Certificate of Need Application

Orthopaedic & Neurosurgery Specialists, P.C.

Acquisition of a 1.5 Tesla MRI by a Private Physician Practice

January 20, 2016

BERSHTEIN, VOLPE & McKEON, P.C.
ATTORNEYS AT LAW
105 COURT STREET—THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
TELEPHONE: (203) 777-5800
FACSIMILE: (203) 777-5806

Michele M. Volpe
michelemvolpe@aol.com
203-777-5802

January 20, 2016

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
Hartford, Connecticut 06134-0308

Ms. Martone:

Enclosed please find a Certificate of Need application for Orthopaedic & Neurosurgery Specialists, P.C. regarding the proposed acquisition of a 1.5 tesla MRI scanner at its private physician practice. As requested, one (1) original and four (4) printed copies are enclosed as well as one (1) electronic CD copy.

If you have any questions or need anything further, please do not hesitate to contact me at 203-777-5802. Thank you.

Very truly yours,

Michele M. Volpe
Bershtein, Volpe & McKeon, P.C.

mmv/kgt

Enclosures

Table of Contents

4655

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.
6 GREENWICH OFFICE PARK
GREENWICH, CT 06831

CHASE
JPMorgan Chase Bank, N.A.
www.Chase.com
51-36/211

1/15/2016

PAY TO THE ORDER OF TREASURER, STATE OF CONNECTICUT $**500.00

Five Hundred and 00/100********** DOLLARS

AUTHORIZED SIGNATURE

MEMO CON Application Filing Fee

⑈046559⑈ ⑆021100361⑆ 603758900⑈

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C. 4655

TREASURER, STATE OF CONNECTICUT	1/15/2016	
8.Other Operating Expenses:Licenses an		500.00

Chase Disbursements CON Application Filing Fee 500.00

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C. 4655

TREASURER, STATE OF CONNECTICUT	1/15/2016	
8.Other Operating Expenses:Licenses an		500.00

Chase Disbursements CON Application Filing Fee 500.00

The ADVOCATE

BERHSTEIN, VOLPE & MCKEON
105 COURT STREET,3RD FLOOR
NEW HAVEN CT 06511

LEGAL NOTICE:

Orthopaedic & Neurosurgery Specialists, P.C. ("ONS") is requesting Certificate of Need approval pursuant to Conn. Gen. Stat. 19a-638 to obtain an MRI scanner at 6 Greenwich Office Park, Greenwich, Connecticut to serve its practice patients from Greenwich and the High Ridge Road Stamford, Connecticut location. The total capital expenditure is $1,500,337.

THE ADVOCATE
9 Riverbend Drive South
Building 9A
P.O. Box 4910
Stamford, CT 06907-0910
Telephone: 203-330-6208
Fax: 203-384-1158
Legal.notices@scni.com

THE ADVOCATE
CERTIFICATE OF PUBLICATION

I, _____
Being duly sworn, depose and say that I am a Representative in the employ of SOUTHERN CONNECTICUT NEWSPAPERS, INC., Publisher of *The Advocate* and *Greenwich Time*, that a LEGAL NOTICE as stated below was published in THE ADVOCATE.

Subscribed and sworn to before me on this 29th Day of December, A.D. 2015.

_____
Pamela Caluori/Notary Public

My commission expires on January 2018

PO Number

Publication

Greenwich Time

Ad Number	Ad Caption
0002130410-01	Legal Notice: Orthopaedic & N

Publication Schedule

12/9/2015, 12/10/2015, 12/11/2015

00005

Greenwich Time

GREENWICH TIME
1455 East Putnam Avenue
Old Greenwich, CT 06870
Telephone: 203-330-6208
Fax: 203-384-1158
Legal.notices@scni.com

BERNSTEIN, VOLPE & MCKEON
105 COURT STREET, 3RD FLOOR
NEW HAVEN CT 06511

LEGAL NOTICE:

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GREENWICH TIME
CERTIFICATE OF PUBLICATION

I, Stephen Delaney

Being duly sworn, depose and say that I am a Representative in the employ of SOUTHERN CONNECTICUT NEWSPAPERS, INC., Publisher of *The Advocate* and *Greenwich Time*, that a LEGAL NOTICE as stated below was published in the GREENWICH TIME.

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Pamela E. Caluori

Pamela Caluori/Notary Public

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

Certificate of Need Application
Main Form
Required for all CON applications

Contents:

Supplemental Forms

In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** 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)	**Establishment of a new health care facility (mental health and/or substance abuse)** - *see note below**
(2)	**Transfer of ownership of a health care facility** (excludes transfer of ownership/sale of hospital – see "Other" below)
(3)	**Transfer of ownership of a group practice**
(4)	**Establishment of a freestanding emergency department**
(5) (7) (8) (15)	**Termination of a service:** - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - 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)	**Establishment of an outpatient surgical facility**
(9)	**Establishment of cardiac services**
(10) (11)	**Acquisition of equipment:** - 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)	**Increase in licensed bed capacity** of a health care facility
(13)	**Acquisition of equipment utilizing [new] technology** that has not previously been used in the state
(14)	**Increase of two or more operating rooms** within any three-year period by an outpatient surgical facility or short-term acute care general hospital
Other	**Transfer of Ownership / Sale of Hospital**

*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.

**If termination is due to insufficient patient volume, or it is a subspecialty being terminated, a CON is not required.

Application Checklist

Instructions:

1. Complete the following checklist and **submit** as the first page of the CON application:

☒ Attached is a paginated hard copy of the CON application (all social security numbers must be redacted), including a completed affidavit, signed and notarized by the appropriate individuals.

☒ *(*New*).* A completed supplemental application form specific to the proposal type, available on OHCA's website under OHCA Forms (see previous page for the list of supplemental forms).

☒ Attached is the CON application filing fee in the form of a 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 Worksheet (A, B or C) available at OHCA's website under OHCA Forms.

☒ 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; and
2. An electronic copy of the completed application forms in **MS Word** (the applications) and **MS Excel** (Financial Worksheet)

For OHCA Use Only:

Docket No.: 16-32063-CON **Check No.:** 46559
OHCA Verified by: **Date:** 1/21/16

General Information

Name of Applicant:	Name of Co-Applicant:
Orthopaedic & Neurosurgery Specialists, P.C.	n/a

Connecticut Statute Reference:
19a-638(a)(10)

Main Site

MAIN SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Greenwich	none	Private Physician Practice	Orthopaedic & Neurosurgery Specialists, P.C.

STREET & NUMBER		
6 Greenwich Office Park		
TOWN		ZIP CODE
Greenwich		06831

Project Site

PROJECT SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
Greenwich	none	Private Physician Practice	Orthopaedic & Neurosurgery Specialists, P.C.

STREET & NUMBER		
6 Greenwich Office Park		
TOWN		ZIP CODE
Greenwich		06831

Operator

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)
n/a	Private Physician Practice	Orthopaedic & Neurosurgery Specialists, P.C.

STREET & NUMBER		
6 Greenwich Office Park		
TOWN		ZIP CODE
Greenwich		06831

Chief Executive

NAME	TITLE	
Seth R. Miller, M.D.	President	
STREET & NUMBER		
6 Greenwich Office Park		
TOWN	STATE	ZIP CODE
Greenwich	CT	06831

	TELEPHONE	FAX	E-MAIL ADDRESS
	(203) 869-1145	(203)869-2170	miller@onsmd.com

		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 ☐ NO ☒	
Does the Applicant have non-profit status? If yes, attach documentation.	YES ☐ NO ☒	
Identify the Applicant's ownership type.	PC ☒ LLC ☐ Corporation ☐	Other: _____
Applicant's Fiscal Year (mm/dd)	Start Jan 1	End Dec 31

Contact:

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

Contact Information			
NAME		TITLE	
Michele M. Volpe		n/a	
STREET & NUMBER			
105 Court Street, Third Floor			
TOWN	STATE	ZIP CODE	
New Haven	**CT**	**06511**	
TELEPHONE	FAX	E-MAIL ADDRESS	
(203)777-6995	(203)777-5806	michelemvolpe@aol.com	
RELATIONSHIP TO APPLICANT	Attorney, Bershtein, Volpe & McKeon, P.C.		

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

Prepared by			
NAME		TITLE	
STREET & NUMBER			
TOWN	STATE	ZIP CODE	
TELEPHONE	FAX	E-MAIL ADDRESS	
RELATIONSHIP TO APPLICANT			

Affidavit

Applicant: Orthopaedic & Neurosurgery Specialists, P.C.

Project Title: Acquisition of 1.5 Tesla MRI by a Private Physician Practice

I, Seth Miller, M.D., President
(Name) (Position – CEO or CFO)

of Orthopaedic & Neurosurgery Specialists, P.C. 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 1-15-16
Date

Subscribed and sworn to before me on JAN. 15, 2016

Notary Public/Commissioner of Superior Court

My commission expires: AUG. 31, 2019

Pat C Pedersen
NOTARY PUBLIC
State of Connecticut
My Commission Expires
August 31, 2019

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.

Orthopaedic & Neurosurgery Specialists, P.C. ("ONS", "Applicant" or the "Practice") is requesting Certificate of Need ("CON") approval to obtain a second MRI scanner ("Proposed Scanner") for use in its private practice. The Practice maintains an office at 6 Greenwich Office Park, Greenwich, Connecticut and at 5 High Ridge Road, Stamford, Connecticut.

Key Elements of the Proposal:

- ONS currently operates a fixed 1.5 Tesla (1.5T) Magnetom Espree Open Bore MRI scanner ("Existing Scanner") authorized pursuant to Docket Number 08-31150-CON;
- The Existing Scanner only services ONS patients and is operating over capacity. Throughout the last twelve months, the Existing Scanner is operating at 92% utilization, which is over the recommended 85%. In September 2015, the Existing Scanner was operating at over 94% utilization;
- ONS has had to extend its normal business hours to accommodate its patient needs;
- The Proposed Scanner is a Siemens Aera 1.5T MRI - the same strength and capability as the Existing Scanner;
- The Proposed Second scanner will allow ONS to reduce the overutilization of its Existing Scanner in order to provide greater access to all its patients during all hours of operation in a more efficient and timely manner and provide a high level of responsive and quality care;
- The Proposed Scanner will allow all ONS patients to benefit from the enhanced continuity of care, service, communication and coordination that in-office imaging provides and improved patient convenience and access to MRI services; and
- The Proposed Scanner will allow ONS to better accommodate the request of health plans and all health care stakeholders to provide cost effective and outpatient MRI.

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:

Orthopaedic & Neurosurgery Specialists, P.C. ("ONS", "Applicant" or the "Practice") is a private physician practice with offices at 6 Greenwich Office Park, Greenwich, Connecticut and 5 High Ridge Road, Stamford, Connecticut. ONS provides comprehensive and integrated physician and medical services in the specialties of orthopedics, neurosurgery, sports medicine and physical therapy. ONS's primary service area includes the towns and cities of Greenwich, Stamford, New Canaan and Darien, Connecticut as well as Port Chester and Rye, New York (the "Service Area").

