain and review interpreter services policies and contracts as applicable. Additionally, our team will obtain the cultural competency plan, training and related policies. We will also obtain YNHHSC's report and supporting documents and confirm the timely filing of these materials.</p>
<b>Charity Care Policies</b>	
<p><u>15-32033-CON Condition 9</u>: Following the Closing Date, L+MH will adopt YNHHSC's financial assistance (charity and free care) policies or adopt other policies that are at least as generous and benevolent to the community as L+MH's current policies, consistent with state and federal law. These policies shall be posted on the website pages of L+MH and as additionally required by applicable law, OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>D&amp;T will obtain copies of the relevant financial assistance policies and confirm that L+MH has adopted YNHHSC's financial assistance policies (or policies at least as generous as these policies) using L+M Hospital board resolutions. After verifying that this step has been properly completed, we will confirm that these policies are properly posted on L+MH's website.</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 10</u>: For three (3) years following the Closing Date, YNHHSC shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of L+MH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of L+MH simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>After obtaining original L+MH policies on charity care, indigent care, and community volunteer services, D&amp;T will read and assess these policies on an annual basis for changes. When changes are made to these policies, we will confirm OHCA is notified (as required) and revised policies are posted to the L+MH website.</p>
<p><u>15-32033-CON Condition 32e</u>: Affirmation that L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.</p>	<p>For 15-32033-CON Condition 32 requirements a through e and g, D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met.</p>
<b>Employment Conditions</b>	
<p><u>15-32033-CON Condition 27</u>: L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.</p>	<p>D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #27 has been met.</p>
<p><u>15-32033-CON Condition 32g</u>: Affirmation of the labor and employment commitments described herein, including but not limited to L+M's service sites continued honoring of collective bargaining agreements in place as of the date hereof.</p>	<p>See others below</p>

Condition	D&T Procedure
<p><u>15-32033-CON Condition 28</u>: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHS C affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).</p>	<p>D&amp;T will obtain a copy of YNHHS C's Management Representation to OHCA that 15-32033-CON Condition #28 has been met.</p>
<p><u>15-32032-CON Condition 6</u>: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHS C affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).</p>	<p>Refer to procedures for 15-32033-CON Condition #28.</p>
<p><u>15-32033-CON Condition 29</u>: L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.</p>	<p>D&amp;T will obtain a copy of YNHHS C's Management Representation to OHCA that 15-32033-CON Condition #29 has been met.</p>
<p><u>15-32033-CON Condition 30</u>: L+M and YNHHS C shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.</p>	<p>D&amp;T will obtain a copy of YNHHS C's Management Representation to OHCA that 15-32033-CON Condition #30 has been met.</p>

Condition	D&T Procedure
<b>Governance</b>	
<p><u>15-32033-CON Condition 14:</u> For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as voting members of L+MH' s Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>D&amp;T will confirm the appointment of this individual (community representative) to the L+MH Board as evidenced by Board minutes. We will discuss the selection process with Management and document our understanding of the selection process/qualifications of the individual.</p>
<p><u>15-32033-CON Condition 17:</u> For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.</p>	<p>To confirm compliance with this provision, D&amp;T will obtain minutes from these Joint Board Meetings and confirm that notice of the public meetings is posted with proper notice.</p> <p>D&amp;T will attend the public meetings as part of the Monitor role.</p>
<p><u>15-32033-CON Condition 26:</u> As described in the Affiliation Agreement, YNHHSC is committed to maintaining local governance at L+M. The L+M Board of Directors shall continue as a fiduciary board composed of a majority of members who reside in the communities served by L+M with the only change in composition being the addition of the President/CEO of YNHHSC (or his or her designee) serving as an ex-officio member. Each director of the L+M Board of Directors shall have an equal vote. The L+M Board shall be empowered and supported to oversee local performance and to create and sustain connections with the community. Subject to certain reserved powers for YNHHSC, the L+M Board of directors will have the right to approve any major new programs and clinical services, or the discontinuation or consolidation of any such programs.</p>	<p>D&amp;T will obtain and evaluate the Board of Directors bylaws to confirm that L+M Board maintains rights and powers specified in the Order.</p>

Condition	D&T Procedure
<p align="center"><b>Licensure, Physician Office Conversion, Cost Savings Attainment</b></p>	
<p><u>15-32033-CON Condition 13</u>: The Applicants shall abide by all requirements of licensure that may be imposed by the Facility Licensing and Investigations Section ("FLIS") of the Department of Public Health ("DPH") in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA is imposing this Condition to ensure that quality health care services are provided to the patient population.</p>	<p>D&amp;T will, if necessary, work with DPH to ensure compliance with this Condition.</p>
<p><u>15-32033-CON Condition 24</u>: L+M and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.</p>	<p>D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #24 has been met.</p>
<p><u>15-32033-CON Condition 32d</u>: Affirmation that no L+M physician office has been converted to hospital-based status.</p>	<p>D&amp;T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #32d has been met.</p>
<p><u>15-32032-CON Condition 5</u>: L+MH and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.</p>	<p>Refer to procedures for 15-32033-CON Condition #24 above.</p>
<p><u>15-32032-CON Condition 7b</u>: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31st) and April 1 through September 30 (due November 30th) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:</p> <p>Affirmation that no L+M physician office has been converted to hospital-based status.</p>	<p>Refer to procedures for 15-32033-CON Condition #32f above.</p>
<p><u>15-32033-CON Condition 25</u>: L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application.</p>	<p>D&amp;T will obtain and read YNHHSC's reporting created per 15-32033-CON condition #32f.</p>

**Footnote 8 Attachment**

Representative	Thames Valley Council of Community Action
Representative	Universal Health Foundation
Representative	United Community and Family Services
Representative	NL County Food Policy Council
Representative	Groton Parks and Recreation
Representative	Hispanic Alliance
Representative	Ledge Light Health District
Representative	Uncas Health District
Representative	City of New London
Representative	Community Foundation of Eastern CT
Representative	Connecticut College
Representative	Community Health Center, Inc.
Representative	Higher Edge
Representative	UConn Health Disparities Institute
Representative	Chamber of Commerce of Eastern Connecticut
Representative	Greater Mystic Chamber of Commerce
Representative	Rotary Clubs of New London and Groton
Representative	Southeastern Connecticut Women's Network
Representative	Tribal Councils

## APPENDIX B: GENERAL BUSINESS TERMS

### Client: Yale New Haven Health Services Corporation (“Yale New Haven Health” or the “System”)

- 1. Services.** It is understood and agreed that the services provided by Deloitte & Touche LLP (Deloitte & Touche) (as defined in paragraph 13) (the “Services”) under the engagement letter to which these terms are attached (the “Engagement Letter”) may include advice and recommendations, but all decisions in connection with the implementation of such advice and recommendations shall be the responsibility of, and made by, the System. For purposes of these terms and the Engagement Letter, the “System” shall mean Yale New Haven Health Services Corporation and its subsidiaries. Yale New Haven Health Services Corporation represents and warrants that it has the power and authority to execute this agreement on behalf of, and to bind, itself and its subsidiaries.
- 2. Exclusion.** Deloitte & Touche represents and warrants that neither Deloitte & Touche nor any of its employees providing the Services: (1) has ever been (A) convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) excluded or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) otherwise sanctioned by the federal government, including being listed on the General Services Administration’s Excluded Party Listing System and (2) shall notify System immediately in the event that the Consultant (A) is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) is excluded or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) is otherwise sanctioned by the federal government, including being listed on the General Services Administration’s Excluded Party Listing System. System may terminate this Agreement immediately in the event that Deloitte & Touche or any of its employees (A) is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) is excluded from or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) is otherwise sanctioned by the federal government, including being listed on the General Services Administration’s Excluded Party Listing System.
- 3. Payment of Invoices.** Deloitte & Touche’s invoices are due upon presentation. Without limiting its rights or remedies, Deloitte & Touche shall have the right to halt or terminate the Services entirely if payment is not received within sixty (60) days of the invoice date. The System shall be responsible for all taxes imposed on the Services or on the transaction, other than Deloitte & Touche’s income taxes or tax imposed by employment withholding, and other than taxes imposed on Deloitte & Touche’s property.
- 4. Term.** Unless terminated sooner in accordance with its terms, this engagement shall terminate on the completion of the Services. This engagement may be terminated by either party at any time, with or without cause, by giving written notice to the other party not less than sixty (60) days before the effective date of termination, provided that, in the event of a termination for cause, the breaching party shall have the right to cure the breach within the notice period. Deloitte & Touche may terminate this engagement upon written notice to the System if it determines that (a) a governmental, regulatory, or professional entity (including, without limitation, the American Institute of Certified Public Accountants, the Public Company Accounting Oversight Board, or the Securities and Exchange Commission), or an entity having the force of law, has introduced a new, or modified an existing, law, rule, regulation, interpretation, or decision, the result of

which would render Deloitte & Touche's performance of any part of the engagement illegal or otherwise unlawful or in conflict with independence or professional rules; or (b) circumstances change (including, without limitation, changes in ownership of the System or any of its affiliates) such that Deloitte & Touche's performance of any part of the engagement would be illegal or otherwise unlawful or in conflict with independence or professional rules. Upon termination of the engagement, the System will compensate Deloitte & Touche under the terms of the Engagement Letter for the Services performed and expenses incurred through the effective date of termination.

## **5. Deliverables.**

a) Deloitte & Touche has created, acquired, or otherwise has rights in, and may, in connection with the performance of the Services, employ, provide, modify, create, acquire, or otherwise obtain rights in, works of authorship, materials, information, and other intellectual property (collectively, the "Deloitte & Touche Technology").

b) Except as provided below, upon full and final payment to Deloitte & Touche hereunder, the tangible items specified as deliverables or work product in the Engagement Letter (the "Deliverables") shall become the property of the System. To the extent that any Deloitte & Touche Technology is contained in any of the Deliverables, Deloitte & Touche hereby grants the System, upon full and final payment to Deloitte & Touche hereunder, a royalty-free, fully paid-up, worldwide, nonexclusive license to use such Deloitte & Touche Technology in connection with the Deliverables.

c) To the extent that Deloitte & Touche utilizes any of its property (including, without limitation, the Deloitte & Touche Technology or any hardware or software of Deloitte & Touche) in connection with the performance of the Services, such property shall remain the property of Deloitte & Touche and, except for the license expressly granted in the preceding paragraph, the System shall acquire no right or interest in such property. Notwithstanding anything herein to the contrary, the parties acknowledge and agree that (1) Deloitte & Touche shall own all right, title, and interest, including, without limitation, all rights under all copyright, patent, and other intellectual property laws, in and to the Deloitte & Touche Technology and (2) Deloitte & Touche may employ, modify, disclose, and otherwise exploit the Deloitte & Touche Technology (including, without limitation, providing services or creating programming or materials for other clients). Deloitte & Touche does not agree to any terms that may be construed as precluding or limiting in any way its right to (1) provide consulting or other services of any kind or nature whatsoever to any person or entity as Deloitte & Touche in its sole discretion deems appropriate or (2) develop for itself, or for others, materials that are competitive with or similar to those produced as a result of the Services, irrespective of their similarity to the Deliverables.

d) To the extent any Deloitte & Touche Technology provided to the System hereunder is a product (to the extent it constitutes merchandise within the meaning of section 471 of the Internal Revenue Code), such Deloitte & Touche Technology is licensed to the System by Deloitte & Touche as agent for Deloitte & Touche Products Company LLC on the terms and conditions herein. The assignment and license grant in this paragraph 5 do not apply to any works of authorship, materials, information, or other intellectual property (including any modifications or enhancements thereto or derivative works based thereon) that is subject to a separate license agreement between the System and a third party, including without limitation, Deloitte & Touche Products Company LLC.