To accommodate its patients and to achieve effective coordination of care, ONS also offers ancillary services such as imaging services, fluoroscopy and x-rays, physical therapy and pain management. Because of the nature of ONS's practice, many patients require advanced imaging services such as MRI. ONS currently operates a fixed 1.5 Tesla (1.5T) Magnetom Espree Open Bore MRI scanner ("Existing Scanner") authorized pursuant to Docket Number 08-31150-CON at its practice located at 6 Greenwich Office Park, Greenwich. The Existing Scanner is fully-accredited by The American College of Radiology. The MRI services performed at the practice are provided only to patients who are under the direct care of ONS physicians. ONS has contracted with Greenwich Radiology to provide professional radiological services including the review and interpretation of all MRI scans of its patients. ONS will continue to bill for all MRI services.

The Existing Scanner is operating over capacity and has been for several years. ONS has had to extend its normal business hours to accommodate its patient need. Even with the extended hours, ONS cannot accommodate the needs and access of practice patients in the time frame the patients desire. Additionally, ONS is continually expanding its business to include new physicians which has also increased its patient volume and therefore increased demand for MRI scans. ONS has brought on numerous new physicians in the past few years, increasing from 17 physicians in 2012 to 23 physicians in 2015.

ONS proposes to obtain an additional MRI scanner for use at its practice ("Proposed Scanner"). The Proposed Scanner is a Siemens Aera 1.5T MRI and will be of the same strength and capability of the Existing Scanner. The Proposed Scanner will be able to offer various types of scans including orthopedic, arthogram, spine, head, neck, chest,

and MRA. The Proposed Scanner will allow ONS to reduce the overutilization of its Existing Scanner in order to provide access to all its patients in a more efficient and timely manner while allowing for greater flexibility in patient scheduling. ONS is committed to continuity of service and responsive quality care. The Proposed Scanner and Existing Scanner will also act as a backup scanner for each other when such scanner may be out of service for repairs or maintenance. ONS will also be able to continually provide its patients with MRI services should either of the MRI scanners require service or incur a backlog. ONS will seek accreditation by The American College of Radiology for this Proposed Scanner and maintain all of the same quality and accreditation requirements of its existing scanner. All reads will continued to be provided by radiologists.

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:

The Applicant has been closely monitoring the utilization of the MRI and the volume of scans. The applicant consulted with industry experts on capacity and determined the need for an additional MRI. Following and adhering to accreditation standards, the Applicant determined it had over-utilization of the Existing Scanner. All of this resulted in a determination that a second MRI is required to best serve ONS patients. The Practice has been tracking the volume of scans and the increase in the size of the Practice, both from physician and patient growth. The Applicant has been in discussion with the Siemens vendor and received a preliminary lease proposal.

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:

See OHCA Table 1.

   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:

See OHCA Table 2.

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

Response:

No health care facility licenses will be needed to implement the proposal. ONS is a private physician practice.

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:
No licenses are currently held. ONS is a private physician practice.

   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:

See Attachment A for a list of key professional, administrative, clinical and direct service personnel related to the proposal and a copy of their CVs.

   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:

N/A.

   d. letters of support for the proposal;

Response:

See Attachment B.

   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:

See Attachment C for the current MRI guidelines followed by ONS: The American College of Radiology Standard of Practice Guidelines. These same guidelines will be adopted and utilized for the Proposed Scanner.

   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:

No new agreements are contemplated or required. The current agreement with Greenwich Radiology requires no amendment to include the additional professional radiological services required to cover the Proposed Scanner. The agreement with Greenwich Radiology covers "all MRI scans performed at ONS."

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 OHCA's need methodology established in the Statewide Health Care Facilities and Services Plan published in October 2012 (the "Plan") and the Applicant has met all other criteria in the Plan. Specifically, the Applicant has established that the percent utilization of the current capacity of the Existing Scanner exceeds 85%. In 2014, the Existing Scanner had an average utilization of 91%. In 2015, the Existing Scanner is averaging a utilization of 92% and in September 2015, the Existing Scanner averaged over 94% utilization.

§ *"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:

The Proposed Scanner aligns with all standards and guidelines enumerated in the Statewide Health Care Facilities and Services Plan (the "Plan") published by OHCA in October of 2012 and supplemented in 2014.

The guiding principles of the Plan are intended to:

- **Promote and support the long term viability of the state's health care delivery system;**
- **Ensure that any regulated service will maintain overall access to quality health care;**
- **Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;**
- **Encourage collaboration among health care providers to develop health care delivery networks;**
- **Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of**

primary and specialty care providers);

- Maintain and improve the quality of health care services offered to the state's residents;
- Promote planning that helps to contain the cost of delivering health care services to its residents;
- Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;
- Promote public policy development through measuring and monitoring unmet need; and
- Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state." (Plan at p. 2).

The long term viability of ONS will be increased as it will be better equipped to adapt to the demands and needs of its patients to continue to receive the benefit of enhanced continuity of care, service, communication and coordination that in-office imaging provides. Further, the proposal will maintain access to ONS's in-office MRI services as all ONS patients will be able to receive the benefit of in-office MRI services and accommodate the volume and demand fluctuations. ONS will be able to accommodate all its patients for MRI services even if one of the MRI machines is down or is being serviced. Equitable access to ONS's MRI services will be promoted because ONS will be able to accommodate more patients for in-office MRI and health plan desire for outpatient office imaging. The proposal will encourage collaboration because ONS providers will be able to better track patient compliance with any necessary scans and have immediate access to patient scans resulting in better tracking of the patient health and following up care.

The proposal supports the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner by having more ONS patients receiving in-office imaging which offers a more convenient and more appropriate level of care than hospital-based or other off-site alternatives. The proposal will also maintain the quality of MRI services at ONS by providing access to all patients of in-office MRI services which will allow ONS to control the quality and better track patient compliance. The proposal also promotes planning to contain costs by being able to accommodate all ONS patients who require MRI services at its in-office location by offering a lower cost and more convenient alternative to hospital-based MRI. As a result of acquiring the Proposed Scanner, ONS will be better equipped to measure and monitor specific MRI needs among its patients.

§ "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:

The target population to be served is ONS's existing patient base. Also, please see detailed lists of cities and towns in Table 8.

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

Response:

The target population is being served by ONS on the Existing Scanner.

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

Response:

The need for the Proposed Scanner is documented through the current overutilization of the Existing Scanner. As stated above in the response to Question 1, the Existing Scanner is operating over capacity. In 2014, the Existing Scanner had an average utilization of 91%. In 2015, the Existing Scanner is averaging a utilization of 92% and in September 2015, the Existing Scanner averaged over 94% utilization. ONS has had to extend its normal business hours to accommodate its patient load. Additionally, ONS is continually expanding its business to include new physicians which has, in turn, increased its patient population and volume.

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

Response:

The location of the Proposed Scanner will be in the private physician office maintained by ONS to make it convenient for patients and providers. The location of the Existing Scanner offers many benefits to patients and to ONS. Specifically, the existing location currently has a relationship with the Greenwich Radiology providers and ONS already staffs the necessary radiologists and other technical personnel at its offices. Further, the office based location will allow for flow between the MRI scanners as needed. Further, ONS's private practice facilitates communication and collaborative care between radiologists, technical personnel and ONS's providers. ONS patients also benefit from the physician office setting due to its familiarity and the private practice environment.

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

Response:

Need has been established by the overutilization of ONS's Existing Scanner. As stated above in the response to Question 1 and 8(c), the Existing Scanner is operating over capacity. In 2014, the Existing Scanner had an average utilization of 91%. In 2015, the Existing Scanner is averaging a utilization of 92% and in September 2015, the Existing Scanner averaged over 94% utilization. ONS has had to extend its normal business hours to accommodate its patient load. Additionally, ONS is continually expanding its business to include new physicians which has increased ONS patient base and thus increased need for scans.

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

Response:

ONS offers MRI services to any current ONS patients who need such MRI services. To the extent that any of ONS's current patients who require MRI services are low income, racial and ethnic minorities, disabled or of another underserved group, such patients will benefit from the availability of the Proposed Scanner in the same manner as all patients of the Practice. Of particular benefit to patients who may have difficulty traveling such as low income or disabled persons, such patients will no longer need to visit multiple providers or travel to an additional secondary site for MRI services because ONS anticipates it will be able to accommodate all necessary MRI scans at its office.

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

Response:

No changes to the clinical services offered by the Applicant is anticipated.

h. explain how access to care will be affected;

Response:

Access to MRI services will be improved for ONS's patients who require such MRI services because ONS patients can be accommodated at the Practice's office location and on a more timely basis and will not have to seek MRI services at another location.

i. discuss any alternative proposals that were considered.

Response:

No alternative proposals were considered.

§ *"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; (Conn.Gen.Stat. § 19a-639(a)(5))*

9. Describe how the proposal will:

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

Response:

The quality of health care in the region will be improved because more ONS patients will be able to receive MRI scans at their physician's office and thus benefit from the enhanced communication and coordination that physician based in-office imaging provides. The Proposed Scanner will offer high quality MRI services to ONS patients who require such services. ONS will also be able to accommodate patients should the Existing Scanner be down for repairs or servicing.

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

Response:

The Proposed Scanner will improve ONS patient's accessibility of health care by improving such patients' access to timely and in-office MRI services. The Practice will be able to offer patients better flexibility in scheduling.

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

Response:

The Proposed Scanner will improve the cost effectiveness of health care delivery in the region because in-office scanning will enable more ONS patients to receive MRI services at their private practice. As such, patients who could not be accommodated but required MRI services will no longer have to use hospital-based or hospital-owned MRIs which may result in additional costly facility fees. Additionally, ONS is able to better track its patient's compliance with any necessary scans and have immediate access to its patient's scans which assists ONS providers in better tracking the health of their patients and following up with patients. This enhanced communication and coordination that in-office imaging provides results in collaboration, cost effective of health care, saves valuable time and resources and eliminates the need for multiple imaging/scans and provider visits.

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:

This proposal will help improve the coordination of patient care because more ONS patients will be able to receive MRI scans at the physician office and thus benefit from

the face to face communication and coordination between radiologists and ONS providers and patients. ONS will be able to accommodate patients if an MRI is down or being serviced. Further, with immediate access to all in-office imaging, ONS providers are better equipped to provide efficient and coordinated follow-up care.

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

Response:

This proposal will not impact access to Medicaid recipients or indigent persons.

12. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.

Response:

ONS is dedicated to ensuring that thorough treatment and complete follow up care occurs with each of its patients regardless of financial status. Although ONS does not have a written charity care policy or sliding fee scale, ONS will provide assistance to patients who state they may be unable to pay all or part of their bills and works with such patients on a case-by-case basis. ONS works with patients who are self-pay and require a payment plan or patients whose procedures are not approved by their health insurance plan.

> *§ "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))*

13. 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:

This proposal will not impact access to Medicaid recipients or indigent persons and as such will not reduce access to services by Medicaid recipients.

> *§ "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))*

14. 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 will not adversely affect patient health care costs. No change in billing or pricing is anticipated with the addition of the Proposed Scanner. ONS does not charge facility fees and there is no anticipated imposition of facility fees with the addition of the Proposed Scanner.