**6. Limitation on Warranties. THIS IS A SERVICES ENGAGEMENT. DELOITTE & TOUCHE WARRANTS THAT IT SHALL PERFORM THE SERVICES IN GOOD FAITH AND WITH DUE PROFESSIONAL CARE. DELOITTE & TOUCHE DISCLAIMS ALL OTHER WARRANTIES, EITHER EXPRESS OR IMPLIED, INCLUDING, WITHOUT LIMITATION, WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.**

**7. Limitation on Damages and Indemnification.**

a) The System agrees that Deloitte & Touche, its subcontractors, and their respective personnel shall not be liable to the System for any claims, liabilities, or expenses relating to this engagement (“Claims”) for an aggregate amount in excess of two (2) times the fees paid by the System to Deloitte & Touche pursuant to this engagement, except to the extent finally judicially determined to have resulted primarily from the bad faith, or intentional misconduct of Deloitte & Touche or its subcontractors.

b) Except with respect to Claims for which a party has an indemnification obligation hereunder, in no event shall either party, its subcontractors, or their respective personnel be liable for any loss of use, data, goodwill, revenues, or profits (whether or not deemed to constitute a direct Claim), or any consequential, special, indirect, incidental, punitive, or exemplary loss, damage, or expense relating to this engagement.

c) Except for those claims for which Deloitte & Touche has agreed to indemnify the System pursuant to paragraph 7(d) and, 7(e), the System shall indemnify and hold harmless Deloitte & Touche, its subcontractors, and their respective personnel from all Claims of third parties arising from the use or disclosure of the Services or the Deliverables, except to the extent finally judicially determined to have resulted primarily from the recklessness, bad faith, or intentional misconduct of Deloitte & Touche or its subcontractors.

d) Deloitte & Touche shall indemnify, defend and hold harmless the System, its directors, officers, employees and agents from and against any and all Claims, including reasonable attorneys' fees, in each case solely for bodily injury, death or physical damage to real or tangible personal property, to the extent such Claims are caused by Deloitte & Touche's negligent acts, negligent errors or negligent omissions. In the event such Claims are caused by the joint or concurrent negligence of the parties, they shall be borne by each party in proportion to such party's negligence.

e) Deloitte & Touche agrees to defend the System, its officers and employees from and against any and all claims and pay any settlement costs or any final judgments, including reasonable defense costs and reasonable legal fees, arising out of infringement by the Deliverables of any U.S. patent known to Deloitte & Touche or copyright or any unauthorized use of any trade secret or trademark, except to the extent that such infringement or unauthorized use arises from (i) the System's modification of the Deliverables or use thereof in a manner not contemplated by this engagement, (ii) the failure of the System to use any corrections or modifications made available by Deloitte & Touche, (iii) information, materials, instructions or specifications provided by or on behalf of the System, (iv) the System's distribution, marketing or use for the benefit of third parties of the Deliverables, or (v) the use of the Deliverable in combination with any product or data not provided by Deloitte & Touche whether or not with Deloitte & Touche's consent. If any such Deliverable, or any portion thereof, becomes, or in Deloitte & Touche's reasonable judgment, is likely to become the subject of a claim based upon infringement or unauthorized use, or if any such Deliverable or

any portion thereof, is found by final, non-appealable order of a court of competent jurisdiction to be such an infringement or unauthorized use, Deloitte & Touche, at its option and expense, shall have the right to (x) procure for the System the continued use of such Deliverable, (y) replace or modify such Deliverable provided that the replacement or modified Deliverable is reasonably capable of performing substantially the same function, or (z) require the System to cease use of such Deliverable and refund an appropriate portion of the fee paid with respect to the affected Deliverable. The foregoing provisions of this Paragraph constitute the sole and exclusive remedy of the System, and the sole and exclusive obligation of Deloitte & Touche, relating to a claim that a Deliverable infringes any patent, copyright or other intellectual property right of a third party.

**8. Client Responsibilities.** The System shall cooperate with Deloitte & Touche in the performance by Deloitte & Touche of the Services, including, without limitation, providing Deloitte & Touche with reasonable facilities and timely access to data, information, and personnel of the System. The System shall be responsible for the performance of its personnel and agents and for the accuracy and completeness of all data and information provided to Deloitte & Touche for purposes of the performance by Deloitte & Touche of the Services. The System acknowledges and agrees that Deloitte & Touche's performance is dependent upon the timely and effective satisfaction of the System's responsibilities hereunder and timely decisions and approvals of the System in connection with the Services. Deloitte & Touche shall be entitled to rely on all decisions and approvals of the System. The System shall be solely responsible for, among other things (a) making all management decisions and performing all management functions, (b) designating a competent management member to oversee the Services, (c) evaluating the adequacy and results of the Services, (d) accepting responsibility for the results of the Services, and (e) establishing and maintaining internal controls, including, without limitation, monitoring ongoing activities.

**9. Force Majeure.** Neither party shall be liable for any delays or nonperformance directly or indirectly resulting from circumstances or causes beyond its reasonable control, including, without limitation, acts or omissions or the failure to cooperate by the other party (including, without limitation, entities or individuals under its control, or any of their respective officers, directors, employees, other personnel and agents), acts or omissions or the failure to cooperate by any third party, fire, epidemic or other casualty, act of God, strike or labor dispute, war or other violence, or any law, order, or requirement of any governmental agency or authority.

**10. [Reserved]**

**11. Independent Contractor.**

(a) Deloitte & Touche and System acknowledge and agree that Deloitte & Touche is being retained as an independent contractor, and that Deloitte & Touche shall be responsible for determining the manner and means by which Deloitte & Touche performs the Services. Nothing herein shall be construed to make Deloitte & Touche an employee or agent of System, to entitle Deloitte & Touche to receive the benefits of any employee benefit plan of System, or to create a joint venture or partnership or fiduciary relationship between the parties. Neither party shall not make an unauthorized representation or warranty concerning the products or services of the other party or commit the other party to any agreement or obligation.

(b) No payroll or employment taxes of any kind shall be withheld or paid with respect to payments to Deloitte & Touche hereunder. Deloitte & Touche agrees to indemnify System against, and to defend and hold System harmless from, any liabilities, claims, costs or expenses (including reasonable attorneys' fees) which may be made against System, or incurred by System, in respect of any such payroll or employment taxes.

(c) No workers' compensation insurance has been or will be obtained by System on account of Deloitte & Touche.

## **12. Confidentiality and Internal Use.**

a) The System agrees that all Services and Deliverables shall be solely for the System's informational purposes and internal use, and are not intended to be, and should not be, used by any person or entity other than the System. Except as otherwise specifically provided in the Engagement Letter, the System further agrees that such Services and Deliverables shall not be circulated, quoted, disclosed, or distributed to, nor shall reference to such Services or Deliverables be made to, any person or entity other than the System and other contractors of the System to whom the System may disclose the Deliverables solely for the purpose of such contractors providing services to the System relating to the subject matter of this engagement, provided that the System shall ensure that such contractors do not further circulate, quote, disclose, or distribute such Deliverables, or make reference to such Deliverables, to any person or entity other than the System. Notwithstanding the foregoing, the System shall not be prohibited from creating its own materials based on the content of such Services and Deliverables and using and disclosing such System-created materials for external purposes, provided that the System does not, expressly or by implication, in any manner whatsoever, attribute such materials to Deloitte & Touche or otherwise refer to or identify Deloitte & Touche in connection with such materials.

b) To the extent that, in connection with this engagement, either party (each, the "receiving party") comes into possession of any trade secrets or other proprietary or confidential information of the other (the "disclosing party"), it will not disclose such information to any third party without the disclosing party's consent. The disclosing party hereby consents to the receiving party disclosing such information (1) to subcontractors, whether located within or outside of the United States, that are providing services in connection with this engagement and that have agreed to be bound by confidentiality obligations similar to those in this paragraph 12(b); (2) as may be required by law, regulation, judicial or administrative process, or in accordance with applicable professional standards or rules, or in connection with litigation or arbitration pertaining hereto; or (3) to the extent such information (i) shall have otherwise become publicly available (including, without limitation, any information filed with any governmental agency and available to the public) other than as the result of a disclosure in breach hereof, (ii) becomes available to the receiving party on a nonconfidential basis from a source other than the disclosing party that the receiving party believes is not prohibited from disclosing such information to the receiving party by obligation to the disclosing party, (iii) is known by the receiving party prior to its receipt from the disclosing party without any obligation of confidentiality with respect thereto, or (iv) is developed by the receiving party independently of any disclosures made by the disclosing party to the receiving party of such information. In satisfying its obligations under this paragraph 12(b), each party shall maintain the other's trade secrets and proprietary or

confidential information in confidence using at least the same degree of care as it employs in maintaining in confidence its own trade secrets and proprietary or confidential information, but in no event less than a reasonable degree of care. Nothing in this paragraph 12(b) shall alter the System's obligations under paragraph 12(a). Notwithstanding anything to the contrary herein, the System acknowledges that Deloitte & Touche, in connection with performing the Services, may develop or acquire experience, skills, knowledge, and ideas that are retained in the unaided memory of its personnel. The System acknowledges and agrees that Deloitte & Touche may use and disclose such experience, skills, knowledge, and ideas.

**13. Survival and Interpretation.** All paragraphs herein relating to payment of invoices, deliverables, limitation on warranties, limitation on damages and indemnification, limitation on actions, confidentiality and internal use, survival and interpretation, assignment, nonexclusivity, waiver of jury trial and governing law shall survive the expiration or termination of this engagement. For purposes of these terms, "Deloitte & Touche" shall mean Deloitte & Touche LLP and, for purposes of paragraph 7, shall also mean Deloitte & Touche Products Company LLC, one of its subsidiaries. The System acknowledges and agrees that no affiliated or related entity of Deloitte & Touche, whether or not acting as a subcontractor, or such entity's personnel shall have any liability hereunder to the System or any other person and the System will not bring any action against any such affiliated or related entity or such entity's personnel in connection with this engagement. Without limiting the foregoing, affiliated and related entities of Deloitte & Touche are intended third-party beneficiaries of these terms, including, without limitation, the limitation on liability and indemnification provisions of paragraph 7, and the agreements and undertakings of the System contained in the Engagement Letter. Any affiliated or related entity of Deloitte & Touche may in its own right enforce such terms, agreements, and undertakings. **The provisions of paragraphs 7, 13, 15, and 18 hereof shall apply to the fullest extent of the law, whether in contract, statute, tort (such as negligence), or otherwise, notwithstanding the failure of the essential purpose of any remedy.**

**14. Assignment and Subcontracting.** Except as provided below, neither party may assign, transfer, or delegate any of its rights or obligations hereunder (including, without limitation, interests or Claims) without the prior written consent of the other party. The System hereby consents to Deloitte & Touche subcontracting any of Deloitte & Touche's rights or obligations hereunder to (a) any affiliate or related entity, whether located within or outside of the United States. Services performed hereunder by Deloitte & Touche's subcontractors shall be invoiced as professional fees on the same basis as Services performed by Deloitte & Touche's personnel, unless otherwise agreed.

**15. Waiver of Jury Trial. THE PARTIES HEREBY IRREVOCABLY WAIVE, TO THE FULLEST EXTENT PERMITTED BY LAW, ALL RIGHTS TO TRIAL BY JURY IN ANY ACTION, PROCEEDING, OR COUNTERCLAIM RELATING TO THIS ENGAGEMENT.**

**16. Nonsolicitation.** During the term of this engagement and for a period of one (1) year thereafter, each party agrees that its personnel (in their capacity as such) who had direct and substantive contact in the course of this engagement with personnel of the other party shall not, without the other party's consent, directly or indirectly employ, solicit, engage, or retain the services of such personnel of the other party. In the event a party breaches this provision, the breaching party shall be liable to the aggrieved party for an amount equal to thirty percent (30%) of the annual base compensation of the relevant personnel in his or her new position. Although such payment shall be the aggrieved party's exclusive means of monetary recovery from the breaching party for breach of this provision, the aggrieved party shall be entitled to seek injunctive or other

equitable relief. This provision shall not restrict the right of either party to solicit or recruit generally in the media.

**17. Entire Agreement, Amendment, and Notices.** These terms, and the Engagement Letter, including exhibits, constitute the entire agreement between the parties with respect to this engagement; supersede all other oral and written representations, understandings, or agreements relating to this engagement; and may not be amended except by written agreement signed by the parties. In the event of any conflict, ambiguity, or inconsistency between these terms and the Engagement Letter, these terms shall govern and control. All notices, requests, demands and other communications hereunder shall be in writing and shall be deemed to have been duly given when either personally served or mailed by certified or registered mail, return receipt requested to the addresses first set forth above.

**18. Governing Law, Jurisdiction and Venue, and Severability.** These terms, the Engagement Letter, including exhibits and all matters relating to this engagement shall be governed by, and construed in accordance with, the laws of the State of Connecticut (without giving effect to the choice of law principles thereof). Any action based on or arising out of this engagement or the Services provided or to be provided hereunder shall be brought and maintained exclusively in any court of the State of Connecticut or any federal court of the United States, in each case located in the State of Connecticut. Each of the parties hereby expressly and irrevocably submits to the jurisdiction of such courts for the purposes of any such action and expressly and irrevocably waives, to the fullest extent permitted by law, any objection which it may have or hereafter may have to the laying of venue of any such action brought in any such court and any claim that any such action has been brought in an inconvenient forum. If any provision of these terms or the Engagement Letter is found by a court of competent jurisdiction to be unenforceable, such provision shall not affect the other provisions, but such unenforceable provision shall be deemed modified to the extent necessary to render it enforceable, preserving to the fullest extent permissible the intent of the parties set forth herein.

**19. Non-Use of YNHHS Name.** Deloitte & Touche shall not use YNHHS name or logo, or the name of any YNHHS facility, in any way other than in connection with the Services, including in any advertising or promotional media as a customer or client of Deloitte & Touche, without obtaining the prior written consent of System.

**20. False Claims.** Deloitte & Touche acknowledges that System has provided it with access to its policy on False Claims and Payment Fraud Prevention (the "Policy") located on its internet site at [www.ynhhs.org/FalseClaims.pdf](http://www.ynhhs.org/FalseClaims.pdf). The False Claims Act imposes civil penalties on people and companies who knowingly submit a false claim or statement to a federally funded program, or otherwise conspire to defraud the government, in order to receive payment. It also protects people who report suspected fraud.

**21. Personal Inducements.** Deloitte & Touche represents and warrants that no cash, equity interest, merchandise, equipment, services or other forms of remuneration have been offered, shall be offered or will be paid or distributed by or on behalf of Deloitte & Touche to YNHHS and/or the employees, officers, or directors of YNHHS or its member hospitals, or to any other person, party or entity affiliated with YNHHS or its member hospitals, as an inducement to purchase or to influence the purchase of services by YNHHS or its member hospitals from Deloitte & Touche.

**22. No Undisclosed Relationships.** Deloitte & Touche represents and warrants to the System that, except for those relationships (if any) Deloitte & Touche has disclosed to the System in writing, as of the date of this Agreement the Deloitte & Touche and Deloitte FAS personnel that provide services under this Agreement: (i) do not have a financial relationship with any of the System's trustees, officers, employees, or medical staff members, (ii) will not establish or otherwise create any such relationship after the Effective Date without disclosing such relationship to the System in writing, and (iii) Deloitte & Touche will promptly notify the System in writing if its Engagement Partner for the Services becomes aware of the existence of any such relationship during the course of the services provided under this Agreement. Notwithstanding any other provision of this Agreement or any other agreement between the System and Deloitte & Touche, the System may terminate this Agreement upon written notice to Deloitte & Touche in the event the System becomes aware of any such relationship (through disclosure by Deloitte & Touche or otherwise).