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 applicant;" (Conn.Gen.Stat. § 19a-639(a)(4))

15. 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 impact the financial strength of the state's health care system because ONS will be offering its patients more cost effective collaborative MRI scans. Additionally, this proposal is financially feasible for the Applicant because ONS has the utilization volume numbers to support an additional scanner. In 2014, the Existing Scanner had an average utilization of 91%. In 2015, the Existing Scanner is averaging a utilization of 92% and in September 2015, the Existing Scanner averaged over 94% utilization.

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

Response:

See OHCA Table 3. See Attachment D.

17. 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:

The Applicant will be leasing the Proposed Scanner from Siemens Corp. Siemens proposal is for $1,250,337 for a 60-month term. See Attachment E for the proposal from Siemens. The funding for the build out cost for the Proposed Scanner will be

approximately $250,000 and be financed by ONS's existing line of credit with the bank serving the Practice.

18. 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:

See Attachment F for financial statement for the ONS MRI operations for 2014, the most recent Fiscal Year.

b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, 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:

See Attachment G for OHCA Financial Worksheet B.

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

Response:

See OHCA Table 4.

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

Response:

Assumptions used in developing the financial projections are as follows:

- **A standard 3% annual increase is assumed for employee salaries and fringe benefits with and without the Proposed Scanner.**
- **The incremental cost of additional MRI staff for the Proposed MRI is based on current employee costs.**
- **Physician fees are based on a per-read fee and adjust directly based on the projected volume with or without the Proposed Scanner.**
- **Supplies and drugs are directly related to volume and adjust directly based on projected volume with or without the Proposed Scanner.**

- **Lease expenses are based on the Current MRI lease schedule (which is adjusted annually) and the projected annual rent for the Proposed MRI.**
- **"Other Operating Expenses" listed in the Financial Form are inclusive of:**
  - **billing fees, which adjust directly based on volume;**
  - **the Practice's occupancy fee, which (i) for the Current MRI is the pro-rata share of the Practice's leased office space attributed to the Current MRI and is based on the Practice's rent from its landlord and (ii) for the Proposed MRI is the additional incremental cost based on the additional space required for the Proposed MRI;**
  - **additional equipment required, which is assumed to double with the addition of the Proposed MRI;**
  - **transcription fees which adjust directly based on volume;**
  - **licenses and permits fees, which are assumed to double with the addition of the Proposed MRI; and**
  - **other miscellaneous expenses which are assume to double with the addition of the Proposed MRI.**
- **Proposed revenue is based on current payor mix, projected volume and projected reimbursement rates.**
- **Projected utilization without the Proposed MRI is based on a modest 0.3% annual growth. Based on the Practice's current high utilization rate, potential growth is limited. Growth with the Proposed MRI is based on historic MRI utilization growth based on the growth of providers in the Practice.**

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

Response:

There are no incremental losses from operations resulting from the implementation of the CON proposal.

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

Response:

Based on all fixed costs necessary to operate the Proposed MRI (the Proposed MRI annual lease, employee salaries and wages, fringe benefits, the occupancy fee, other equipment, license and permit fees, and other miscellaneous expenses) and the pro rata share of all adjustable costs (professional fees, supplies and drugs, billing fees, and transcription fees), the minimum number of MRI scans required to show an incremental gain for each fiscal year is 1,071 scans in 2017, 1,130 scans in 2018 and 1,461 scans in 2019.

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))*

21. 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:

See OHCA Table 5 and OHCA Table 6.

22. 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 Table 5 and 6.

Response:

23. 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:

See OHCA Table 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;" (Conn.Gen.Stat. § 19a-639(a)(7))*

24. 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:

As stated above in the response to Question 8(a), the target population to be served is ONS's existing patient base. Based on the overutilization of the Existing MRI, ONS's current patient base is sufficiently large to support the addition of a second MRI without demonstrating additional community need. Further, ONS will not be seeking outside referrals for the Proposed MRI.

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

Response:

See OHCA Table 8.

§ "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))

26. 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:

See OHCA Table 9.

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

Response:

There will be minimal effect on existing providers because ONS only provides MRI services to its own patients. Annual volume increases and proposed annual volume increases are on account of ONS's patient base that is continually growing due to the addition of new providers to the practice. ONS had added an additional five (5) providers since 2012 and is continuing to grow.

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

Response:

ONS physicians are the sole referral source for the Existing Scanner. There is no publically available information on existing referral patterns for other physicians in the Service Area.

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

Response:

Current referral patterns will not change as ONS physicians will continue to be the sole referral source for the Proposed Scanner. It is anticipated this will have no effect on non-ONS referring physicians as ONS will be able to accommodate future patient base growth.

§ *"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))*

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

Response:

The Proposed Scanner will not result in unnecessary duplication of existing or approved health care services because ONS provides MRI services only to its own patients. Because of the limited clinical scope of services (e.g. patients with orthopedic and/or neurological needs), MRI activity at ONS has no effect on the MRI volume needed on other body systems.

§ *"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))*

31. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

The Proposed Scanner will positively impact the diversity of patient choice in the geographic region because more ONS patients will have a choice to receive MRI services at ONS's private practice setting. With the addition of the Proposed Scanner, ONS will be able to offer all expanding patient base the choice to receive MRI services at its convenient office based location.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Private Practice	6 Greenwich Office Park Greenwich, CT	ONS patients	Current Hours: Monday – Friday 7am to 9pm; Saturday 7am to 5pm; Sunday 7am to 1pm Proposed Hours: Monday – Saturday 8am - 6pm	MRI
Private Practice	5 High Ridge Road Stamford, CT	ONS patients		

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TABLE 2
SERVICE AREA TOWNS

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

Town*	Reason for Inclusion
Connecticut Towns: Greenwich Stamford Darien New Canaan Wilton New York Towns: Port Chester Rye Scarsdale White Plains New Rochelle	These are the geographic areas, by town, for the service location in the application consisting of the lowest number of contagious zip codes from which the Applicant draws at least 75% of its patients for this service.

* 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)	1,250,337
Land/Building Purchase*	0
Construction/Renovation**	250,000[1]
Other (specify)	
Total Capital Expenditure (TCE)	**1,500,337**
Lease (Medical, Non-medical, Imaging)***	0
Total Lease Cost (TLC)	**0**
Total Project Cost (TCE+TLC)	**1,500,337**

* 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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[1] See Attachment E.

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2016*	FY 2017*	FY 2018*
Revenue from Operations	$ 0	$1,584,305	$1,814,561
Total Operating Expenses	$0	$1,271,794	$1,334,800
Gain/Loss from Operations	$ 0	$312,512	$479,761

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

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TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 2012***	FY 2013***	FY 2014***	FY 2015***
MRI Scans	4,565	4,800	5,189	5,244[2]
Total	4,565	4,800	5,189	5,244

* 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

Service*	Projected Volume			
	FY 2016**	FY 2017**	FY 2018**	FY 2019
MRI Scans	5,474[3]	6,675	6,942	7,029
Total	**5,474**	**6,675**	**6,942**	**7,029**

* 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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[2] FY 2015 volume represents annualized volume, which is based on 9 months of actual volume (January 1, 2015 to September 30, 2015).

[3] FY 2016 represents Existing MRI only; Proposed MRI will not be in service until of FY 2017.

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2015**		Annualized FY 2015		Projected							
					FY 2016		FY 2017		FY 2018		FY 2019	
	Discharges[4]	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	930	24%	1,240	24%	1,294	24%	1,578	24%	1,642	24%	1,662	24%
Medicaid*	0		0		0		0		0		0	
CHAMPUS & TriCare	1	>1%	1	>1%	1	>1%	1	>1%	1	>1%	1	>1%
NY Gov	111	3%	148	3%	154	3%	188	3%	196	3%	199	3%
Total Government	**1,042**	**26%**	**1,389**	**26%**	1,450	**26%**	1,768	**26%**	1,839	**26%**	1,862	**26%**
Commercial Insurers	2,784	71%	3,712	71%	3,875	71%	4,725	71%	4,914	71%	4,976	71%
Uninsured/Self Pay	12	>1%	16	>1%	17	>1%	20	>1%	21	>1%	21	>1%
Private Pay	11	>1%	15	>1%	16	>1%	19	>1%	20	>1%	20	>1%
Workers Compensation	84	2%	112	2%	117	2%	143	2%	148	2%	150	2%
Total Non-Government	**2,891**	**73%**	**3,855**	**73%**	**4,024**	**73%**	**4,907**	**73%**	**5,103**	**73%**	**5,167**	**73%**
Total Payer Mix	**3,933**	**100%**	**5,244**	**100%**	**5,474**	**100%**	**6,675**	**100%**	**6,942**	**100%**	**7,029**	**100%**

* 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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[4] Discharges from January 1, 2015 through September 30, 2015.

TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 2014**
Connecticut Towns:	
Greenwich	1,154
Stamford	572
Darien	257
New Canaan	250
Old Greenwich	207
Riverside	194
Cos Cob	182
Wilton	105
Westport	104
Norwalk	90
Fairfield	53
Weston	49
Ridgefield	40
Redding	19
Bridgeport	16
Newtown	12
Danbury	11
Trumbull	11
Southport	10
Oxford	6
Stratford	4
Branford	4
Easton	4
New Fairfield	4
New Milford	4
Shelton	4
Bethel	3
Milford	3
Monroe	3
Guilford	2
Hamden	2
Madison	2
Milford	2
Sandy Hook	2
Ansonia	1
Avon	1
Baltic	1

Botsford	1
Cheshire	1
Danielson	1
Derby	1
Farmington	1
Litchfield	1
Mystic	1
New Haven	1
Orange	1
Plainville	1
Rocky Hill	1
Roxbury	1
Salisbury	1
Southbury	1
Uncasville	1
Washington Depot	1
Waterbury	1
West Haven	1
Woodbridge	1
Woodbury	1
Westport	
Connecticut Total	3,408
Other Towns and Cities outside of Connecticut	1,781
TOTAL	**5,189**

* List inpatient/outpatient/ED volumes separately, if applicable
** Fill in most recently completed fiscal year.

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TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS [5]

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
1.5T MRI Fixed Closed	Not publically available	Not publically available	Greenwich Hospital 5 Perryridge Road, Greenwich	M-F 7:30am to 7pm Sa-Su 7:30 am to 5:30pm	4,693 scans performed in 2014
3.0T MRI Fixed Closed	Not publically available	Not publically available	Greenwich Hospital 5 Perryridge Road, Greenwich	M-F 7:15am to 7pm Sa-Su 7am to 5pm	3,218 scans performed in 2014
1.5T MRI Fixed Closed	Not publically available	Not publically available	Greenwich Hospital, Diagnostic Center 2015 West Main Street, Stamford	M-F 7:30am to 5pm	1,991 scans performed in 2014
1.5T MRI Fixed Closed	Not publically available	Not publically available	The Stamford Hospital 30 Shelburne Road, Stamford	24 hours a day, 7 days a week	6,427 scans performed in 2014
1.5T MRI Fixed Closed	Not publically available	Not publically available	The Stamford Hospital, Tully Health Center 32 Strawberry Hill Court, Stamford	M-F 8am to 8pm Sa-Su 8am to 4pm	4,360 scans performed in 2014
1.5T MRI Fixed Closed	Not publically available	Not publically available	The Stamford Hospital, Darien Imaging Center 6 Thorndale Circle, D	M, W,F 8am to 4pm Tu,Th 8am to 8pm Sa-Su 8am to 12pm	1,827 scans performed in 2014
1.5T MRI Fixed Open	Not publically available	Not publically available	Advanced Radiology Consultants, LLC 1315 Washington Blvd, Stamford	M-F 7am to 11pm Sa-Sun 7 am to 3:30pm	6,705 scans performed in 2014

* 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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[5] *Statewide Healthcare Facilities and Services Inventory – 2014, Table 8 ("Magnetic Resonance Imaging (MRI) Scanning Providers")* published by the Department of Public Health (2014). http://www.ct.gov/dph/cwp/view.asp?a=3902&q=557564&dphNav=|56694|

Attachment A

List and CVs of Key Professional, Administrative, Clinical and Direct Service Personnel Related to the Proposal

1. Catherine Costello, R.T., ONS
2. Scott J. Sullivan, M.D., Greenwich Radiology
3. Seth Miller, M.D., ONS
4. Mark Camel, M.D., ONS
5. James Cunningham, M.D., ONS
6. Sally Frank, ONS, Administrative

CATHERINE COSTELLO R.T.(R)(CT)(MR)(ARRT)
35E Putnam Green, Greenwich, CT 06830
(203) 470-0070
Stella12cos@optimum.net

PROFESSIONAL SUMMARY

Registered MRI Technologist

- Highly skilled career professional with more than 20 years practical experience in hospital & private office environments.
- Provide quality & compassionate care to all patients ranging from newborn to geriatric.
- Produce high-quality imaging service for physicians & radiologist on all anatomical areas including Head & Neck, Spine, Thorax, Abdomen, Pelvis & Musculoskeletal, Including Angiography & Contrast studies.
- Computer skilled, managing heavy daily patient volume as well as answering pre-appointment questions. Proficient in all documentation/record maintenance/paperwork to ensure accuracy and patient safety & confidentiality.
- Adept in creating, modifying & managing of all MRI site protocols.
- Directly involved in acquiring ACR (American College of Radiology) site accreditations.

CREDENTIALS

American Registry of Radiologic Technologists #207629 — 1987 - Current
- **Advanced Certification in Magnetic Resonance Imaging**

License, State of Connecticut #000491 — 1989 –Current

License, State of New York #296739 w/Injection — 1987 –Current

License, State of Florida #CRT 85382 — 2013 –Current

Intravenous Catheter Administration, Hospital/Office Certified — 1987 –Current

CPR, First Aid & AED Training, American Red Cross — 1987 –Current

EXPERIENCE

MRI Manager — 2006 - Present
Orthopaedic & Neurosurgery Specialists, Greenwich, Connecticut
- *Siemens Espree 1.5T*
- *G.E Horizon 1.0T*

Senior MRI Technologist — 1989 - 2006
Greenwich Hospital, Greenwich, Connecticut
- *G.E. Signa HDX 3.0T*
- *G.E. Signa LX 1.5T*

EDUCATION

Radiologic Technology — 1985-1987
Mercy School of Radiography, Rockville Center, New York

Liberal Arts Associates Degree — 1982-1984
Nassau Community College, Garden City, New York

Current in all Continuing Education Credits

AFFILIATIONS

American Society of Radiologic Technologists #114689 — 1989 - Current
Connecticut Society of Radiologic Technologists — 1989 - Current

REFERNCES

Upon Request

Scott J. Sullivan, M.D.
4 Dewart Road
Greenwich, CT 06830
(203) 661-0787

EMPLOYMENT

12/02 – Present	Greenwich Radiological Group Associate Attending Radiologist Department of Radiology Greenwich, CT
12/01 – 12/02	Greenwich Radiological Group Assistant Attending Radiologist Department of Radiology Greenwich, CT
7/96 – 12/01	White Plains Radiology, P.C., White Plains, NY Assistant Radiologist, Lead Physician for CT Scanning Responsible for reading 30% of cases from dedicated PET Scanner
10/98 – 4/00	Our Lady of Mercy Medical Center, Bronx, NY Director, Department of Radiology

EDUCATION

Fellowship 1/01 – 12/01	Neuroradiology Yale-New Haven Hospital, New Haven, CT
Apprenticeship 10/98	PET Scanning, West Haven VA, West Haven, CT
Residency 7/92 – 6/96	Yale-New Haven Hospital, New Haven, CT Department of Diagnostic Radiology
7/95 – 6/96	Acting Fellow, Cross-Sectional Imaging
3/94 – 2/95	Chief Resident, Department of Diagnostic Radiology
Internship 7/91 – 6/92	Winthrop University Hospital, Mineola, NY Department of Internal Medicine
Medical School 8/87 – 5/91	Georgetown University, Washington, DC Awards: Elected AOA, 10/90 John C. Caruso Award, 5/91

Undergraduate 9/81 – 5/85	Tufts University, Medford, MA B.S. in Chemical Engineering, 5/85

RESEARCH

2/89 – 9/89	National Institute of Health, Bethesda, MD "CT Imaging of Central Venous Thrombosis" Scott J. Sullivan and Irwin Feuerstein, MD Radiologic Society of North America, 11/90

OTHER EMPLOYMENT

9/86 – 8/87	ColumbiaUniversity, New York, NY Genetics Laboratory Technician • Designed and performed experiments in human and microbial genetics
6/85 – 9/86	PEPSICO, Valhalla, NY Marketing Equipment Engineer • Managed and organized technicians in experiments with new production equipment

CURRICULUM VITAE

SETH R. MILLER, M.D.

DATE OF BIRTH: November 18, 1956

PLACE OF BIRTH: New York, New York

OFFICE ADDRESS: Orthopaedic & Neurosurgery Specialists, PC
6 Greenwich Office Park
Greenwich, CT 06831

OFFICE PHONE: (203) 869-1145

EDUCATION

1978 - 1982	Mount Sinai School of Medicine New York, New York M.D.
1974 - 1978	Harvard University Cambridge, Massachusetts B.A., Magna Cum Laude, Biology
1968-1974	Horace Mann School Bronx, New York

MEDICAL TRAINING

Senior Annie C. Kane Fellow and Visiting Clinical Fellow in Shoulder and Elbow Surgery with Charles S. Neer, II, M.D., The New York Orthopaedic Hospital At Columbia-Presbyterian Medical Center, New York, New York, July 1988- June 1989

Resident in Orthopedic Surgery, The New York Orthopaedic Hospital at Columbia-Presbyterian Medical Center, New York, New York, September 1985- June 1988

Research Fellow, Children's Service, The Hospital for Special Surgery, New York Hospital-Cornell Medical Center, New York, New York, July 1985- September 1985

Resident in General Surgery, The Mount Sinai Medical Center, New York, New York, July 1983- June 1985

Surgical Internship, The Mount Sinai Medical Center, New York, New York, July 1982- June 1983

PROFESSIONAL EMPLOYMENTS AND APPOINTMENTS

Orthopedic Consultant to New York Mets, 2003 - Present

Clinical Assistant Professor of Orthopaedic Surgery, Hospital for Joint Diseases/ NYU Medical Center, New York, New York, February 2003 – Present

Instructor and Assistant Attending of Orthopaedic Surgery at Columbia-Presbyterian Medical Center, Present

Orthopedic Surgeon, Orthopaedic and Neurosurgery Specialists, PC, Greenwich, Connecticut, October 1998 - Present

Orthopedic Surgeon, Greenwich Orthopedic Associates, PC, Greenwich, Connecticut, August 1989 - September 1998

Associate Attending in Orthopedic Surgery, Greenwich Hospital, Greenwich, Connecticut, July 1989 - Present

Assistant Attending in Orthopedic Surgery, Columbia-Presbyterian Medical Center, New York, New York, July 1989 - Present

Instructor in Orthopedic Surgery, College of Physicians and Surgeons, Columbia University, New York, New York, July 1989 – Present

Panel of Reviewers, Journal of Musculoskeletal Medicine, 1998 - Present

Course Instructor, American Academy of Orthopaedic Surgeons, The Shoulder: Advances in Open and Arthroscopic Techniques, Orthopaedic Learning Center Chicago, Illinois, May 1999 & October 2000

PROFESSIONAL SOCIETIES

Columbia Shoulder Society
American Medical Association
Connecticut State Medical Society
Alpha Omega Alpha
Fairfield County Medical Association, Alternate Delegate, May 1992 – Present

COMMUNITY APPOINTMENTS

Board of Trustees, Putnam-Indian Field School, 2000-2002
Co-Founder and Board of Directors, Greenwich Police Foundation, 2001- Present

CERTIFICATIONS

Diplomate, American Board of Orthopaedic Surgery
Diplomate, National Board of Medical Examiners

HONORS

Westchester Magazine Top Doctors, 2003

Connecticut Magazine Top Doctors, 2001 - 2005, 2007, 2009- 2012

The Wag Best Doctors 2010, 2011

Becker's Top 65 Shoulder Surgeons in the US

US News and World Report Top Doctor 2011

Castle Connolly New York Metro Area Top Doctor 2009 - 2012

The New York Pediatric Orthopedic Society Award for Outstanding Resident Paper, 1986

Frank E. Stinchfield Award for Excellence in Orthopedic Surgery, The New York Orthopedic Hospital at Columbia-Presbyterian Medical Center, 1986

Lester R. Tuchman Award for Excellence in Clinical Medicine, The Mount Sinai School of Medicine, 1982

Alpha Omega Alpha Honor Society, 1981

RESEARCH

Research Fellow, Children's Service, The Hospital for Special Surgery, New York Hospital-Cornell Medical Center, New York, New York, July 1985-September 1985

Summer Research Fellowship, National Institute of Health, 1980

Summer Research Fellowship, Department of Surgery, The Mount Sinai Hospital, New York, New York 1979

Undergraduate Thesis, Department of Microbiology & Molecular Genetics, Harvard Medical School, Boston, Massachusetts. Thesis: Studies on the Relationship Between Corynebacteriophages tox+ and tox- of Corynebacterium Diphtheriae Grade: Magna Cum Laude, 1978

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CURRICULUM VITAE

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EDUCATION AND PROFESSIONAL TRAINING

1977	Bachelor of Arts: Political Science and Biology University of Rochester Rochester, New York
1981	Doctor of Medicine Washington University School of Medicine Saint Louis, Missouri
1981-1982	Internship: General Surgery Barnes Hospital Saint Louis, Missouri
1982-1985	Resident: Neurological Surgery Barnes Hospital Saint Louis, Missouri
1985-1986	Chief Resident: Neurological Surgery Barnes Hospital Saint Louis, Missouri
1986-1987	Fellowship: Neurological Surgery Washington University School of Medicine Saint Louis, Missouri