**23. General Compliance.** Deloitte & Touche shall comply with all applicable standards, statutes, rules, regulations, acts and orders of the United States, its departments, agencies, and bureaus, and of any applicable state or political subdivision thereof, including without limitation, laws and regulations pertaining to labor, wages, hours, conditions of employment, environmental protection, hazardous and infectious materials, identity theft, as applicable to Deloitte & Touche in its performance of the Services hereunder.

**24. Equal Employment Opportunities.** Deloitte LLP (the parent company of Deloitte & Touche) and its subsidiaries (together, referred to as "Deloitte" for purposes of this Section 24) are equal opportunity employers. Deloitte recruits, employs, trains, compensates, and promotes without regard to race, religion, creed, color, citizenship, national origin, age, gender, gender identity/expression, sexual orientation, marital status, disability, veteran status, or any other legally protected basis, in accordance with applicable federal, state, or local law. Deloitte makes reasonable attempts to accommodate the expression of religious beliefs, as long as that expression does not harass or intimidate coworkers or place an undue hardship on its business.

As a federal contractor, Deloitte also provides an affirmative action program for minorities, women, disabled and Vietnam-era veterans, and persons with disabilities.

In response to a request from a qualified individual with a disability, Deloitte will make a reasonable accommodation that would allow that individual to perform the essential functions of his or her job, unless doing so would create undue hardship on its business.

**25. Access to Records.** In the event that the Engagement Letter provides for services to be performed by Vendor worth \$10,000 or more over a 12-month period, Deloitte & Touche agrees, until the expiration of four years after the termination of the Arrangement, to make available to the Secretary, U.S. Department of Health and Human Services, and the U.S. Comptroller General and their representatives, pursuant to a proper request, the Agreement, if any, and all books, documents and records necessary to certify the nature and extent of the cost of those services. If Deloitte & Touche carries out any of the duties described herein through a subcontract worth \$10,000 or more over a 12-month period with a related organization, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General and their representatives pursuant to a proper request to the related organization's books, documents and records necessary to certify the nature and extent of the cost of those services. In the event Deloitte & Touche receives a request for access, Deloitte & Touche agrees to notify YNHHS immediately and to consult with YNHHS regarding the response to the request.

**26. Security and Access.** Deloitte & Touche shall comply with all YNHHS policies and procedures pertaining to visitation, confidentiality, security and vendor identification as are provided to it in writing prior to execution of the Engagement Letter. YNHHS may issue non-employee identification badges under certain conditions; in the event that any non-employee identification badge is issued to an employee of Deloitte & Touche, Deloitte & Touche agrees to cause such employee to prominently display such badge at all times while on YNHHS premises. All badges must be surrendered by Deloitte & Touche when requested by YNHHS. Non-compliance with any of the above policies shall be deemed a breach of the Engagement Letter.

## **APPENDIX C: Business Associate Addendum**

This Appendix (“Appendix C”) is part of the attached engagement letter dated November 7, 2016 between Deloitte & Touche LLP (“D&T”) and Yale New Haven Health Services Corporation and its subsidiaries (“YNHH”). If and to the extent, and so long as, required by HIPAA or HITECH (each as defined below), and not otherwise, D&T and YNHH hereby agree to the following in connection with D&T’s performance of services under the engagement letter to which this Business Associate Appendix is attached (such engagement letter, the “Engagement Letter,” together with this Business Associate Appendix and all other attachments, appendices, and exhibits to the Engagement Letter, this “Agreement”). D&T agrees that for purposes of this Appendix C, D&T is a business associate of YNHH to the extent that, in performance of the Services, D&T qualifies as a “business associate” as that term is defined at 45 C.F.R §160.103.

- (A) Unless otherwise specified in this Business Associate Appendix, all capitalized terms used in this Business Associate Appendix shall have the meanings established for purposes of HIPAA or HITECH, as applicable. Specific statutory or regulatory citations used in this Business Associate Appendix shall mean such citations as amended and in effect from time to time.
1. “Compliance Date” shall mean, with respect to any applicable provision in this Business Associate Appendix, the later of the date by which compliance with such provision is required under HITECH and the effective date of this Agreement.
  2. “Electronic Protected Health Information” shall mean Protected Health Information that is transmitted or maintained in electronic media.
  3. “HIPAA” shall mean the Health Insurance Portability and Accountability Act, 42 U.S.C. §§ 1320d through 1320d-8, as amended from time to time, and all associated existing and future implementing regulations, when effective and as amended from time to time.
  4. “HITECH” shall mean Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§ 17921-17954, as amended from time to time, and all associated existing and future implementing regulations, when effective and as amended from time to time.
  5. “Protected Health Information” shall mean the term as defined in 45 C.F.R. § 160.103, and is limited to the Protected Health Information received from, or received or created on behalf of, the Client by D&T pursuant to performance of the Services.
  6. “Privacy Rule” shall mean the federal privacy regulations issued pursuant to HIPAA, as amended from time to time, codified at 45 C.F.R. Part 164 (Subparts A and E).
  7. “Security Rule” shall mean the federal security regulations issued pursuant to HIPAA, as amended from time to time, codified at 45 C.F.R. Part 164 (Subparts A and C).
  8. “Services” shall have the meaning set forth in the attached engagement letter, and, if not therein defined, shall mean the services described in the Engagement Letter to be performed by D&T for the Client.
  9. “Unsecured Protected Health Information” shall mean Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a

technology or methodology specified by the Secretary in the regulations or guidance issued pursuant to 42 U.S.C. § 17932(h)(2).

(B) With regard to D&T's use and disclosure of Protected Health Information:

1. D&T may use and disclose Protected Health Information as reasonably required or contemplated in connection with the performance of the Services, excluding the use or further disclosure of Protected Health Information in a manner that would violate the requirements of the Privacy Rule, if done by the Client. Notwithstanding the foregoing, D&T may use and disclose Protected Health Information for the proper management and administration of D&T as provided in 45 C.F.R. § 164.504(e)(4).
2. D&T will not use or further disclose Protected Health Information other than as permitted or required by this Business Associate Appendix, and in compliance with each applicable requirement of 45 C.F.R. § 164.504(e), or as otherwise Required by Law.
3. D&T will implement and use appropriate administrative, physical, and technical safeguards to (1) prevent use or disclosure of Protected Health Information other than as permitted or required by this Business Associate Appendix; (2) reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that D&T creates, receives, maintains, or transmits on behalf of the Client; and (3) as of the Compliance Date of 42 U.S.C. § 17931, comply with the Security Rule requirements set forth in 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316.
4. D&T will, without unreasonable delay report to the Client (1) any use or disclosure of Protected Health Information not provided for by this Business Associate Appendix of which it becomes aware in accordance with 45 C.F.R. § 164.504(e) (2) (ii) (C); and/or (2) any Security Incident affecting Electronic Protected Health Information of which D&T becomes aware in accordance with 45 C.F.R. § 164.314(a) (2) (C).
5. D&T will, without unreasonable delay, and in any event no later than ten (10) business days after Discovery, notify the Client of any Breach of Unsecured Protected Health Information. The notification shall include, to the extent possible (and subsequently as the information becomes available), the identification of all individuals whose Unsecured Protected Health Information is reasonably believed by D&T to have been Breached along with any other available information that is required to be included in the notification to the Individual, the Secretary, and/or the media, all in accordance with the data breach notification requirements set forth in 42 U.S.C. § 17932 and 45 C.F.R. Parts 160 and 164 (Subparts A, D, and E), as of their respective Compliance Dates.
6. D&T will ensure that any subcontractors or agents to whom D&T provides Protected Health Information agree to the same restrictions and conditions that apply to D&T with respect to such Protected Health Information. To the extent that D&T provides Electronic Protected Health Information to a subcontractor or agent, it will require the subcontractor or agent to implement reasonable and appropriate safeguards to protect the Electronic Protected Health Information consistent with the requirements of this Business Associate Appendix.

7. D&T will, to the extent that Protected Health Information in D&T's possession constitutes a Designated Record Set, make available such Protected Health Information in accordance with 45 C.F.R. § 164.524.
8. In the event that D&T, in connection with the Services, uses or maintains an Electronic Health Record of Protected Health Information of or about an Individual, D&T will provide an electronic copy of such Protected Health Information in accordance with 42 U.S.C. § 17935(e) as of its Compliance Date.
9. D&T will, to the extent that Protected Health Information in D&T's possession constitutes a Designated Record Set, make available such Protected Health Information for amendment and incorporate any amendments to such information as directed by the Client, all in accordance with 45 C.F.R. § 164.526.
10. D&T will document and make available the information required to provide an accounting of disclosures of Protected Health Information, in accordance with 45 C.F.R. § 164.528.
11. In the event that D&T, in connection with the Services, uses or maintains an Electronic Health Record of Protected Health Information of or about an Individual, D&T will make an accounting of disclosures of such Protected Health Information in accordance with the requirements for accounting of disclosures made through an Electronic Health Record in 42 U.S.C. § 17935(c), as of its Compliance Date.
12. D&T will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary for purposes of determining the Client's compliance with the Privacy Rule.
13. D&T will, as of the Compliance Date of 42 U.S.C. § 17935(b), limit any request, use, or disclosure by D&T of Protected Health Information, to the extent practicable, to the Limited Data Set of such Protected Health Information (as defined in 45 C.F.R. § 164.514(e)(2)), or, if the request, use, or disclosure by D&T of Protected Health Information, not in a Limited Data Set, is necessary for D&T's performance of the Services, D&T will limit the amount of such Protected Health Information requested, used, or disclosed by D&T to the minimum necessary to accomplish the intended purpose of such request, use, or disclosure, respectively; provided, however, that the requirements set forth above in this subsection (13) shall be superseded and replaced by the requirements of the "minimum necessary" regulations or guidance to be issued by the Secretary (pursuant to 42 U.S.C. § 17935(b)(1)(B)) on and after its Compliance Date.
14. D&T will not directly or indirectly receive remuneration in exchange for any Protected Health Information as prohibited by 42 U.S.C. § 17935(d) as of its Compliance Date.
15. D&T will not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. § 17936(a) as of its Compliance Date.
16. D&T will not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. § 17936(b) as of its Compliance Date.

(C) In addition to any other obligation set forth in this Agreement, including this Business Associate Appendix, the Client agrees that it will: (1) not make any disclosure of Protected Health Information to

D&T if such disclosure would violate HIPAA, HITECH, or any applicable federal or state law or regulation; (2) not request D&T to use or make any disclosure of Protected Health Information in any manner that would not be permissible under HIPAA, HITECH, or any applicable federal or state law or regulation if such use or disclosure were done by the Client; and (3) limit any disclosure of Protected Health Information to D&T, to the extent practicable, to the Limited Data Set of such Protected Health Information, or, if the disclosure of Protected Health Information that is not in a Limited Data Set is necessary for D&T's performance of the Services, to limit the disclosure of such Protected Health Information to the minimum necessary to accomplish the intended purpose of such disclosure, provided, however, that the requirements set forth above in this part (3) shall be superseded and replaced by the requirements of the "minimum necessary" regulations or guidance to be issued by the Secretary (pursuant to 42 U.S.C. § 17935(b)(1)(B)) on and after its Compliance Date.

- (D) If either the Client or D&T knows of either a violation of a material term of this Business Associate Appendix by the other party or a pattern of activity or practice of the other party that constitutes a material breach or violation of this Business Associate Appendix, the non-breaching party will provide written notice of the breach or violation to the other party that specifies the nature of the breach or violation. In the event that the breaching party does not cure the breach or end the violation on or before thirty (30) days after receipt of the written notice, the non-breaching party may do the following:
- (i) if feasible, terminate this Agreement; or
  - (ii) if termination of this Agreement is infeasible, report the issue to the Secretary.
- (E) D&T will, at termination of this Agreement, if feasible, return or destroy all Protected Health Information that D&T still maintains in any form and retain no copies of Protected Health Information or, if such return or destruction is not feasible (such as in the event that the retention of Protected Health Information is required for archival purposes to evidence the Services), D&T may retain such Protected Health Information and shall thereupon extend the protections of this Business Associate Appendix to such Protected Health Information and limit further uses and disclosures to those purposes that make the return or destruction of such Protected Health Information infeasible.
- (F) Any other provision of this Agreement that is directly contradictory to one or more terms of this Business Associate Appendix shall be superseded by the terms of this Business Associate Appendix to the extent and only to the extent of the contradiction and only for the purpose of the Client's and D&T's compliance with HIPAA and HITECH. The terms of this Business Associate Appendix, to the extent they are unclear, shall be construed to allow for compliance by the Client and D&T with HIPAA and HITECH.

In addition, the Client agrees to compensate D&T for any time and expenses that we may incur in responding to requests for documents or information under HIPAA, HITECH, or any regulations promulgated under HIPAA or HITECH.

Nothing contained in this Business Associate Appendix is intended to confer upon any person (other than the parties hereto) any rights, benefits, or remedies of any kind or character whatsoever, whether in contract, statute, tort (such as negligence), or otherwise, and no person shall be deemed a third-party beneficiary under or by reason of this Business Associate Appendix.

## Greer, Leslie

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**From:** Roberts, Karen  
**Sent:** Wednesday, November 23, 2016 8:41 AM  
**To:** Greer, Leslie  
**Cc:** Cotto, Carmen  
**Subject:** FW: Yale and L&M acquisition  
**Attachments:** union.pdf

Please put in the Yale/L+M records (both records). Karen

*Karen Roberts*

Principal Health Care Analyst  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308  
P: (860) 418-7041 / F: (860) 418-7053 / E: [karen.roberts@ct.gov](mailto:karen.roberts@ct.gov)



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**From:** Martone, Kim  
**Sent:** Tuesday, November 22, 2016 3:06 PM  
**To:** Capozzalo, Gayle ([Gayle.Capozzalo@ynhh.org](mailto:Gayle.Capozzalo@ynhh.org))  
**Subject:** Yale and L&M acquisition

Gayle, please see the attached letter from multiple organizations and individuals objecting to the approval of Deloitte and Touche as the Independent Monitor for the Yale-New Haven Hospital System settlement agreement. Please address all allegations in full detail with supporting documentation as needed. As I advised when we met on November 15th, I do feel it is important for you and/or your community representative to meet with these organizations and individuals to inform them of such decisions as this acquisition moves forward. In light of the assertions made in the attached letter, I am hereby restating my request and ask that your discussions include the points outlined in the letter. Further, OHCA reserves the right to reverse its approval of the monitor based on your response to the attached letter.

Kim

**Kimberly R. Martone**

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)

November 17, 2016

Honorable Raul Pino  
Commissioner of Public Health  
State of Connecticut  
410 Capitol Ave.  
PO Box 340308  
Hartford CT 06134

Dear Commissioner Pino:

The undersigned organizations and individuals write to express our strong objection to your approval of Deloitte & Touche as the Independent Monitor for the Yale New Haven Hospital System settlement agreement.

We are local and statewide community leaders and organizations, committed to ensuring quality, affordable health care services continue to be provided in this region. We believe the appointment of Deloitte & Touche undermines this essential objective. Deloitte & Touche have been one of Yale-New Haven Health's top five outside contractors for each of the past 10 years, earning \$30 million over that time. Last year the Securities and Exchange Commission charged these consultants with violating auditor independence rules — charges that Deloitte agreed to settle by paying the federal agency more than \$1 million. We do not believe these are the appropriate credentials for the important task of overseeing the transformation of our region's health care.

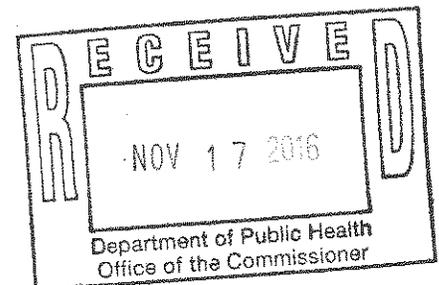
The Independent Monitor and Independent Consultant required by the Agreement must act with, and be perceived to act with unimpeachable integrity. The enforcement burdens on the Independent Monitor and Consultant are extremely heavy — the Agreement contains unprecedented consumer protections, and as the first in the history of the state, the Cost and Market Impact Review will establish the standard for future analyses under the statute. Financial or other conflicts of interest between Yale New Haven Health and the Independent Monitor and Consultant will create powerful incentives to weaken the protections. Even the appearance of conflict will severely damage public confidence in the Office of Health Care Access, the statute and the integrity of Yale New Haven Health Services Corporation.

We urge you, Commissioner Pino, to reject Yale's proposal to assign any consultant with such a clear conflict of interest or a record of violating independent auditing rules

Please feel free to contact us with any questions.

Thank you in advance for your consideration of our request.

Sincerely,





Tom Swan, Executive Director  
Connecticut Citizen Action Group



David Pickus, President  
SEIU Healthcare 1199NE



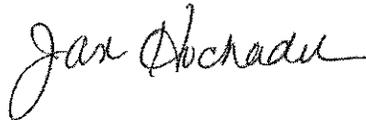
Ellen Andrews, Executive Director  
Connecticut Health Policy Project



Connie Holt, Secretary-Treasurer  
UNITE HERE Local 217



Ocean Pellet  
United Action Connecticut



Jan Hochadel, President  
AFT Connecticut

## Greer, Leslie

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**From:** Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>  
**Sent:** Tuesday, November 29, 2016 4:49 PM  
**To:** User, OHCA; Martone, Kim; Roberts, Karen; Cotto, Carmen  
**Cc:** O'Connor, Christopher; Cummings, Bruce (L and M); Borgstrom, Marna; Petrini, Vincent; Tammaro, Vincent; Willcox, Jennifer; Aseltyne, Bill; Anderson, Maureen (LMHOSP); 'Tia.Sawhney@milliman.com'; 'Bruce Pyenson'; Rosenthal, Nancy; 'Sauders, Kelly (US - New York)'  
**Subject:** CMIR Independent Consultant: CON Docket #s 15-32033-CON and 15-32032-CON  
**Attachments:** Milliman Consulting Svs Agreement SIGNED 112916.pdf

Kim and Karen,

To comply with Docket #15-32033 CON Condition 20.a., Condition 20.b., Condition 21.a., Condition 21.b., Condition 22, Condition 23, Condition 32.c., and Docket #15-32032 CON Condition 1, Condition 2.a., Condition 2.b., Condition 3, Condition 4, and Condition 7.a., attached please find the signed engagement letter and scope of work for Milliman to conduct the initial and annual updates of the CMIR for the next five years. The attached document also includes their detailed proposal. If you have any questions, please don't hesitate to call. Thank you.

Gayle

Gayle Capozzalo, FACHE  
Chief Strategy Officer  
789 Howard Avenue  
New Haven, CT 06519  
**Phone:** 203-688-2605  
**Fax:** 203-688-3472  
[gayle.capozzalo@ynhh.org](mailto:gayle.capozzalo@ynhh.org)

**YaleNewHavenHealth**

This message originates from the Yale New Haven Health System. The information contained in this message may be privileged and confidential. If you are the intended recipient you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you.

## CONSULTING SERVICES AGREEMENT

This Consulting Services Agreement (this "*Agreement*") is entered into as of this 28th day of November, 2016 (the "*Effective Date*") by and between Yale New Haven Health Services Corporation with a principal place of business at 789 Howard Avenue, New Haven, CT ("*Customer*") and Milliman, Inc., a Washington corporation with a place of business at One Pennsylvania Plaza, 38<sup>th</sup> Floor, New York, NY 10119 ("*Contractor*").

### 1. Scope of Services.

(a) Statement of Work. Contractor shall furnish the services (the "*Services*") described and further specified in the Statement of Work or proposal (whether or not separately executed) attached hereto as Exhibit A ("*SOW*"). If either party reasonably believes the performance of additional services not described in any applicable SOW are advisable or desirable, then such party shall request a written change order, in a form mutually agreed upon, that describes the services requested to be performed and the terms upon which such services shall be performed. Any such change order, if executed by both parties, shall be incorporated into the SOW. In the event of conflict between a provision in the SOW (or change order) and a provision in this Agreement, the provision in this Agreement prevails, unless the SOW (or change order) expressly refers to the provision in this Agreement and states the parties' intention to supersede such provision.

(b) Performance of Services. The Services shall be performed in a professional manner by personnel of Contractor having a level of skill in the area commensurate with the requirements of the scope of work to be performed. Contractor and any personnel engaged to perform the Services shall at all times maintain any and all licenses, certifications, and/or other qualifications required under applicable federal, state or local laws or rules to perform the Services.

2. Compensation. Customer shall pay Contractor the fees for the Services specified in the applicable SOW. Unless otherwise specified in the SOW, Contractor shall invoice Customer on a monthly basis, and payment on all uncontested invoices shall be made by Customer within sixty (60) days of receipt of a complete invoice.

### 3. Term and Termination.

(a) Term. This Agreement shall commence on the Effective Date and shall continue in full force and effect until the later of: (i) the expiration or termination of the last SOW or (ii) [one year] following the Effective Date, unless earlier terminated pursuant to this Section 3.

(b) Termination for Non-Performance. Customer may terminate this Agreement at its option, in the event Contractor ceases providing services hereunder for any reason whatsoever, immediately upon notice to Contractor to that effect

(c) Termination by Customer. Customer may terminate this Agreement at any time for any or no reason by providing the Contractor thirty (30) days' prior written notice of termination, provided that such termination is consistent with the terms of the Agreed Settlement with the Connecticut Office of Health Care Access (OHCA) under Docket Number 15-32033-CON (the "*Order*").

(d) Termination for Cause. Either party may terminate this Agreement, if the other party is in material breach of this Agreement and the breaching party has not cured such breach to the non-breaching party's reasonable satisfaction within thirty (30) days after the non-breaching party's

notice of the breach to the breaching party. Customer reserves the right to stop all work if any bill goes unpaid for 90 days. In the event of such termination, Contractor shall be entitled to collect the outstanding balance, as well as charges for all services and expenses incurred up to the date of termination.

(e) Effects of Termination. Upon termination or expiration of this Agreement, all rights and obligations of the parties hereunder shall terminate; provided, that, Sections 3(d), 4, 5, 6, 8, 9, 10, 11, 12, 13, 14 and 15 shall survive any such expiration or termination. Notwithstanding anything herein to the contrary, expiration or termination of this Agreement shall not relieve either party of any obligations that may have accrued prior to such termination or expiration.

#### 4. Ownership.

(a) Work Made For Hire. Contractor is performing the Services for Customer on a work-for-hire basis. Except as otherwise set forth herein, Customer shall be the sole owner of all rights (including copyright and any other intellectual property and proprietary rights) in all final deliverables created by Contractor during its performance of the Services and provided to Customer as set forth in Exhibit A (the "*Work Product*"). To the extent any Work Product does not qualify as a work made for hire, to transfer all rights in the Work Product to Customer, Contractor hereby irrevocably assigns to Customer all rights (including copyright and any other intellectual property and proprietary rights) in all such Work Product.

(b) Contractor Tools. Contractor shall retain all rights, title and interest (including, without limitation, all copyrights, patents, service marks, trademarks, trade secret and other intellectual property rights) in and to all technical or internal designs, methods, ideas, concepts, know-how, techniques, generic documents and templates that have been previously developed by Contractor or developed during the course of the provision of the Services ("Contractor Tools") provided such Contractor Tools do not contain any Customer Confidential Information or proprietary data. Rights and ownership by Contractor of Contractor Tools shall not extend to or include all or any part of Customer's proprietary data or Customer Confidential Information. To the extent that Contractor may include in the Work Product any Contractor Tools, Contractor agrees that Customer shall be deemed to have a fully paid up license to make copies of the Contractor Tools as part of its use of the Work Product for its internal business purposes and provided that such Contractor Tools cannot be modified or distributed outside Customer without the written permission of Contractor or as otherwise permitted herein.

(c) Third Party Distribution. Work Product is prepared solely for the internal business use of Customer and for purposes of Customer's compliance with the terms of the Order. Work Product may not be provided to third parties without Contractor's prior written consent, which consent may be conditioned on execution by the third party of Contractor's standard Third Party Release Agreement; provided, however, Customer may share Contractor's work with its parent or affiliates, but only if either (a) the Customer has the full power and authority to bind such parent or affiliate to the terms of this agreement and does bind such affiliate to the terms, or (b) the parent or affiliate acknowledges in writing that the work of Contractor is subject to certain limitations and restrictions contained in this Agreement and that the parent or affiliate acquires no greater rights than are possessed by Customer under this Agreement. Contractor does not intend to benefit any third party recipient of Work Product, even if Contractor consents to the release of Work Product to such third party. Notwithstanding anything herein to the contrary, Contractor agrees that Customer may provide Work Product to OHCA and to the independent monitor retained by Customer pursuant to, and consistent with, the terms of the Order.

**5. Indemnification.** Customer agrees to indemnify and hold Contractor, its officers, directors, agents and employees, harmless from and against all loss, damages, liability, and Expense, with respect to the work in question where such loss, damages, liability or Expense was incurred by reason of any claims, actions, suits or governmental investigations or proceedings, brought by any third party against or involving Contractor, its officers, directors, agents and employees, which relate to or arise out of the engagement of Contractor by Customer. Provided, however, that Customer shall not be required to indemnify Contractor, its officers, directors, agents and employees, for any damages determined by a court or an arbitration panel to have resulted from Contractor's intentional fraud or willful misconduct. For purposes of this paragraph, "Expense" shall include: all legal expenses incurred by Contractor in the investigation, defense or settlement of any claim, action, suit or proceeding, and all other reasonable costs and expenses, including the services of Contractor based on normal hourly rates, together with its out-of-pocket expenses, incurred in the investigation, defense or settlement of same.

**6. Confidentiality.** Each party shall be bound by the confidentiality and non-disclosure obligations in Section 3 of the Compliance Addendum (as defined in Section 7 hereof).

**7. Compliance Addendum.** If required by Customer, Contractor shall each execute and deliver a mutually agreeable Compliance Addendum contemporaneous with the execution of this Agreement (the "*Compliance Addendum*").

**8. Notices.** Any notice required or permitted under this Agreement or required by law shall be made in writing and shall be: delivered in person; sent by first class registered mail; sent by overnight air courier; or sent by telefax or e-mail with a confirmation copy sent by one of the foregoing methods within twenty-four (24) hours of transmission, in each case to the appropriate address as set forth in this Agreement or as notified by the other party from time to time. Notices shall be deemed given at the time of actual delivery in person, by telefax or e-mail; three (3) business days after deposit in the mail; or one (1) day after delivery to an overnight air courier service.