BOARD CERTIFICATION

1990 American Board of Neurological Surgery

LICENSURE

Missouri
Connecticut
New York

PROFESSIONAL EMPLOYMENTS

1987-1998 Neurological Surgeon
Private Practice
Stamford, Connecticut

1998-Present Neurological Surgeon
Private Practice
Greenwich, Connecticut

PROFESSIONAL SOCIETIES

Congress of Neurological Surgeons
American Association of Neurological Surgeons
The New England Neurosurgical Society
The Physician's Scientific Society

PROFESSIONAL ACTIVITIES

1995-1996 Vice President, Congress of Neurological Surgeons

1992-2000 Member, Executive Committee, Congress of Neurological Surgeons

1999-2000 Chairman, Strategic Financial Planning Committee,
Congress of Neurological Surgeons

1993-1995 Chairman, Membership Committee, Congress of Neurological Surgeons

1992-1995 Chairman, Exhibits Committee, Congress of Neurological Surgeons

1991-1992 Member, Editorial Board, Clinical Neurosurgery

1993-1995 Member, Professional Conduct Committee,
Congress of Neurological Surgeons

PROFESSIONAL ACTIVITIES (Continued)

1993-1994	Member, Guidelines and Outcomes Committee, American Association of Neurological Surgeons
1991-1992	Member, Executive Committee, Greenwich Hospital
1996-1997	Member, Credentials Committee, Greenwich Hospital

ACADEMIC AFFILIATIONS

2010-2011	Clinical Assistant Professor of Neurological Surgery, Weill Cornell Medical College

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POSTGRADUATE TRAINING

7/88-6/89	Sports Medicine Fellowship New England Baptist Brookline, Massachusetts
7/84-6/88	Resident, Department of Orthopaedics Mount Sinai Medical New York
7/83-6/84	Resident, Department of Surgery Mount Sinai, New York

EDUCATION

9/79-6/83	New York University School of Medicine Degree: M.D. New York, New York
9/75-6/79	Manhattan College Degree: B.S. (Biochemistry) Summa Cum Laude Bronx, New York

PROFESSIONAL SOCIETIES/ MEMBERSHIPS

American Academy of Orthopaedic Surgeons

Diplomate, American Board of Medical Examiners

Diplomate, National Board of Medical Examiners

Connecticut State Medical Society

Fairfield County Medical Society

HONORS/ AWARDS

1979	Epsilon Sigma Pi- Manhattan College
1979	Phi Beta Kappa- Manhattan College
1979	Chemistry Award- Manhattan College

Attachment B

Letters of Support

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Fax (203)983-3318
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January 14, 2016

State of Connecticut
Department of Public Health
Office of Health Care Access
410 Capital Avenue
Hartford, CT 06134

Re: Certificate of Need Acquisition of 1.5 Tesla MRI by Orthopaedic & Neurosurgery Specialists, P.C.

To Whom It May Concern:

On behalf of Greenwich Radiology, P.C. ("Greenwich Radiology"), I am writing in support of the Orthopaedic & Neurosurgery Specialists, P.C. ("ONS") Certificate of Need application to acquire a second 1.5 Tesla MRI. Greenwich Radiology has an excellent working relationship with ONS and provides all professional radiology services for ONS patients who receive MRI scans at ONS. For ONS patients who receive scans at ONS, Greenwich Radiology and ONS work together to create an efficient system that results in timely and responsive care for patients.

Greenwich Radiology supports the acquisition of the additional scanner to address the overutilization of ONS's current MRI scanner and provide a consistent service in case one scanner is down or being serviced. The additional MRI scanner will allow all ONS patients to benefit from the enhanced continuity of care, service, communication and coordination that in-office imaging provides. Patients enjoy the improved convenience and access to MRI services in a private physician office setting.

Please approve the ONS Certificate of Need application to acquire a second 1.5 Tesla MRI.

Thank you.

Regards,

Scott J Sullivan, MD
President, Greenwich Radiological Group, PC

Attachment C

Current MRI guidelines followed by ONS: The American College of Radiology Standard of Practice Guidelines

00054

Amended 2014 (Resolution 39)*

ACR PRACTICE PARAMETER FOR PERFORMING AND INTERPRETING MAGNETIC RESONANCE IMAGING (MRI)

PREAMBLE

This document is an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. Practice Parameters and Technical Standards are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care[1]. For these reasons and those set forth below, the American College of Radiology and our collaborating medical specialty societies caution against the use of these documents in litigation in which the clinical decisions of a practitioner are called into question.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the practitioner in light of all the circumstances presented. Thus, an approach that differs from the guidance in this document, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in this document when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of this document. However, a practitioner who employs an approach substantially different from the guidance in this document is advised to document in the patient record information sufficient to explain the approach taken.

The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment. Therefore, it should be recognized that adherence to the guidance in this document will not assure an accurate diagnosis or a successful outcome. All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The sole purpose of this document is to assist practitioners in achieving this objective.

[1] Iowa Medical Society and Iowa Society of Anesthesiologists v. Iowa Board of Nursing, ___ N.W.2d ___ (Iowa 2013) Iowa Supreme Court refuses to find that the *ACR Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures* (Revised 2008) sets a national standard for who may perform fluoroscopic procedures in light of the standard's stated purpose that ACR standards are educational tools and not intended to establish a legal standard of care. See also, Stanley v. McCarver, 63 P.3d 1076 (Ariz. App. 2003) where in a concurring opinion the Court stated that "published standards or guidelines of specialty medical organizations are useful in determining the duty owed or the standard of care applicable in a given situation" even though ACR standards themselves do not establish the standard of care.

I. INTRODUCTION

Magnetic resonance imaging (MRI) is a multiplanar imaging method based on an interaction between radiofrequency (RF) electromagnetic fields and certain nuclei in the body (usually hydrogen nuclei) after the body has been placed in a strong magnetic field[2]. MRI differentiates between normal and abnormal tissues, providing a sensitive examination to detect disease. This sensitivity is based on the high degree of inherent contrast due to variations in the magnetic relaxation properties of different tissues, both normal and diseased, and the dependence of the MRI signal on these tissue properties.

II. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL

A. Physician

A physician must be responsible for all aspects of the study including, but not limited to, reviewing indications for the examination, specifying the pulse sequences to be performed, specifying the use and dosage of contrast agents, interpreting images, generating official interpretations (final reports), and assuring the quality of the images and the interpretations.

Physicians assuming these responsibilities for MR imaging of all anatomical areas (exclusive of cardiac MRI) should meet one of the following criteria:

Certification in Radiology or Diagnostic Radiology by the American Board of Radiology, the American Osteopathic Board of Radiology, the Royal College of Physicians and Surgeons of Canada, or the Collège des Médecins du Québec, and involvement with the supervision, interpretation, and reporting of 300 MRI examinations within the last 36 months[3].

or

Completion of a diagnostic radiology residency program approved by the Accreditation Council for Graduate Medical Education (ACGME), the Royal College of Physicians and Surgeons of Canada (RCPSC), the Collège des Médecins du Québec, or the American Osteopathic Association (AOA) to include involvement with the supervision, interpretation, and reporting of 500 MRI examinations in the past 36 months.

or

Physicians not board certified in radiology or not trained in a diagnostic radiology residency program who assumes these responsibilities for MR imaging exclusively in a specific anatomical area, excluding cardiac MRI, should meet the following criteria:

Completion of an ACGME approved residency program in the specialty practiced, plus 200 hours of Category I CME in MRI to include, but not limited to: MRI physics, recognition of MRI artifacts, safety, instrumentation, and clinical applications of MRI in the subspecialty area where MRI reading occurs; and supervision, interpretation, and reporting of 500 MRI cases in the past 36 months in a supervised situation. For neurologic MRI, at least 50 of the 500 cases must have been MR angiography (MRA) of the central nervous system.

Specific qualifications for physicians performing cardiac MRI are described in the ACR–NASCI–SPR Practice Parameter for the Performance and Interpretation of Cardiac MRI.

Maintenance of Competence

All physicians performing MRI examinations should demonstrate evidence of continuing competence in the interpretation and reporting of those examinations. If competence is assured primarily on the basis of continuing experience, a minimum of 100 examinations per year is recommended in order to maintain the physician's skills. Because a physician's practice or location may preclude this method, continued competency can also be assured

[2]See ACR Glossary of MR Terms, 5th edition, 2005.

[3]Board certification and completion of an accredited radiology residency in the past 24 months will be presumed to be satisfactory experience for the reporting and interpreting requirement.

through monitoring and evaluation that indicates acceptable technical success, accuracy of interpretation, and appropriateness of evaluation.

Continuing Medical Education

The physician's continuing education should be in accordance with the ACR Practice Parameter for Continuing Medical Education (CME) and should include CME in MRI as is appropriate to the physician's practice needs.

B. Medical Physicist / MR Scientist

The personnel qualified to carry out acceptance testing and monitoring of MRI equipment for the purposes of this practice parameter include a medical physicist or an MR scientist.

A Qualified Medical Physicist is an individual who is competent to practice independently one or more subfields in medical physics. The American College of Radiology (ACR) considers certification, continuing education, and experience in the appropriate subfield(s) to demonstrate that an individual is competent to practice in one or more subfields in medical physics, and to be a Qualified Medical Physicist. The ACR strongly recommends that the individual be certified in the appropriate subfield(s) by the American Board of Radiology (ABR), the Canadian College of Physics in Medicine, or by the American Board of Medical Physics (ABMP).

The Qualified Medical Physicist should meet the ACR Practice Parameter for Continuing Medical Education (CME). (ACR Resolution 17, 1996 – revised in 2012, Resolution 42)

The appropriate subfield of medical physics for this practice parameter is Diagnostic Medical Physics. (Previous medical physics certification categories including Radiological Physics, Diagnostic Radiological Physics, and Diagnostic Imaging Physics are also acceptable.)

A Qualified MR Scientist is an individual who has a graduate degree in a physical science involving nuclear magnetic resonance (NMR) or MRI. These individuals should have 3 years of documented experience in a clinical MR environment.

The medical physicist/MR scientist must be familiar with the principles of MRI safety for patients, personnel, and the public; the Food and Drug Administration's guidance for MR diagnostic devices; and other regulations pertaining to the performance of the equipment being monitored. The medical physicist/MR scientist must be knowledgeable in the field of nuclear MR physics and familiar with MRI technology, including function, clinical uses, and performance specifications of MRI equipment, as well as calibration processes and limitations of the performance testing hardware, procedures, and algorithms. The medical physicist/MR scientist must have a working understanding of clinical imaging protocols and methods of their optimization. This proficiency must be maintained by participation in continuing education programs of sufficient frequency to ensure familiarity with current concepts, equipment, and procedures.

The medical physicist/MR scientist may be assisted in obtaining test data for performance monitoring by other properly trained individuals. These individuals must be properly trained and approved by the medical physicist/MR scientist in the techniques of performing the tests, the function and limitations of the imaging equipment and test instruments, the reason for the tests, and the importance of the test results. The medical physicist/MR scientist must review and approve all measurements. The MR scientist should meet the ACR Practice Parameter for Continuing Medical Education (CME).