**9. Governing Law and Dispute Resolution.** This Agreement shall be interpreted and construed in accordance with the laws of the State of Connecticut, without regard to its conflict of laws principles. In the event of any dispute arising out of or relating to the engagement of Contractor by Customer, the parties agree that the dispute will be resolved by final and binding arbitration under the Commercial Arbitration Rules of the American Arbitration Association. The arbitration shall take place before a panel of three arbitrators. Within 30 days of the commencement of the arbitration, each party shall designate in writing a single neutral and independent arbitrator. The two arbitrators designated by the parties shall then select a third arbitrator. The arbitrators shall have a background in either insurance, actuarial science or law. The arbitrators shall have the authority to permit limited discovery, including depositions, prior to the arbitration hearing, and such discovery shall be conducted consistent with the Federal Rules of Civil Procedure. The arbitrators shall have no power or authority to award punitive or exemplary damages. The arbitrators may, in their discretion, award the cost of the arbitration, including reasonable attorney fees, to the prevailing party. Any award made may be confirmed in any court having jurisdiction. Any arbitration shall be confidential, and except as required by law, neither party may disclose the content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors.

**10. Assignment.** Neither party may assign its rights or obligations pursuant to this Agreement without the other party's prior written consent; except that either party may, upon notice to the

other party, assign its rights and obligations to any of its affiliates or subsidiaries. Any attempted transfer or assignment contrary to the terms of this Section 10 shall be void and of no effect.

**11. Entire Agreement.** This Agreement, including any SOWs or other exhibits hereto, and the Compliance Addendum shall contain the entire agreement between the parties in respect of the subject matter hereof. No amendments or modifications to this Agreement shall be effective unless made in writing and signed by authorized representatives of both parties.

**12. Waiver.** The failure of either Party hereto to enforce at any time, or for any period of time, any provision of this Agreement shall not be construed as a waiver of such provision or of the right of such Party thereafter to enforce each and every provision. Any waiver by a Party of any of its rights under this Agreement in one or more instances shall be made in a writing signed by such Party and shall not be construed as constituting a continuing waiver or as a waiver in other instances.

**13. Independent Contractors.**

(a) The Contractor and Customer acknowledge and agree that the Contractor is being retained as an independent contractor, and that the Contractor shall be responsible for determining the manner and means by which the Contractor performs the duties and responsibilities assigned to the Contractor under this Agreement. Nothing in this Agreement shall be construed to make the Contractor an employee or agent of Customer, to entitle the Contractor to receive the benefits of any employee benefit plan of Contractor, or to create a joint venture or partnership between the parties. The Contractor shall not make an unauthorized representation or warranty concerning the products or services of Customer or commit Customer to any agreement or obligation without the express authorization of an authorized officer of Customer.

(b) No payroll or employment taxes of any kind shall be withheld or paid with respect to payments to the Contractor. The Contractor shall be responsible for the payment of all taxes, including but not limited to any income, sales or use tax, levied with respect to the services provided hereunder by the Contractor. The Contractor agrees to indemnify Customer against, and to defend and hold Customer harmless from, any liabilities, claims, costs or expenses (including reasonable attorneys' fees) which may be made against Customer, or incurred by Customer, in respect to any such payroll or employment taxes.

(c) No workers' compensation insurance has been or will be obtained by Customer on account of the Contractor.

**14. Limitation of Liability.** In the event of any claim arising from services provided by Contractor at any time, the total liability of Contractor, its officers, directors, agents and employees to Customer shall not exceed three million dollars (\$3,000,000). This limit applies regardless of the theory of law under which a claim is brought, including negligence, tort, contract or otherwise. In no event shall Contractor be liable for lost profits of Customer or any other type of incidental or consequential damages. The foregoing limitations shall not apply in the event of the intentional fraud or willful misconduct of Contractor.

**15. Use of Name.** Customer agrees that it shall not use Contractor's name, trademarks or service marks, or refer to Contractor directly or indirectly in any media release, public announcement or public disclosure, including in any promotional or marketing materials, customer lists, referral lists, websites or business presentations without Contractor's prior written consent for each such use or release, which consent shall be given in Contractor's sole discretion. Contractor shall not use or

permit the use of Customer's name, logo or likeness, or that of any Customer facility, in any way, including, without limitation, advertising or promotional media identifying Customer as a customer or client of Contractor, without obtaining the prior written consent of Customer.

16. **Counterparts.** This Agreement may be executed in multiple counterparts, each of which shall be deemed an original but all of which, when taken together shall constitute one and the same agreement. Delivery of a signature page to this Agreement via facsimile or other electronic image transmission is legal, valid and binding execution and delivery for all purposes.

*[Signature Page follows.]*

IN WITNESS WHEREOF, the duly authorized representative of each party has executed this Agreement as of the Effective Date.

**Yale New Haven Health Services**

**Corporation**

By: 

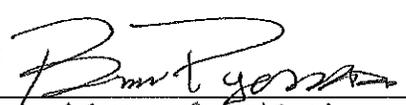
Name:

GAYLE CAPOZZALO

Title:

EXEC VP / CHIEF STRATEGY  
OFFICER

**Milliman, Inc.**

By: 

Name:

BRUCE PYENSON

Title:

PRINCIPAL & CONSULTING ACTUARY.

*[Signature Page of the Master Consulting Services Agreement]*

**Exhibit A**

**Form of Statement of Work**

**TERM:** The services set forth in this Statement of Work shall begin as of Click here to enter text. and shall be completed by Click here to enter text..

**SERVICES:**

*[List here services to be provided by Contractor.]*

**PAYMENTS:**

*[Include here payment terms and fee schedule]*

The duly authorized representatives of each party hereby agree to the terms of this Statement of Work.

**Choose an item.**

**[CONTRACTOR]**

By:

By:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

[CLICK HERE TO ACCESS COMPLIANCE ADDENDUM.docx](#)

# **EXHIBIT A**

## Lawrence+Memorial Cost and Market Impact Review Statement of Work

**TERM:** The services set forth in this Statement of Work shall begin as of December 7, 2016 and shall be completed by December 31, 2020.

### **SERVICES:**

Milliman will serve as an independent consultant, as required under YNHHS's Agreed Settlement with the Connecticut Office of Health Care Access (OHCA), evaluate the non-governmental fee levels of services provided by L+MC's Lawrence + Memorial Hospital (L+MH) and Lawrence & Memorial Medical Group (LMMG), and annually set maximum fee increases, for 5 years for L+MH and 28 months for LMMG. Milliman's work will be summarized in Cost and Market Impact Review (CMIR) reports. The services are further described in Milliman's Proposal "Lawrence+Memorial Cost and Market Impact Review" dated November 28, 2016.

### **PAYMENTS:**

Milliman bills for time and travel expenses. Time is tracked by professional on a quarter-hour basis and billed monthly. We estimate the following prices by deliverable.

Phase	Deliverables	Estimated Price
Baseline CMIR: L+MH	Report to OHCA	\$200,000
Baseline CMIR: LMMG	Report to OHCA	\$100,000
3 annual updates: L+MH*	Report to OHCA	\$120,000 each

The estimates are based on the following hourly rates and budgeted hours.

### **2016 Hourly Billing Rates**

Professional	Role	Hourly Billing Rate for 2016
Bruce Pyenson, FSA, MAAA Principal and Consulting Actuary	Project oversight and communications	\$650
Rong Yi, PhD Principal and Consultant	Analytics manager	\$460
Tia Sawhney, DrPH, FSA, MAAA Healthcare Consultant and Actuary	Policy, technical and design	\$385
Maggie Alston Manager, Data Analysis	Project manager	\$260
Feng Han, MS Data Scientist	Statistical methods and analysis	\$225
Other Consultants	As needed	\$280-\$650
Analysts	SAS data extraction and Excel modeling	\$160-\$280

**Budgeted Hours**

CMIR	Staff	Hours	Avg. Hourly Rate	Cost
Baseline LM+H	Consultant	202	\$500	\$101,000
	Analyst	450	\$220	\$99,000
	Total	652		\$200,000
Baseline LMMG	Consultant	101	\$500	\$50,500
	Analyst	225	\$220	\$49,500
	Total	326		\$100,000
LM+H Update	Consultant	100	\$500	\$50,000
	Analyst	318	\$220	\$69,960
	Total	418		\$119,960

Substantial revisions and work outside the proposal will be billed at Milliman's usual hourly rates plus travel expenses at price.

The duly authorized representatives of each party hereby agree to the terms of this Statement of Work.

**Yale New Haven Health System**

By: 

Name: GAYLE CAPOZZALO

Title: EXEC VP / CHIEF STRATEGY OFFICER

**Milliman**

By: 

Name: BRUCE PYENSON

Title: PRINCIPAL & CONSULTING ACTUARY



## **Lawrence+Memorial Cost and Market Impact Review**

Proposal to:

### **Yale New Haven Health Services Corporation**

Gale Capozzalo, Chief Strategy Officer  
Vincent Tammaro, EVP and CFO

Presented by:

Bruce Pyenson, FSA, MAAA  
Principal  
Rong Yi, PhD  
Principal  
Tia Sawhney, DrPH, FSA, MAAA  
Healthcare Consultant and Actuary

Milliman, Inc.  
New York, NY

REVISED  
November 28, 2016

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## A. BACKGROUND

In early September 2016, The Connecticut Office of Health Care Access (OHCA) granted Yale New Haven Health Services Corporation (YNHHSO) approval to acquire Lawrence + Memorial Corporation (L+MC). The "Agreed Settlement" had a number of terms, including requiring YNHHSO to engage an independent consultant to evaluate the non-governmental fee levels of services provided by L+MC's Lawrence + Memorial Hospital (L+MH) and Lawrence & Memorial Medical Group (LMMG) and to annually set maximum fee increases, for 5 years for L+MH and 28 months for LMMG. This proposal sets out the Milliman proposal to serve as the independent consultant.

## B. ABOUT MILLIMAN

Milliman is, by a large margin, the dominant source of health actuarial expertise with more qualified health actuaries than any other organization in the world. We have active health practices across the globe (including Europe, Japan and Brazil). With almost 3000 employees, 2015 revenue of close to \$1 billion, and a focus on professional services, we have the expertise and resources to support the biggest challenges.

We have been pioneers in the pricing of ACA exchange products, Medicare Part D, Medicare Advantage, and managed care strategies. We have been leaders in actuarial consulting to provider organization including ACOs; in particular, we are supporting hundreds of provider organizations in their bundled payment and risk contracts. We have contributed significant leadership to the Actuarial profession, including presidents plus many officers of all professional actuarial bodies. Milliman provides more MA-PD and PDP bids than any other consulting firm, and we have certified hundreds of Exchange bids.

To support our consulting work, we have accumulated and organized huge datasets and developed detailed price, utilization and bid development tools. We also have normative actuarial models that contain detailed utilization and cost figures, along with models that allow actuaries to calculate the impact of benefit designs, utilization management, area factors, delivery systems, and demographics. These tools are part of our *Health Cost Guidelines* suite, which are licensed to over 100 health plans for use by actuaries. For more details, see <http://www.milliman.com/expertise/healthcare/products-tools/health-cost-guidelines/>.

Our proposed team has worked with numerous insurers, ACOs, and state agencies and has the expertise and stature to provide independent, objective, and authoritative analytic reports. The team, from the New York City office of Milliman, is led by the following individuals:

**Bruce Pyenson, FSA, MAAA, Principal and Consulting Actuary.** Bruce has consulted across the healthcare spectrum. His publications include monographs on provider risk sharing (published by the American Hospital Association), columns on scientific method for the Society of Actuaries health newsletter, and over 30 peer-reviewed publications. This is Bruce's 30<sup>th</sup> year at Milliman. He was recently appointed to serve on the Medicare Payment

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Advisory Commission (MedPAC), which advises Congress on policy. Bruce will advise and guide the project and communications.

**Tia Goss Sawhney**, DrPH, FSA, MAAA, Healthcare Consultant and Actuary. Tia is dual credentialed as a doctor of public health and an actuary. Before joining Milliman 2 years ago she was a member of the executive leadership team of Illinois Medicaid. Her diverse background includes using medical claims databases to identify treatment patterns and cost drivers and due diligence reviews in healthcare. Tia frequently writes and speaks on policy issues. Tia will lead the policy and technical design portions of the project.

**Rong Yi**, PhD, Principal and Healthcare Consultant. Rong is a national expert on risk adjustment, predictive modeling and other quantitative methods. She led the development of the Massachusetts Connector's risk adjustment methodology and is instrumental in its on-going operations, working with several state agencies, the carriers and other stakeholders in Massachusetts. She is also leading several projects for the Minnesota Department of Health, using the MN all-payer claims database for purposes of rate review, risk adjustment and understanding market dynamics. Rong has been at Milliman for 7 years and will lead the data analytics portion of the project.

Bruce, Tia, and Rong will be supported by the Milliman New York City office's highly-experienced team of healthcare analysts.

Milliman, with about 3,000 employees, serves as an objective, analytically focused, independent advisor to a myriad of organizations in healthcare and insurance. We establish fire-walls to preserve the independence and confidentiality of particular projects and to avoid the appearance of conflicts of interest. The above team has no conflicts in performing this project and we will maintain the independence of our team throughout the project.

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### c. HIGH LEVEL SUMMARY OF RELEVANT SECTIONS OF AGREED SETTLEMENT

Detailed settlement conditions are spelled out in the Order section of the Agreed Settlement. Below, we summarize conditions that directly relate to our potential work as independent consultant. (This summary is for general informational purposes and context and is neither a legal interpretation nor intended to be a complete description.)

#### Condition 22:

- a. Describes the role of the independent consultant that YNHHS must hire to conduct a baseline Cost and Market Impact Review (CMIR) for each of L+MH and LMMG. It acknowledges that there may be initial data limitations.
- b. Describes the baseline and updated CMIRs and the basis for establishing maximum market price increases, including the various factors that the independent consultant should consider.
- c. Describes the development of maximum price increases, the monitoring of price increases, and possible corrective actions.
- d. Describes the role of the independent consultant, including that the consultant will report to and take direction from the DPH Commissioner.
- e. Describes CMIR distribution and confidentiality: OHCA shall keep all nonpublic information obtained as part of the CMIR and the CMIR report confidential and not release without the consent of YNHHS and L+MC, unless required to do so by law.

<p><b>Only our final report will be public.</b> Our analysis will rely on non-public data, data that we will describe and reference in our final report, including summary data tables.</p>
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#### Condition 23:

Defines key terms for the CMIR analysis described in Section 22, including the units of service for inpatient hospital, outpatient hospital, and physician services

#### Condition 20:

Maintains L+MH and LMMG pre-affiliation commercial health plan negotiated contracts as of the date of closing through December 31, 2017. Caps fee increases for a period of five years from the date of closing in the case of L+MH and twenty-eight months from the date of closing in the case of LMMG. (The date of closing was September 8, 2016.)

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#### D. ANALYSIS METHODOLOGY

This section details our analysis methodology. The methodology aligns with Sections 22 and 23 of the Agreed Settlement and may change somewhat based on the limitations of the data and direction from OHCA.

##### Calculation of Pre-Affiliation Fee Ratios

1. For inpatient hospital, outpatient hospital, and physician services we will define a basket of services.
  - a. IP: Using the Department of Insurance (DOI) service lists as prescribed by the Agreed Settlement,<sup>1</sup> we will map the top inpatient primary diagnoses, top procedures, and top surgical DRGs to a basket of DRG codes.
  - b. OP: Using the DOI service lists as prescribed by the Agreed Settlement,<sup>2</sup> we will map the top outpatient procedures to a basket of HCPCS codes.
  - c. Physicians: Using Milliman data, we will create a basket of the 50 most frequent physician service procedure codes and the wRVU for the services.
2. For the most recent pre-affiliation period that we have data, we will calculate the average market fee for each basket as a weighted average across payers and among the services in the basket.
  - a. IP: Fee per average admission.
  - b. OP: Fee per average service.
  - c. Physicians: Fee per average wRVU.
3. For the pre-affiliation period we will calculate the average L+M fee for each basket as a weighted average across payers and among the services in the basket.
4. For the pre-affiliation period we will calculate the ratio of the average L+M fee for each basket to other providers in the market. We will calculate the maximum commercial fee increase that will maintain (not exceed) this ratio.

##### Calculation of Maximum Commercial Fee Increase for CY 2018 (First CMIR Year)

1. For each payer within each basket we will project market fee increases from the pre-affiliation period through 2018 and any anticipated shifts between payers. We will then calculate a 2018 average market fee.
2. For each non-commercial payer within each basket we will project L+M fee increases from the pre-affiliation period through 2018 and any anticipated shifts among payers. We will then calculate the L+M maximum fee increase for the pre-affiliation period through 2018 that will produce a L+M average market fee that maintains the pre-affiliation ratio.

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<sup>1</sup> Connecticut Acute Care Hospital and Outpatient Surgical Facility Data: FY2015, August 1, 2016.

<sup>2</sup> Ibid.

3. We will reduce the maximum fee increase, as necessary, to reflect any increases that L+M has already received or will receive after the pre-affiliation period and before 2018.

**Calculation of Maximum Commercial Fee Increase for CY's 2019+ (Subsequent CMIR Years)**

1. For the most recent period that we have data (update period) we will calculate the average market fee for each basket as a weighted average across payers and among the services in the basket.
2. For the update period, we will calculate the average L+M fee for each basket as a weighted average across payers and among the services in the basket.
3. For each payer within each basket we will project market fee increases from the update period through the CMIR year and any observed or anticipated shifts between payers. We will then calculate a CMIR year average market fee.
4. For each non-commercial payer within each basket we will project L+M fee increases from the update period through the CMIR year and any observed or anticipated shifts between payers. We will then calculate the L+M maximum fee increase for the update period through CMIR year that will produce a L+M average market fee that maintains the pre-affiliation ratio.
5. We will reduce the maximum fee increase, as necessary, to reflect any increases that L+M has already received or will receive after the update period and before the CMIR year.

Note: The CMIR methodology is inherently self-correcting. If L+M provides less Medicaid or uninsured care than anticipated in a period, their average fee for that period will increase, reducing their next year's maximum commercial fee increase.

Note: The above CMIR methodology is aligned with the Agreed Settlement and, where required by the Agreed Settlement, with Connecticut General Statute Section 19a-639f. It is therefore different than the methodologies for Massachusetts CMIRs, which are aligned with Massachusetts regulation<sup>3</sup> and law,<sup>4</sup> and which are completed prior to affiliation. We will, however, examine Massachusetts CMIRs for potential learnings and practices.<sup>5</sup>

<sup>3</sup> Massachusetts Health Policy Commission, Technical Bulletin for 958 CMR 7.00: Notices of Material Change and Cost and Market Impact Reviews.

<sup>4</sup> Massachusetts General Laws, Part I, Title II, Chapter 6D, Section 13.

<sup>5</sup> Mass.gov, Administration and Finance, Material Change Notices/Cost and Market Impact Reviews.

**E. DATA SOURCES**

While Section 22.a of the Agreed Settlement acknowledges that there may be limitations in data available to the independent consultant, we believe there are a number of potential data sources and these limitation can be overcome. We will spend substantial time early in the project identifying potential data sources and assessing their reliability, usability, appropriateness, and timeliness.

Market prices are central to our analysis. Prices are assigned to services and paid by payers as claims; claims data therefore is ideal for understanding market prices. Other data sources, such as the hospital discharge dataset, can illuminate payer mix, uncompensated care, and the volume of select services in the market.

Potential data sources and their potential uses include:

Potential Data Source	Potential Use of the Data
1. Pricing and other data provided by L+MH and LMMG*	L+MH and LMMG prices; payer mix; uncompensated care; service mix
2. CMS Medicare 5% sample and 100% data* and fee schedules	Prices for Medicare; market share and service mix for Medicare
3. CT Medicaid fee schedules	Prices for Medicaid
4. Truven Health Analytics MarketScan claims database as licensed by Milliman*	Provider prices for multiple payers
5. Milliman's proprietary Consolidated Health Cost Guidelines Sources Database (CHSD), a "MarketScan-like" claims database*	Provider prices for multiple payers
6. Connecticut hospital discharge dataset*	Hospital size and market share; payer mix; uncompensated care; service mix
7. Connecticut hospital reports submitted to OHCA and Medicare Cost Reports	Hospital size and market share; payer mix; uncompensated care
8. Connecticut All Payer Claims Database (APCD)*	Prices for all payers; market share; payer mix; uncompensated care; service mix
9. Connecticut employee health benefits program claims database*	Prices for payers covering state employees; market share and service mix for employee population
10. Other data submitted to OHCA or other Connecticut state agencies by Connecticut healthcare providers or payers**	TBD

\* Non-public data. Non-public = restricted to certain users and/or uses.

\*\* May include non-public data.

While the APCD (#8 above) and employee health claims database (#9 above) would be excellent data sources, if they are not available or insufficiently populated we can proceed without them.

Milliman has, for about two decades, licensed the Truven MarketScan commercial database and predecessor databases, and has developed routine processing to speed its use, improve its accuracy, and increase its utility. In recent years, this data source has included claims for about 50 million lives. Milliman also has a similar, non-overlapping, database (CHSD) with about 20 million lives of data from Milliman client data contributors across the U.S.

We will review data sources annually for relevant changes, including the possibility of incorporating new data sources into our analysis.

## F. PRICE

Milliman bills for time and travel expenses. Time is tracked by professional on a quarter-hour basis and billed monthly.

Phase	Deliverables	Estimated Price
Baseline CMIR: L+MH	Report to OHCA	\$200,000
Baseline CMIR: LMMG	Report to OHCA	\$100,000
3 annual updates: L+MH*	Report to OHCA	\$120,000 each

\* The L+MH fee monitoring period is 5 years from September, 2016. L+MH pre-affiliation negotiated contracts are maintained through December 31, 2017. The baseline L+MH CMIR is applicable to fee increases for calendar year 2018 and updates are applicable for 2019, 2020, and 2021 through August.

The LMMG fee monitoring period is 28 months from September, 2016. LMMG pre-affiliation negotiated contracts are maintained through December 31, 2017. The Baseline LMG CMIR is applicable to fee increases for calendar year 2018. There will be no updates.

Substantial revisions and work outside the above will be billed at Milliman's usual hourly rates plus travel expenses at price.

## G. TIMING

We will deliver the CMIRs by June each year, with the first CMIR delivered in June 2017.

## H. CONSULTING SERVICES AGREEMENT

This work will be subject to the terms of a Milliman – YNHHSO consulting services agreement.

# **COMPLIANCE ADDENDUM**

## COMPLIANCE ADDENDUM

**THIS COMPLIANCE ADDENDUM** (this “Addendum”) is made as of November 28, 2016 (the “**Effective Date**”), by and between Yale-New Haven Health Services Corporation, Inc., acting on behalf of Bridgeport Hospital, Greenwich Hospital, Yale-New Haven Hospital, Inc. and/or Northeast Medical Group, Inc. (“**YNHHS**”) and Milliman, Inc., having offices at One Pennsylvania Plaza, 38th Floor, New York, NY 10119 (“**Vendor**”).

YNHHS and Vendor have entered into an agreement for November 28th, 2016, dated as of the Effective Date (“**Agreement**”), pursuant to which the Vendor will provide certain goods and/or services to YNHHS.

YNHHS and Vendor understand that the Agreement is subject to numerous requirements imposed by federal law, state law, and accreditation agencies, and YNHHS and Vendor desire to perform their respective obligations under the Agreement in full compliance with those requirements.

Therefore, the parties agree as follows:

1. **Exclusion.** Vendor agrees as follows:

(a) Vendor represents and warrants that neither it nor any of its employees or representatives performing services under the Agreement has ever been: (1) convicted of a criminal offense related to health care or related to the provision of services paid for by Medicare, Medicaid or another federal health care program (“**Government Health Care Programs**”); (2) excluded or debarred from participation in any Government Health Care Program; or (3) otherwise sanctioned by the federal government, including being listed on the General Services Administration’s Excluded Party Listing System or Office of Foreign Assets Control (OFAC) list of Specially Designated Nationals and Blocked Persons List.

(b) Vendor shall notify YNHHS immediately if any representation or warranty in paragraph (a) above is or becomes untrue at any time during the term of the Agreement.

(c) If any representation or warranty in paragraph (a) above is or becomes untrue at any time during the term of the Agreement, YNHHS may, in its sole discretion, either terminate the Agreement or require Vendor to replace any employee or representative causing the breach of warranty with another appropriate employee or representative acceptable to YNHHS.

2. **Access to Records.** If the Agreement provides for services to be performed by Vendor worth \$10,000 or more over a 12-month period, Vendor will, until the expiration of four years after the termination of the Agreement, make available to the Secretary, U.S. Department of Health and Human Services, and the U.S. Comptroller General and their representatives, the Agreement and all books, documents and records necessary to certify the nature and extent of the cost of those services. If Vendor carries out any of the duties described herein through a subcontract worth \$10,000 or more over a 12-month period with a related organization, the subcontract must also

contain an access clause to permit access by the Secretary, Comptroller General and their representatives to the related organization's books, documents and records. In the event Vendor receives a request for access, Vendor will notify YNHHS immediately and consult with YNHHS regarding the response to the request.

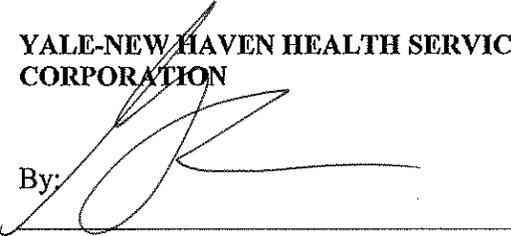
3. **Confidentiality.** Each party expressly undertakes to retain in confidence all information and know-how transmitted to it by the disclosing party that the disclosing party has identified as being proprietary and/or confidential or that, by the nature of the circumstances surrounding disclosure or the nature of the information disclosed, ought in good faith to be treated as proprietary or confidential ("Confidential Information") and will make no use of such information and know-how except under the terms and during the existence of the Agreement. The parties' obligations under this Section shall survive termination or expiration of the Agreement. Confidential Information shall include, by way of example and not limitation, any and all information regarding a party's finances, practices, employees, or management. Confidential Information shall not include information which (i) at the time of disclosure was, is or thereafter becomes disclosed or available to or known by the public (other than as a result of a disclosure in violation of any of obligations hereunder), (ii) was or is or thereafter becomes available on a non-confidential basis from a source that is not and was not prohibited from disclosing such information by a contractual, legal or fiduciary obligation, or (iii) has been or thereafter becomes independently acquired or developed without access to any of the information provided by the disclosing party. Notwithstanding anything herein to the contrary, or any prior understanding or agreement between the parties, YNHHS shall have the right to disclose all pricing and other terms stated in or relating to the Agreement to any of YNHHS' attorneys, accountants, Consultants (including members of the medical staff and physicians members of clinical evaluation committees or other committees evaluating purchases), group purchasing organizations, and other third parties retained by YNHHS in the ordinary course, on a need-to-know basis (that is, their duties, requirements or contract for services require such disclosure), and, with the exception of group purchasing organizations, agree to take appropriate action by instruction or agreement with such individuals permitted access to the Confidential Information to satisfy the obligations under this Section. Unauthorized use of Confidential Information is a material breach of the Agreement resulting in irreparable harm for which the payment of money damages is inadequate. It is agreed that the non-breaching party, upon adequate proof of unauthorized use, may immediately obtain injunctive relief in any court of competent jurisdiction enjoining any continuing or further breaches and may obtain entry of judgment for injunctive relief. Nothing in the Agreement shall be construed to limit remedies at law or equity in the event of a breach.