C. Registered Radiologist Assistant

A registered radiologist assistant is an advanced level radiographer who is certified and registered as a radiologist assistant by the American Registry of Radiologic Technologists (ARRT) after having successfully completed an advanced academic program encompassing an ACR/ASRT (American Society of Radiologic Technologists) radiologist assistant curriculum and a radiologist-directed clinical preceptorship. Under radiologist supervision,

the radiologist assistant may perform patient assessment, patient management, and selected examinations as delineated in the Joint Policy Statement of the ACR and the ASRT titled "Radiologist Assistant: Roles and Responsibilities" and as allowed by state law. The radiologist assistant transmits to the supervising radiologists those observations that have a bearing on diagnosis. Performance of diagnostic interpretations remains outside the scope of practice of the radiologist assistant. (ACR Resolution 34, adopted in 2006) [1]

D. Radiology Technologist

The technologist should participate in assuring patient comfort and safety, preparing and positioning the patient for the MRI examination, and obtaining the MRI data in a manner suitable for interpretation by the physician. The technologist should also perform frequent quality control testing in accordance with the MRI manufacturer's recommendations.

The technologist performing MRI should:

1. Be certified by the American Registry of Radiologic Technologists (ARRT), the American Registry of MRI Technologists (ARMRIT), or the Canadian Association of Medical Radiation Technologists (CAMRT) as an MRI technologist (RTMR).

   or

2. Be certified by the ARRT and/or have appropriate state licensure and have 6 months supervised clinical experience in MRI scanning.

   or

3. Have an associate's degree in an allied health field or a bachelor's degree and certification in another clinical imaging field and have 6 months of supervised clinical MRI scanning.

To assure competence, the responsible physician should evaluate any technologist who began performing MRI prior to October 1996 and who does not meet the above criteria.

Any technologist practicing MRI scanning should be licensed in the jurisdiction in which he/she practices, if state licensure exists. To assure competence, all technologists must be evaluated by the supervising physician.

III. TECHNIQUES AND INDICATIONS

The currently accepted techniques and indications for MRI are discussed in various ACR practice parameters that are based on anatomic sites of examination. It is important that each site offering MRI have documented procedures and technical expertise and appropriate equipment to examine each anatomic site. Because the clinical applications of MRI continue to expand, the enumerated techniques and indications in the reference documents may not be all-inclusive.

Each site's procedures should be reviewed and updated at appropriate intervals. The final judgment regarding appropriateness of a given examination for a particular patient is the responsibility of the ordering physician or other appropriately licensed health care provider and radiologist. The decision to use MRI to scan a particular part of the human body depends on the MRI software and hardware available and the relative cost, efficacy, and availability of alternative imaging methods. The examination should provide images with suitable contrast characteristics, spatial resolution, signal-to-noise ratio, and section geometry appropriate to the specific clinical indications.

IV. POSSIBLE CONTRAINDICATIONS

Possible contraindications include, but are not limited to, the presence of cardiac pacemakers, ferromagnetic intracranial aneurysm clips, certain neurostimulators, certain cochlear implants, and certain other ferromagnetic foreign bodies or electronic devices [2-5]. Possible contraindications should be listed on a screening questionnaire. All patients should be screened for possible contraindications prior to MRI scanning [6-7]. Published test results and/or on-site testing of an identical device or foreign body may be helpful to determine whether a patient with a particular medical device or foreign body may be safely scanned. There is no known

adverse effect of MRI on the fetus. The decision to scan during pregnancy should be made on an individual basis [8].

V. SPECIFICATIONS OF THE EXAMINATION

The examination should be performed within parameters currently approved by the FDA. Examinations that use techniques not approved by the FDA may be considered when they are judged to be medically appropriate.

The written or electronic request for an MRI examination should provide sufficient information to demonstrate the medical necessity of the examination and allow for its proper performance and interpretation of the examination.

Documentation that satisfies medical necessity includes 1) signs and symptoms and/or 2) relevant history (including known diagnoses). Additional information regarding the specific reason for the examination or a provisional diagnosis would be helpful and may at times be needed to allow for the proper performance and interpretation of the examination.

The request for the examination must be originated by a physician or other appropriately licensed health care provider. The accompanying clinical information should be provided by a physician or other appropriately licensed health care provider familiar with the patient's clinical problem or question and consistent with the state's scope of practice requirements. (ACR Resolution 35, adopted in 2006)

Images should be labeled with the following: a) patient identification, b) facility identification, c) examination date, and d) image orientation indicated by unambiguous polarity symbols (e.g., R, L, A, P, H, F).

VI. DOCUMENTATION

High-quality patient care requires adequate documentation. There should be a permanent record of the MRI examination and its interpretation. Imaging of all appropriate areas, both normal and abnormal, should be recorded in a suitable archival format. If contrast material is administered during the MRI examination, the brand name of the contrast agent and the administered dose should be recorded and included in the permanent record of the MRI examination. An official interpretation (final report) of the MRI findings should be included in the patient's medical record regardless of where the study is performed. Retention of the MRI examination should be consistent both with clinical need and with relevant legal and local health care facility requirements.

Reporting should be in accordance with the ACR Practice Parameter for Communication of Diagnostic Imaging Findings.

VII. SAFETY GUIDELINES

Safety guidelines, practices, and policies must be written, enforced, reviewed, and documented at least annually by the supervising physician. These guidelines should take into consideration potential magnetic field interactions for ferromagnetic objects in the MRI environment [9]. They should also consider potential patient hazards (e.g., from magnetic field interactions, tissue heating, and induced electrical currents) and potential hazards posed by implanted objects and materials within the patient as well as other individuals in the MR environment [4-5].

A screening program should be implemented to assure appropriate and safe use of MR contrast material and to reduce the risk of nephrogenic systemic fibrosis (NSF) [10-11]. For further information on ACR screening recommendations see the ACR Manual on Contrast Media [12] and the ACR Guidance Document on MR Safe Practices [8]. Peer-reviewed literature pertaining to MR safety should be reviewed on a regular basis.

In pregnancy, gadolinium-based contrast agents (GBCAs) cross the placental barrier, enter the fetal circulation, and pass via the kidneys into the amniotic fluid. Although no definite adverse effects of GBCA administration on the human fetus have been documented, the potential bioeffects of fetal GBCA exposure are not well understood.

GBCA administration should therefore be avoided during pregnancy unless no suitable alternative imaging is possible and the benefits of contrast administration outweigh the potential risk to the fetus. (See the ACR–SPR Practice Parameter for the Safe and Optimal Performance of Fetal MRI).

When GBCAs are administered to nursing women, a small amount of the contrast agent is excreted in the breast milk. It is unlikely that the minute amount of GBCA absorbed by a nursing infant's gastrointestinal tract will be harmful. If there is concern on the part of the referring physician, radiologist, or patient, the nursing mother can be advised to discard her breast milk for 24 hours after GBCA administration.

When contrast and/or sedation are necessary, they must be administered in accordance with institutional policy and state and federal law by a qualified practitioner with training in cardiopulmonary resuscitation [13]. (See the ACR–SPR Practice Parameter for the Use of Intravascular Contrast Media and the ACR–SIR Practice Parameter for Sedation/Analgesia.)

Appropriate emergency equipment and medications must be immediately available to treat adverse reactions associated with administered medications. The equipment and medications should be monitored for inventory and drug expiration dates on a regular basis. The equipment, medications, and other emergency support must also be appropriate for the range of ages and sizes in the patient population.

VIII. EQUIPMENT SPECIFICATIONS

The MRI equipment specifications and performance must meet all state and federal requirements. The requirements include, but are not limited to, specifications of maximum static magnetic field strength, maximum rate of change of magnetic field strength (dB/dt), maximum radiofrequency power deposition (specific absorption rate), and maximum acoustic noise levels.

IX. QUALITY CONTROL PROGRAM

A documented quality control program must be maintained at the MR site. Quality control testing should be conducted by the technologist and/or service engineer with review at least annually by the supervising physician and/or a medical physicist/MR scientist [14-16].

X. QUALITY CONTROL AND IMPROVEMENT, SAFETY, INFECTION CONTROL, AND PATIENT EDUCATION

Policies and procedures related to quality, patient education, infection control, and safety should be developed and implemented in accordance with the ACR Policy on Quality Control and Improvement, Safety, Infection Control, and Patient Education appearing under the heading *Position Statement on QC & Improvement, Safety, Infection Control, and Patient Education* on the ACR website (http://www.acr.org/guidelines).

Equipment performance monitoring should be in accordance with the ACR–AAPM Technical Standard for Diagnostic Medical Physics Performance Monitoring of Magnetic Resonance Imaging (MRI) Equipment.

ACKNOWLEDGEMENTS

This guideline was revised according to the process described under the heading *The Process for Developing ACR Practice Guidelines and Technical Standards* on the ACR website (http://www.acr.org/guidelines) by the ACR Commission on Body Imaging.

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*Practice parameters and technical standards are published annually with an effective date of October 1 in the year in which amended, revised or approved by the ACR Council. For practice parameters and technical standards published before 1999, the effective date was January 1 following the year in which the practice parameter or technical standard was amended, revised, or approved by the ACR Council.

Development Chronology for this Practice Parameter
1992 (Resolution 14)
Amended 1995 (Resolution 53)
Revised 1996 (Resolution 1)
Revised 2000 (Resolution 16)
Revised 2001 (Resolution 12)
Amended 2002 (Resolution 2)
Revised 2006 (Resolution 15,16g,34,35,36)
Revised 2011 (Resolution 19)
Amended 2014 (Resolution 39)

Attachment D

Build Out

The Applicant is in the process of interviewing construction/renovation contractors. Based on their build out for the Existing MRI, ONS has determined with the contractors the approximate costs stated in Table 3. The Proposed MRI will be located within one of ONS's offices. ONS physicians practice regularly out of the Greenwich and Stamford offices.

Attachment E

Proposal from Siemens

SIEMENS

Siemens Medical Solutions USA, Inc.
40 Liberty Boulevard, Malvern, PA 19355

SIEMENS REPRESENTATIVE
Mike Obuchon - (860) 462-6620

Customer Number: 0000129029

Date: 9/24/2015

Orthopaedic & Neurological Surgery
6 Greenwich Office Park
GREENWICH, CT 06831

Siemens Medical Solutions USA, Inc. is pleased to submit the following quotation for the products and services described herein at the stated prices and terms, subject to your acceptance of the terms and conditions on the face and back hereof, and on any attachment hereto.

Table of Contents **Page**

Contract Total: $1,250,337
(total does not include any Optional or Alternate components which may be selected)

Proposal valid until 9/30/2015

Estimated Delivery Date: 4/15/2016

Estimated delivery date is subject to change based upon factory lead times, acceptance date of this quote, customer site readiness, and other factors. A Siemens representative will contact you regarding the final delivery date.

Pricing in this proposal is contingent up Customer signing a POS Service contract on the equipment for a period of 5 (five) years.