4. **Security.** If Vendor personnel will be on YNHHS's premises, Vendor and Vendor personnel must comply with all YNHHS policies and procedures pertaining to visitation, confidentiality, security and vendor identification. YNHHS may issue non-employee identification badges under certain conditions. If YNHHS provides an identification badge, Vendor will require its personnel to prominently display such badge at all times while on YNHHS premises. Vendor shall surrender any badge immediately upon request by YNHHS. Vendor's or Vendor Personnel's non-compliance with any of the policies described in this Section is to be construed as a breach of the Agreement.

5. **Relationship to Agreement.** To the extent there is any conflict between the terms and conditions of this Addendum and the Agreement, the terms and conditions of this Addendum shall control. All other terms and conditions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, each of the parties has caused this Addendum to be executed as of the date set forth above.

YALE-NEW HAVEN HEALTH SERVICES  
CORPORATION

By: 

Name:

GAYLE LAPOZZALO

Title:

EXEC VP / CHIEF STRATEGY OFFICER

Milliman, Inc.

By: 

Name:

Bruce Pyenson

Title:

Principal & Consulting Actuary

## Greer, Leslie

---

**From:** Martone, Kim  
**Sent:** Thursday, December 01, 2016 8:50 AM  
**To:** Roberts, Karen  
**Cc:** Greer, Leslie  
**Subject:** FW: Yale and L&M acquisition  
**Attachments:** Response to intevenors 113016.pdf

FYI

Kim

### ***Kimberly R. Martone***

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



---

**From:** Capozzalo, Gayle [<mailto:Gayle.Capozzalo@ynhh.org>]  
**Sent:** Wednesday, November 30, 2016 4:13 PM  
**To:** Martone, Kim  
**Cc:** Borgstrom, Marna; Petrini, Vincent; Cummings, Bruce (L and M); 'Sauders, Kelly (US - New York)'; Tammaro, Vincent; Aseltyne, Bill; Rosenthal, Nancy; Willcox, Jennifer; O'Connor, Christopher  
**Subject:** RE: Yale and L&M acquisition

Kim,

Attached please find a letter addressing the issues you raised in your email. I look to hearing from you at your convenience.

Gayle

Gayle Capozzalo, FACHE  
Chief Strategy Officer  
789 Howard Avenue  
New Haven, CT 06519  
**Phone:** 203-688-2605  
**Fax:** 203-688-3472  
[gayle.capozzalo@ynhh.org](mailto:gayle.capozzalo@ynhh.org)

**YaleNewHavenHealth**

---

**From:** Martone, Kim [<mailto:Kimberly.Martone@ct.gov>]  
**Sent:** Tuesday, November 22, 2016 3:06 PM  
**To:** Capozzalo, Gayle  
**Subject:** Yale and L&M acquisition

Gayle, please see the attached letter from multiple organizations and individuals objecting to the approval of Deloitte and Touche as the Independent Monitor for the Yale-New Haven Hospital System settlement agreement. Please address all allegations in full detail with supporting documentation as needed. As I advised when we met on November 15th, I do feel it is important for you and/or your community representative to meet with these organizations and individuals to inform them of such decisions as this acquisition moves forward. In light of the assertions made in the attached letter, I am hereby restating my request and ask that your discussions include the points outlined in the letter. Further, OHCA reserves the right to reverse its approval of the monitor based on your response to the attached letter.

Kim

***Kimberly R. Martone***

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
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This message originates from the Yale New Haven Health System. The information contained in this message may be privileged and confidential. If you are the intended recipient you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you.

November 30, 2016

Ms. Kimberly Martone  
Office of Healthcare Access  
State of Connecticut  
410 Capitol Avenue  
P.O. Box 340308  
Hartford, CT 06134

Dear Ms. Martone:

I am writing in response to concerns raised by a group of former intervenors regarding the selection of Deloitte and Touche as the Independent Monitor for the affiliation of Lawrence + Memorial Healthcare with Yale New Haven Health System. As you know, the appointment of the Monitor was made in compliance with the detailed conditions set forth in the Agreed Settlement which approved the affiliation on September 8, 2016.

Deloitte and Touche was recommended for this role because of its unique and comprehensive set of skills and knowledge of the healthcare environment. Deloitte and Touche has been engaged by healthcare organizations throughout the United States, including the State of Connecticut Health Exchange, for its expertise and broad perspective on changes affecting the delivery of healthcare. Deloitte has worked for 10 out of the 11 largest non-profit healthcare systems in the nation, 75 percent of all honor roll hospitals and more than 90 percent of the Fortune 500 life sciences and healthcare companies. Deloitte also has been a national leader in transaction monitoring and has thoroughly reviewed its ability to fulfill the responsibilities of the Independent Monitor to ensure that there are no conflicts of interest.

The group of former intervenors has cited work that Deloitte has done in the past for Yale New Haven Health as disqualifying the firm from serving as the Independent Monitor. They cite \$30 million in billings over the past decade-plus. To put this number in perspective, during that time, Yale New Haven Health grew from a \$1.5 billion system to more than \$4 billion. The System spent more than \$340 million on professional fees during that period of which approximately \$30 million was paid to Deloitte, which is less than .0815% of its 2016 U.S. revenue of \$36.8 billion.

Deloitte has been engaged by Yale New Haven Health for the following matters. From 2005 through 2015, Deloitte provided internal audit services, averaging approximately \$1.7 million annually – nearly half the amount cited in the letter. In this capacity, Deloitte reported directly to the Audit Committee of the Board to preserve independence from management. In 2015, Yale New Haven Health selected Ernst & Young to replace Deloitte in this role.

In 2012, Deloitte provided consulting services in connection with Yale New Haven Hospital's integration with the former Hospital of Saint Raphael. This role included identifying opportunities for economic efficiencies while preserving access to care and jobs. The Saint Raphael transaction was subject to OHCA approval and post-approval monitoring, and by all accounts, the integration has been successful. In 2015, Deloitte provided similar services in pre-closing discussions with Lawrence and Memorial regarding potential synergies.

In 2013, Deloitte was selected from a competitive bidding process to provide consultation as Yale New Haven Health implemented a new, System-wide electronic health record. That same year, Deloitte also provided transitional support for the Chief Information and Chief Compliance Officer roles.

We firmly believe that none of this past work would interfere with the proposed role for Deloitte as the Independent Monitor. Further, it is our understanding that Deloitte's internal conflict assessment review would have resulted in their withdrawing from this engagement if a conflict was identified.

Finally, unrelated to this work, the former intervenors cite a \$1 million fine that Deloitte received from the Securities Exchange Commission back in 2015. It is important to note that this isolated event was self-disclosed by Deloitte and was part of a series of cases reviewed by regulators at the time, including a \$4 million fine against Ernst & Young and an \$8.2 million fine against KPMG.

While the organizations that have raised concerns about Deloitte uniformly opposed the affiliation during the approval process, we are committed to listening to their perspectives, along with those of community leaders throughout southeastern Connecticut. Our goal is simple. We want this affiliation to succeed. To do so we intend to demonstrate that we will keep the commitments we made to the State, just as we did in 2012 during the integration with the Hospital of Saint Raphael. In fact, just two months into our formal affiliation with Lawrence + Memorial Healthcare, we have already made important investments and recruitments to support access to cost-effective healthcare services in the communities served by Lawrence + Memorial Healthcare.

We hope this provides helpful context by the concerns raised by the former intervenors. We stand ready to continue to work with OHCA to ensure that this affiliation achieves the lofty goals we have jointly set for it in the years to come.

Sincerely,



Gayle Capozzalo  
Chief Strategy Officer

## Olejarz, Barbara

---

**From:** Olejarz, Barbara  
**Sent:** Monday, December 05, 2016 3:36 PM  
**To:** 'andrews@chhealthpolicy.org'; 'jhochadel@svft.org'  
**Cc:** Martone, Kim  
**Subject:** FW: Yale and L&M acquisition

12/5/26

Ellen Andrews and Jan Hochadel,

Kimberly Martone of the Office of Health Care Access asked me to forward this email to you. For more information regarding the Yale-New Haven Hospital System Agreement and Gayle Capozzalo's response to the issues please click the link below to the OHCA website. Please forward to other organizations and individuals we did not have the email addresses for.

Thank you

[http://www.ct.gov/dph/lib/dph/ohca/con\\_completed/2016/15\\_32033\\_con.pdf](http://www.ct.gov/dph/lib/dph/ohca/con_completed/2016/15_32033_con.pdf)

Barbara K. Olejarz  
Administrative Assistant to Kimberly Martone  
Office of Health Care Access  
Department of Public Health  
Phone: (860) 418-7005  
Email: [Barbara.Olejarz@ct.gov](mailto:Barbara.Olejarz@ct.gov)



**From:** Martone, Kim  
**Sent:** Monday, December 05, 2016 12:12 PM  
**To:** 'Capozzalo, Gayle' <Gayle.Capozzalo@ynhh.org>  
**Cc:** Borgstrom, Marna <Marna.Borgstrom@ynhh.org>; Petrini, Vincent <Vincent.Petrini@ynhh.org>; Cummings, Bruce (L and M) <bcummings@lmhosp.org>; 'Sauders, Kelly (US - New York)' <ksauders@deloitte.com>; Tammaro, Vincent <Vincent.Tammaro@ynhh.org>; Aseityne, Bill <Bill.Aseityne@ynhh.org>; Rosenthal, Nancy <Nancy.Rosenthal@greenwichhospital.org>; Willcox, Jennifer <Jennifer.Willcox@ynhh.org>; O'Connor, Christopher <christopher.oconnor@ynhh.org>  
**Subject:** RE: Yale and L&M acquisition

Hi Gayle, thank you for your response and additional information on the issues raised in the letter. The Office confirms the approval of Deloitte and Touche as the Independent Monitor for the Yale-New Haven Hospital System settlement agreement. We continue to recommend that you meet with the organizations and individuals who signed the letter to inform them of decisions made regarding the acquisition of L&M.

Kim

**Kimberly R. Martone**

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134

Phone: 860-418-7029 Fax: 860-418-7053

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**Sent:** Wednesday, November 30, 2016 4:13 PM  
**To:** Martone, Kim  
**Cc:** Borgstrom, Marna; Petrini, Vincent; Cummings, Bruce (L and M); 'Sauders, Kelly (US - New York)'; Tammaro, Vincent; Aselyne, Bill; Rosenthal, Nancy; Willcox, Jennifer; O'Connor, Christopher  
**Subject:** RE: Yale and L&M acquisition

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Gayle

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Chief Strategy Officer  
789 Howard Avenue  
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**Phone:** 203-688-2605  
**Fax:** 203-688-3472  
[gayle.capozzalo@ynhh.org](mailto:gayle.capozzalo@ynhh.org)

YaleNewHavenHealth

---

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**Sent:** Tuesday, November 22, 2016 3:06 PM  
**To:** Capozzalo, Gayle  
**Subject:** Yale and L&M acquisition

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Kim

**Kimberly R. Martone**  
Director of Operations, Office of Health Care Access

**Olejarz, Barbara**

---

**From:** Microsoft Outlook  
**To:** andrews@cthealthpolicy.org  
**Sent:** Monday, December 05, 2016 3:38 PM  
**Subject:** Relayed: FW: Yale and L&M acquisition

**Delivery to these recipients or groups is complete, but no delivery notification was sent by the destination server:**

[andrews@cthealthpolicy.org](mailto:andrews@cthealthpolicy.org) ([andrews@cthealthpolicy.org](mailto:andrews@cthealthpolicy.org))

Subject: FW: Yale and L&M acquisition

## Olejarz, Barbara

---

**From:** postmaster@svft.org  
**To:** jhochadel@svft.org  
**Sent:** Monday, December 05, 2016 3:47 PM  
**Subject:** Undeliverable: FW: Yale and L&M acquisition

### Delivery has failed to these recipients or groups:

[jhochadel@svft.org](mailto:jhochadel@svft.org)

This message was rejected by the recipient email system. Please check the recipient's email address and try resending this message, or contact the recipient directly.