This quote is based upon standard delivery terms and conditions (e.g., standard work hours, first floor delivery, etc.), basic rigging, mechanical installation and calibration. Siemens Medical Solutions USA, Inc., Project Management shall perform a site-specific assessment to ascertain any variations that are out of scope and not covered by the standard terms (examples such as, but not limited to: larger crane, nonstandard work hours, removal of existing equipment, etc.). Any noted variations identified by Siemens Project Management shall remain the responsibility of the customer and will be subject to additional fees.

SIEMENS / NOVATION GROUP BUY 2015 PROMOTIONAL OFFERING

Confidentiality Agreement: This Quotation is strictly confidential and you agree that this information will be held in the strictest of confidence and not shared with any third parties, buying evaluation groups or anyone not directly employed by your facility.

Siemens & Novation Group Buy Promotion:
- Group Buy ends September 30, 2015.
- Binding purchase orders and signed Service Agreements must be received by Siemens on or before September 30, 2015.
- Contingent purchase orders (except State CON) are not acceptable.
- 45 day quote validity period is not applicable for this proposal.

SIEMENS

Siemens Medical Solutions USA, Inc.
40 Liberty Boulevard, Malvern, PA 19355

SIEMENS REPRESENTATIVE
Mike Obuchon - (860) 462-6620

As part of the Novation Group Buy, Siemens is providing up to an additional 4% discount on discountable items for all qualified orders of two or more systems for which four (4) year point of sale (POS) Service Contracts are purchased. This quote already reflects either (i) the 2% Multiple System discount or (ii) 2% POS discounts or (iii) a combination of both (i) and (ii) for applicable AX,CT,MI, MR,US or XP systems. Siemens will charge the customer for the Multiple System discount if a binding purchase order for the second or more systems is not received by Siemens within two days of the first system order or is received after September 30, 2015. Siemens will charge the customer for the POS Service Contract Discount if a signed POS Service Contract is not received by Siemens with the system order or is recevied after September 30, 2015.

This order is contingent upon CON approval from the State of Connecticut and Orthopaedic & Neurological Surgery executing a signed service agreement. If the CON is not granted, customer may cancel this order without penalty.

Accepted and Agreed to by:

Siemens Medical Solutions USA, Inc.

By (sign): _____
Name: Mike Obuchon
Title: Account Executive - NGAGE
Date: _____

Orthopaedic & Neurological Surgery

By (sign): _____
Name: _____
Title: _____
Date: _____

By signing below, signor certifies that no modifications or additions have been made to the Quotation. Any such modifications or additions will be void.

By (sign): _____

SIEMENS
Siemens Medical Solutions USA, Inc.
40 Liberty Boulevard, Malvern, PA 19355

SIEMENS REPRESENTATIVE
Mike Obuchon - (860) 462-6620

Quote Nr:	**1-CSEV71 Rev. 3**
Terms of Payment:	00% Down, 80% Delivery, 20% Installation Free On Board: Destination
Purchasing Agreement:	NOVATION (UHC, VHA, Provista) NOVATION (UHC, VHA, Provista) terms and conditions apply to Quote Nr 1-CSEV71

MAGNETOM Aera

All items listed below are included for this system: *(See Detailed Technical Specifications at end of Proposal.)*

Qty	Part No.	Item Description
1	14441600	**MAGNETOM Aera - System** MAGNETOM Aera is designed to provide you the versatility you need to meet the increasing demands in healthcare. Maximize 1.5T with its core technologies Tim(r) 4G and Dot(r), along with its comprehensive application portfolio and experience unique functionalities to increase patient comfort. Every case. Every day. System Design - Short and open appearance (145 cm system length and 70 cm Open Bore Design) to reduce patient anxiety and claustrophobia - Whole-body superconductive Zero Helium Boil-Off 1.5T magnet - Actively Shielded water-cooled Siemens gradient system for maximum performance - TrueForm Magnet and Gradient Design Tim 4G (Total imaging matrix in the 4th generation) for excellent image quality and speed - Siemens unique DirectRF(tm) technology enabling the all digital-in/ digital-out design - Dual-Density Signal Transfer Technology - Head/Neck 16 DirectConnect - Spine 24 DirectConnect - Body 6 - Flex Large 4 - Flex Small 4 - Flex Coil interface - Tim Coil interface Dot (Day optimizing throughput) for higher consistency, flexibility and efficiency - Dot Display - Dot Control Centers - Brain Dot Engine Tim Application Suite allowing excellent head-to-toe imaging - Neuro Suite - Angio Suite - Cardiac Suite - Body Suite - Onco Suite - Breast Suite - Ortho Suite

Qty	Part No.	Item Description

- Pediatric Suite
- Scientific Suite

Further included
- High performance host computer and measurement and reconstruction system
- Siemens uniqueTimCT FastView localizer and CAIPIRINHA
- syngo MR software including
- 1D/2D PACE
- BLADE
- iPAT²
- Phoenix
- Inline Diffusion
- WARP
- MDDW (Multiple Direction Diffusion Weighting)
- CISS
- DESS

The system (magnet, electronics and control room) can be installed in 30sqm space. For system cooling either the Eco Chiller options or the Separator is required.

1 14436777

Tim [204x24] XJ Gradients #Ae

Tim [204x24] XJ-gradient performance level

Tim 4G with it's newly designed RF system and innovative coil architecture enables high resolution imaging and increased throughput.
Up to 204 simultaneously connected coil elements can be combined with the 24 independent RF channels for the most flexible parallel imaging and support demanding applications.
Maximum SNR is ensured through the new Tim 4G matrix coil technology.

XJ - gradients
The XJ- gradients are designed combining high performance and linearity to support clinical whole body imaging at 1.5T. The force compensated gradient system minimizes vibration levels and accoustic noise. The XJ gradients combine 33 mT/m peak amplitude with a slew rate of 125 T/m/s.

1 08464872

PC Keyboard US english #Tim

Standard PC keyboard with 101 keys.

1 14416914

Pure White Design #T+D

The MAGNETOM Aera / MAGNETOM Skyra design is available in different light and appealing variants which perfectly integrates into the different environments. The color of the main face plate cover of the Pure White Design Variant with the integrated Dot Control Centers and the unique Dot Display is brilliant white surrounded by a brilliant silver trim. The asymetrical deco area on the left side is colored white matte and also with a brilliant surrounding silver trim.
The table cover is presented also in the same color and material selection.

1 14416906

Tim Dockable Table #Ae

The Tim Dockable Table is designed for maximum patient comfort and smooth patient preparation. Tim Dockable Table can support up to 250 kg (550 lbs) patients without restricting the vertical or horizontal movement.

The one step docking mechanism and the innovative multi-directional navigation wheel ensure easy maneuvering and handling. Critically ill or immobile patients can now be prepared outside the examination room for maximum patient care, flexibility and speed.

1 14426310

Angio Dot Engine

The timing of contrast injection and scan is widely considered the most challenging part of an anglographic exam. Angio Dot guides the user through angiographic single or multi station examinations by providing semi-automatic detection of arterial and venous timing windows using a test bolus technique. This information is fed back into the next planning steps automatically adapting scan parameters to the individual patient and patient's condition.
Where needed, AutoVoiceCommands support the communication with the patient and ensure optimal timing of breathing, scanning and contrast media. All steps of contrast injection are presented in a simple, automated graphic

Qty	Part No.	Item Description
		on the monitor. syngo Inline Composing and the Tim Planning Suite are included.
1	14430392	**Large Joint Dot Engine #T+D** Large Joint Dot Engine optimizes image quality of knee, hip and shoulder scans by proposing the most appropriate protocols according to the examination strategy chosen for the specific patient. It ensures reproducible image quality and streamlines large joint examinations to a great extent. The Large Joint Dot Engine features AutoAlign and AutoCoverage for knee, hip and shoulder, syngo WARP with VAT (View Angle Tilting), and Inline MPR.
1	14430391	**RESOLVE #T+D** RESOLVE is a diffusion-weighted, readout-segmented EPI sequence optimized towards high resolution imaging with reduced distortions. The sequence uses a very short echo-spacing compared to single-shot EPI, substantially reducing susceptibility effects. A 2D-navigator correction is applied to avoid artefacts due to motion-induced phase errors. This combination allows diffusion weighted imaging of the breast, prostate, brain and spine with a high level of detail and spatial precision.
1	14416960	**Shoulder 16 Coil Kit #Ae** The new Tim 4G coil technology with Dual Density Signal Transfer and SlideConnect Technolgy combines key imaging benefits: excellent image quality, high patient comfort, and unmatched flexibility. The Shoulder 16 Coil Kit for examinations of the left or right shoulder consists of a base plate and two different sized iPAT compatible 16 channel coils (Shoulder Large 16 and Shoulder Small 16). These will be attached and can be relocated on the base plate.The 16-element coils with 16 integrated pre-amplifiers ensure maximimum signal-to-noise ratio. Shoulder Large 16 and Shoulder Small 16 will be connected via a SlideConnect plug for fast and easy coil set-up and patient preparation.
1	14416962	**Foot/Ankle 16 #Ae** The new Tim 4G coil technology with Dual Density Signal Transfer and DirectConnect Technolgy combines key imaging benefits: excellent image quality, high patient comfort, and unmatched flexibility. Foot/Ankle 16 for examinations of the left or right foot and ankle region consists of a base plate and an iPAT compatible 16-channel coil and allows high resolution imaging of the foot and ankle within one examination. Foot/Ankle 16 is a cable-less coil and will be connected via DirectConnect for fast and easy patient preparation.
1	14430403	**Tx/Rx 15-channel Knee Coil DDST #Ae** New 15-channel transmitter/receiver coil for joint examinations in the area of the lower extremities. Main features : - 15-element design (3x5 coil elements) with 15 integrated preamplifiers, - iPAT-compatible - SlideConnect Technology
1	14416968	**CP Extremity Coil #Ae** Circularly Polarized no-tune transmit/receive coil for joint examinations in the region of the lower extremities.
1	14407258	**MR Workplace Table 1.2m** Table suited for syngo Acquisition Workplace and syngo MR Workplace based on syngo Hardware.
1	14407261	**MR Workplace Container, 50cm** 50 cm wide extra case for the syngo host computer with sliding front door to allow change of storage media (CD/DVD/USB).
1	08857828	**UPS Cable #Tim** Power cable for connecting the UPS Powerware PW 9130-3000i (14413662) to the ACC of MAGNETOM Tim and MAGNETOM Tim+Dot systems for backing up the computer. Standard cable length: 9 m.
1	14413662	**UPS Powerware PW9130G-3000T-XLEU** UPS system Eaton PW9130G-3000T-XLEU for MAGNETOM Tim, MAGNETOM Tim+Dot and MAGNETOM Symphony systems for safeguarding computers. Power output: 3.0 kVA / 2.7 kW Bridge time: 5 min full load / 14 min half load Input voltage: 230 VAC