### Diagnostic information for administrators:

Generating server: CO2PR03MB2165.namprd03.prod.outlook.com

[jhochadel@svft.org](mailto:jhochadel@svft.org)

Remote Server returned '< #5.1.10 smtp;550 5.1.10 RESOLVER.ADR.RecipientNotFound; Recipient not found by SMTP address lookup>'

### Original message headers:

Received: from DM2PR03CA0033.namprd03.prod.outlook.com (10.141.96.32) by CO2PR03MB2165.namprd03.prod.outlook.com (10.166.92.12) with Microsoft SMTP Server (version=TLS1\_2, cipher=TLS\_ECDHE\_RSA\_WITH\_AES\_256\_CBC\_SHA384\_P384) id 15.1.761.9; Mon, 5 Dec 2016 20:46:42 +0000  
Received: from BN1BFFO11FD039.protection.gbl (2a01:111:f400:7c10::1:182) by DM2PR03CA0033.outlook.office365.com (2a01:111:e400:2428::32) with Microsoft SMTP Server (version=TLS1\_2, cipher=TLS\_ECDHE\_RSA\_WITH\_AES\_256\_CBC\_SHA384\_P384) id 15.1.721.10 via Frontend Transport; Mon, 5 Dec 2016 20:46:42 +0000  
Authentication-Results: spf=pass (sender IP is 159.247.0.202) smtp.mailfrom=ct.gov; svft.org; dkim=none (message not signed) header.d=none;svft.org; dmarc=bestguesspass action=none header.from=ct.gov;  
Received-SPF: Pass (protection.outlook.com: domain of ct.gov designates 159.247.0.202 as permitted sender) receiver=protection.outlook.com; client-ip=159.247.0.202; helo=DeltaconX4.ct.gov;  
Received: from DeltaconX4.ct.gov (159.247.0.202) by BN1BFFO11FD039.mail.protection.outlook.com (10.58.144.102) with Microsoft SMTP Server (version=TLS1\_2, cipher=TLS\_RSA\_WITH\_AES\_256\_CBC\_SHA256) id 15.1.734.4 via Frontend Transport; Mon, 5 Dec 2016 20:46:41 +0000  
X-IncomingTopHeaderMarker:  
OriginalChecksum:;UpperCasedChecksum:;SizeAsReceived:1920;Count:24  
Received: from mailgate2.doit.ct.gov (unknown [159.247.5.89]) by DeltaconX4.ct.gov with smtp  
id 21d3\_31cb\_6a5c3dd1\_f9f0\_4890\_8487\_b380059fa63a;  
Mon, 05 Dec 2016 15:46:39 -0500  
X-WSS-ID: 00HQCDP-02-OBB-02

## Olejarz, Barbara

---

**From:** Ellen Andrews <andrews@cthealthpolicy.org>  
**Sent:** Monday, December 05, 2016 3:57 PM  
**To:** Olejarz, Barbara  
**Subject:** Re: Yale and L&M acquisition

Thanks, I will get it to the folks in the coalition.  
Ellen

Ellen Andrews, PhD  
CT Health Policy Project  
cthealthpolicy.org  
@cthealthnotes

---

**From:** "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>  
**Date:** Monday, December 5, 2016 at 3:37 PM  
**To:** Ellen Andrews <andrews@cthealthpolicy.org>  
**Subject:** FW: Yale and L&M acquisition

**From:** Olejarz, Barbara  
**Sent:** Monday, December 05, 2016 3:36 PM  
**To:** 'andrews@chhealthpolicy.org' <andrews@chhealthpolicy.org>; 'jhochadel@svft.org' <jhochadel@svft.org>  
**Cc:** Martone, Kim <Kimberly.Martone@ct.gov>  
**Subject:** FW: Yale and L&M acquisition

12/5/26

Ellen Andrews and Jan Hochadel,

Kimberly Martone of the Office of Health Care Access asked me to forward this email to you. For more information regarding the Yale-New Haven Hospital System Agreement and Gayle Capozzalo's response to the issues please click the link below to the OHCA website. Please forward to other organizations and individuals we did not have the email addresses for.

Thank you

[http://www.ct.gov/dph/lib/dph/ohca/con\\_completed/2016/15\\_32033\\_con.pdf](http://www.ct.gov/dph/lib/dph/ohca/con_completed/2016/15_32033_con.pdf)

Barbara K. Olejarz  
Administrative Assistant to Kimberly Martone  
Office of Health Care Access  
Department of Public Health  
Phone: (860) 418-7005  
Email: [Barbara.Olejarz@ct.gov](mailto:Barbara.Olejarz@ct.gov)



## Olejarz, Barbara

---

**From:** Olejarz, Barbara  
**Sent:** Thursday, January 12, 2017 2:09 PM  
**To:** 'gayle.capozzalo@ynhh.org'  
**Cc:** Roberts, Karen; Cotto, Carmen  
**Subject:** FW: Clarification of the timing of submissions

1/12/17

Gayle,

Regarding the Independent Monitor's request from OHCA related to timeframes for submission of a number of conditions under Docket Number 15-32033-CON. After reviewing the conditions, OHCA staff has prepared the following to clarify the timing of condition submissions, which I am in agreement with. The yellow highlights show where the words "following the Closing Date" appear in the conditions. OHCA's clarifying statements appear in Red/Bold. Please let me know if you need anything else in order to clarify the Hospital's and Independent Monitor's filing obligations.

### **Kimberly R. Martone**

Director of Operations, Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134  
Phone: 860-418-7029 Fax: 860-418-7053  
Email: [Kimberly.Martone@ct.gov](mailto:Kimberly.Martone@ct.gov) Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



- 
1. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, YNHHS shall submit schedules to OHCA setting forth L+MH's inpatient bed allocation and the location and hours of operation. **N/A - THIS MATERIAL WAS FILED AND IS UNDER REVIEW**
  2. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, YNHHS shall notify OHCA of the Closing, in writing, and shall supply final execution copies...:
    - a. the Affiliation Agreement, including any and all schedules and exhibits; and
    - b. Bylaws or similar governance documents for L+M as well as for L+MH. ...**N/A - THIS MATERIAL WAS FILED AND IS UNDER REVIEW**
  3. Following the completion of L+MH's 2016 Community Health Needs Assessment (CHNA), YNHHS shall participate with L+MH, and the key community stakeholders and health organizations, in conducting future CHNAs and shall provide a copy of the 2016 CHNA and its Implementation Strategy to OHCA within thirty (30) days of completion ..... In the event that L+MH has already substantially completed its

2016 Implementation Strategy at the time of the signing of this Order, it may submit the information requested in the 6/18 initiative as an addendum **within six (6) months of the Closing Date**. The CHNA and the Implementation Strategy shall be published on the website of L+MH... ***THIS REFERENCE TO SIX MONTHS OF THE CLOSING DATE REMAINS APPLICABLE.***

4. Within one hundred and eighty (180) days **following the Closing Date**, YNHHS shall submit a plan demonstrating how health care services will be provided by L+MH .... ***THE FILING MAY BE MADE 180 DAYS FOLLOWING THE END OF THE FISCAL YEAR INSTEAD OF THE CLOSING DATE.***
6. Within one hundred and eighty (180) days **following the Closing Date**, the Applicants shall file with OHCA the total price per “unit of service” for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. **The first filing shall be for the period September 1, 2015-August 30, 2016.** The Applicants shall provide the same information for **three (3) full fiscal years thereafter**, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. ***THE INITIAL FILING FOR THE DATA FOR THE PRE-CLOSING PERIOD (9/1/2015 – 8/30/2016) MAY BE FILED 180 DAYS FOLLOWING THE END OF THE FISCAL YEAR INSTEAD OF THE CLOSING DATE. THE SUBSEQUENT ANNUAL FILINGS ARE ALREADY BASED ON A FISCAL YEAR AND MAY BE FILED 60 DAYS FOLLOWING THE FY END AS INDICATED (WHICH IS NOVEMBER 30<sup>TH</sup>).***
7. Within one hundred and eighty (180) days **following the Closing Date** and thereafter until the capital commitment is satisfied, YNHHS shall submit to OHCA a report on the capital investments (“Capital Investment Report”) it has made in L+M and its affiliates from the \$300M Commitment Amount. ....For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31<sup>st</sup> and November 30<sup>th</sup>, beginning November 30, 2016.... ***THE INITIAL FILING MAY BE MADE 180 DAYS FOLLOWING THE END OF THE FISCAL YEAR INSTEAD OF THE CLOSING DATE. ANY UPDATES WILL BE FILED ON THE SEMI-ANNUAL SCHEDULE ALREADY NOTED IN THE STIPULATION. THE NOVEMBER 30, 2016 REFERENCE FOR THIS INITIAL FILING IS INCORRECT.***
8. For three (3) years **following the Closing Date**, YNHHS shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31<sup>st</sup> and November 30<sup>th</sup>, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report: ...

**Financial Measurement/Indicators**

***THIS IS A SEMI-ANNUAL FINANCIAL REPORT IS BASED ON THE FISCAL YEAR AND IS DUE MAY 31<sup>ST</sup> AND NOVEMBER 30<sup>TH</sup>. THE NOVEMBER 30, 2016 REFERENCE FOR THIS INITIAL FILING IS INCORRECT.***

11. The Applicants shall maintain community benefit programs and community building activities for L+MH for three (3) years **after the Closing Date** consistent with L+MH’s most recent Schedule H of IRS Form 990 ...
  - c. On an annual basis, YNHHS shall identify the amounts and uses related to community benefits and community building .... Such reporting shall be filed within **thirty (30) days of the anniversary date of the Closing for three years** and shall be posted on L+MH’s website. ... ***THIS ANNUAL REPORT MAY INSTEAD BE FILED ON NOVEMBER 30<sup>TH</sup> FOR THE THREE YEAR. THIS IS IN KEEPING WITH THE OTHER FINANCIAL INFORMATION THAT WILL BE FILED EACH NOVEMBER 30<sup>TH</sup> AND IS 60 DAYS AFTER THE CLOSE OF THE FISCAL YEAR.***

12. The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. ... For three (3) years following the Closing Date, YNHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website. ***THIS ANNUAL REPORT MAY INSTEAD BE FILED ON NOVEMBER 30<sup>TH</sup> FOR THE THREE YEAR. THIS IS IN KEEPING WITH THE OTHER FINANCIAL INFORMATION FILED EACH NOVEMBER 30<sup>TH</sup> AND IS 60 DAYS AFTER THE CLOSE OF THE FISCAL YEAR.***
32. Every six months (the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHSC shall submit notarized reports to OHCA for the periods of January to June (due July 31<sup>st</sup>) and July through December (due January 31<sup>st</sup>) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: ***THIS NOTARIZED REPORT INCLUDING THE FINANCIAL INFORMATION OUTLINED IN 32(f) MAY INSTEAD BE FILED ON THE SAME SEMI-ANNUAL FISCAL YEAR PERIOD. SO AT THE SAME TIME AS THE FINANCIAL REPORTS (DUE MAY 31<sup>ST</sup> AND NOVEMBER 30<sup>TH</sup>) UNTIL THE REFERENCED DECEMBER 1, 2018 DATE.***

**Olejarz, Barbara**

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**From:** Microsoft Outlook  
**To:** 'gayle.capozzalo@ynhh.org'  
**Sent:** Thursday, January 12, 2017 2:09 PM  
**Subject:** Relayed: FW: Clarification of the timing of submissions

**Delivery to these recipients or groups is complete, but no delivery notification was sent by the destination server:**

['gayle.capozzalo@ynhh.org' \(gayle.capozzalo@ynhh.org\)](mailto:gayle.capozzalo@ynhh.org)

Subject: FW: Clarification of the timing of submissions

## Olejarz, Barbara

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**From:** Roberts, Karen  
**Sent:** Friday, February 03, 2017 3:50 PM  
**To:** Olejarz, Barbara  
**Subject:** FW: question on CON conditions - public forum for CONs #32032 and #32033

Barbara  
Please place in 32032 and 32033 (the two Yale-L+M CONs) - Karen

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**From:** Roberts, Karen  
**Sent:** Friday, February 03, 2017 3:49 PM  
**To:** 'ksauders@deloitte.com'  
**Cc:** Martone, Kim; Cotto, Carmen  
**Subject:** RE: question on CON conditions - public forum for CONs #32032 and #32033

Hi Kelly

Kim asked that I get back to you on your email below. Please note that the following wording is in both CON decisions (the hospital parent transfer of ownership, as well as the L+M Medical Group transfer of ownership).

*L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.*

This event is the Hospitals' event is not an OHCA public hearing; OHCA therefore has no rules, statutes, regulations or past examples to provide for guiding the Hospital and Independent Monitor in how to notify the public of this matter. OHCA expects that the hospital will convene this forum so that it is well noticed to the public, noticed in a timely manner, fully informative and includes both transactions (the hospital and the physician practice). They should put it on all applicable websites.

Sincerely,

*Karen Roberts*  
Principal Health Care Analyst  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308  
P: (860) 418-7041 / F: (860) 418-7053 / E: [karen.roberts@ct.gov](mailto:karen.roberts@ct.gov)



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**From:** Martone, Kim  
**Sent:** Friday, February 03, 2017 9:48 AM  
**To:** Roberts, Karen

**Cc:** Riggott, Kaila  
**Subject:** FW: Question about L+MH Public Meeting and notice

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**From:** Sauders, Kelly (US - New York) [<mailto:ksauders@deloitte.com>]  
**Sent:** Friday, February 03, 2017 9:46 AM  
**To:** Martone, Kim  
**Subject:** RE: Question about L+MH Public Meeting and notice

Good morning Kim – one question I forgot to pose yesterday. With respect to the upcoming public meeting, how should I have YNHSC publish the notice? Gayle Capozzalo mentioned that there is a process OHCA uses, but YNHSC has never had to do this before.

I would imagine the notice should be published in at least the New London Day and the Hartford Courant – again – looking for guidance. I am also not sure of timing? We are planning to hold the meeting on 3/1, so I'm sure we should get the initial notice published at least with a few weeks' notice? Is there also a follow-up posting? Does it have to be posted to the L+MH website?

I would appreciate any guidance you have as I want to make sure this is done correctly.

Thanks,  
Kelly

**Kelly J. Sauders**  
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