Qty	Part No.	Item Description
1	14413663	**UPS Battery module** UPS battery module Eaton PW 9130N-3000T-EBM for all MAGNETOM Tim, MAGNETOM Tim+Dot and MAGNETOM Symphony systems for safeguarding computers. Extension for: PW9130i-3000T Battery type: Closed, maintenance-free Extension of the bridge time to: 24 minutes with a module Dimensions (H x W x D): Battery module: 346 x 214 x 412 mm incl. bracket set Weight: approx. 50 kg
1	MR_STD_RIG_INST	**MR Standard Rigging and Installation** MR Standard Rigging and Installation This quotation includes standard rigging and installation of your new MAGNETOM system Standard rigging into a room on ground floor level of the building during standard working hours (Mon. - Fri./ 8 a.m. to 5 p.m.) It remains the responsibility of the Customer to prepare the room in accordance with the SIEMENS planning documents Any rigging requiring a crane over 80 tons and/or special site requirements (e.g. removal of existing systems, etc.) is an incremental cost and the responsibility of the Customer. All other "out of scope" charges (not covered by the standard rigging and installation) will be identified during the site assessment and remain the responsibility of the Customer.
1	MR_BTL_INST ALL	**MR Standard Rigging & Install**
1	MR_PREINST_DOCK	**T+D Preinstall kit for dockable table**
1	MR_CRYO	**Standard Cryogens**
1	MR_PM	**MR Project Management** A Siemens Project Manager (PM) will be the single point of contact for the implementation of your Siemen's equipment. The assigned PM will work with the customer's facilities management, architect or building contractor to assist you in ensuring that your site is ready for installation. Your PM will provide initial and final drawings and will coordinate the scheduling of the equipment, installation, and rigging, as well as the initiation of on-site clinical education.
1	MR_INITIAL_32	**Initial onsite training 32 hrs** MR_INITIAL_32 Up to (32) hours of on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Training will cover agenda items on the ASRT approved checklist. Uptime Clinical Education phone support is provided during the warranty period for specified posted hours. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	MR_FOLLOWUP_24	**Follow-up training 24 hrs** Up to (24) hours of follow-up on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Uptime Clinical Education phone support is provided during the warranty period for specified posted hours. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	MR_INT_DOT_BCLS	**MR Dot Training Class** Tuition for (1) imaging professional to attend Classroom Course at Siemens Training Center. The objectives of this class are to introduce the user interface of the common syngo platform, including Dot, and instructions on building protocols, demonstration of software functions, and hands-on sessions. This class includes lunch, economy airfare, and lodging for (1) imaging professional. All arrangements must be arranged through Siemens designated travel agency. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.

Qty	Part No.	Item Description
1	MR_ADD_16	**Additional onsite training 16 hours** Up to (16) hours of on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Training will cover agenda items on the ASRT approved checklist if applicable. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	MR_ADD_CLASS	**Additional Training Class** Tuition for (1) attendee for a customer classroom course of choice at one of the Siemens training centers. Includes economy airfare and lodging for (1) attendee. All arrangements must be arranged through Siemens designated travel agency. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	MR_A_INT_SYN_BCLS	**Basic syngo MR Class** Tuition for (1) imaging professional to attend Classroom Course at Siemens Training Center. The objectives of this class are to introduce the user interface of the common syngo platform and instructions on building protocols, demonstration of software functions, and hands-on sessions. This class includes lunch, economy airfare, and lodging for (1) imaging professional. All arrangements must be arranged through Siemens designated travel agency. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	4MR5142869	**Armrest #MR**
1	KKTECOMR_60	**KKT ECOCHILLER 133L** The KKT ECO 133 -L chiller is a dedicated 20°C cooling system for MAGNETOM Aera and MAGNETOM Skyra which automatically adapts to the different cooling requirements (e.g. system in operation, standby, ...) to reduce the energy consumption for cooling. The cooling system must be used in combination with the IFP (Interface Panel), if there is no on-site chilled water supply at all. The IFP is included in the scope of supply.
1	KRAUS_CHILLNST	**Kraus Start-up and Warranty**
1	IECMR480V250A	**IEC Main Disconnect Panel - MR** Integrated Electrical Cabinet/Main Disconnect Panel for MR. Components supplied: The IEC Main Disconnect Panel This Operations & Maintenance Manual (4) sets of Emergency Power Off pushbuttons and installation instructions Drawings and electrical schematics DOES NOT INCLUDE installation. Customer is responsible for the installation of the cabinet. Includes one year warranty.
1	MRLOC_ANGIODOT	**Local Offset - Angio Dot Engine**
1	MR_PR_DOTENG1	**Dot Engine 1 pricing offset** To be eligible for this promotion, a binding purchase order of the application(s) must be received by Siemens Medical on or before September 30, 2015.
1	MRLOC_LRGJDOT	**Local Offset - LargeJoint Dot Engine**
1	MR_PR_DOTENG1	**Dot Engine 1 pricing offset** To be eligible for this promotion, a binding purchase order of the application(s) must be received by Siemens Medical on or before September 30, 2015.
1	MR_BUDG_ADDL_RIG	**Budgetary Add'l/Out of Scope Rigging $15,000**
1	M3SSMREPICBC	**Spectris Solaris EP Injector iCBC** Includes Spectris Solaris EP Injector and Integrated Continuous Battery Charger (ICBC). - Optimized color touch screen with few keystrokes.

Qty	Part No.	Item Description

- Six user-programmable phases for added flexibility.
- Independent Keep Vein Open (KVO) allows more time to focus on patient.
- Large 115 mL saline syringe allows for longer KVO and multiple flushes.
- Design of low pressure tubing eliminates dead space in the "T" connection that can waste contrast.
- The clear barrel design with molded FluidDots help detect the presence of air in a syringe.
- Pressure Limit Setting control software enables user to select from one to six preset maximum pressure limits, ranging from 100-300 psi, and to view current pressure during injection next to the pre-selected maximum value on the Solaris display.

Installation, applications and one year warranty provided by Medrad.

Not for mobile use, refer to Siemens part number M3SSMR300EPM for the Solaris injector used in a mobile environment.

This product has been tested and verified for compatibility with the following Siemens' products: MAGNETOM Trio, Espree, Essenza, Verio, Avanto, Symphony, Aera, Skyra and Biograph mMR. Compatibility with other products cannot be guaranteed and use with any other products may void service contracts and/or system warranties.

1 14416961 **Hand/Wrist 16 #Ae**

The new Tim 4G coil technology with Dual Density Signal Transfer and SlideConnect Technology combines key imaging benefits: excellent image quality, high patient comfort, and unmatched flexibility.

Hand/Wrist 16 for examinations of the left or right hand and wrist region consists of a base plate and an iPAT compatible 16-channel coil and allows high resolution imaging of the wrist and the hand within one examination. Hand/Wrist 16 will be connected via a SlideConnect plug for fast and easy patient preparation.

System Total: $1,250,337

SIEMENS REPRESENTATIVE
Mike Obuchon - (860) 462-6620

FINANCING: The equipment listed above may be financed through Siemens. Ask us about our full range of financial products that can be tailored to meet your business and cash flow requirements. For further information, please contact your local Sales Representative.

ACCESSORIES: Don't forget to ask us about our line of OEM imaging accessories to complete your purchase. All accessories can be purchased or financed as part of this order. To purchase accessories directly or to receive our accessories catalog, please call us directly at 1-888-222-9944 or contact your local Sales Representative.

COMPLIANCE: Compliance with legal and internal regulations is an integral part of all business processes at Siemens. Possible infringements can be reported to our Helpdesk "Tell us" function at www.siemens.com/tell-us.

Attachment F

Financial Statement for the ONS MRI Operations for 2014

ONS MRI: Statement of Operations
2014
Source: PM system and QuickBooks

	2014
Volume	5,188
Collections	$ 4,737,886
Salaries	
Employee Salaries	366,857
Employee Benefits	80,709
Total Employee Expense	**447,566**
Other Expenses:	
Radiologists Fee *(@$95/Read)*	492,860
Billing Fees *(6.2% of Collections)*	285,221
Occupancy Fee *(Rent 10% of total)*	117,927
MRI Machine Lease -*Siemens*	162,000
Other Equipment -Other IS	194,400
MRI Supplies	45,470
Transcription	27,580
Licenses & Permits	975
Other Misc	2,000
Total Other Expenses	**1,328,433**
Total Expenses	1,775,999
Net Gain/Loss	$ 2,961,887

Attachment G

OHCA Financial Worksheet B

FOR-PROFIT

Applicant Name: Orthopaedic & Neurosurgery Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics
Financial Worksheet (B) without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2015 Projected W/out CON	(3) FY 2015 Projected Incremental	(4) FY 2015 Projected With CON	(5) FY 2016 Projected W/out CON	(6) FY 2016 Projected Incremental	(7) FY 2016 Projected With CON	(8) FY 2017 Projected W/out CON	(9) FY 2017 Projected Incremental	(10) FY 2017 Projected With CON	(11) FY 2018 Projected W/out CON	(12) FY 2018 Projected Incremental	(13) FY 2018 Projected With CON
	Description													
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	$4,737,886	$4,496,879	$0	$4,496,879	$4,496,879	$0	$4,496,879	$4,510,370	$1,584,305	$6,094,675	$4,523,901	$1,814,561	$6,338,462
2	Less: Allowances	$0	$0	$0	$0		$0	$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0		$0	$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0		$0	$0			$0			$0
	Net Patient Service Revenue	$4,737,886	$4,496,879	$0	$4,496,879	$4,496,879	$0	$4,496,879	$4,510,370	$1,584,305	$6,094,675	$4,523,901	$1,814,561	$6,338,462
5	Medicare	$0	$0	$0	$0		$0	$0			$0			$0
6	Medicaid	$0	$0	$0	$0		$0	$0			$0			$0
7	CHAMPUS & TriCare	$0	$0	$0	$0		$0	$0			$0			$0
8	Other	$0	$0	$0	$0		$0	$0			$0			$0
	Total Government	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
9	Commercial Insurers	$0	$0	$0	$0		$0	$0			$0			$0
10	Uninsured	$0	$0	$0	$0		$0	$0			$0			$0
11	Self Pay	$0	$0	$0	$0		$0	$0			$0			$0
12	Workers Compensation	$0	$0	$0	$0		$0	$0			$0			$0
13	Other	$0	$0	$0	$0		$0	$0			$0			$0
	Total Non-Government	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue[a] (Government+Non-Government)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
14	Less: Provision for Bad Debts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0			$0
	Net Patient Service Revenue less provision for bad debts	$4,737,886	$4,496,879	$0	$4,496,879	$4,496,879	$0	$4,496,879	$4,510,370	$1,584,305	$6,094,675	$4,523,901	$1,814,561	$6,338,462
15	Other Operating Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0			$0
17	Net Assets Released from Restrictions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0			$0
	TOTAL OPERATING REVENUE	$4,737,886	$4,496,879	$0	$4,496,879	$4,496,879	$0	$4,496,879	$4,510,370	$1,584,305	$6,094,675	$4,523,901	$1,814,561	$6,338,462
B.	OPERATING EXPENSES													
1	Salaries and Wages	$366,857	$368,697	$0	$368,697	$379,757	$0	$379,757	$391,150	$391,150	$782,299	$402,884	$402,884	$805,768
2	Fringe Benefits	$80,709	$81,113	$0	$81,113	$83,547	$0	$83,547	$86,053	$86,053	$172,107	$88,635	$88,635	$177,270
3	Physicians Fees	$492,860	$498,180	$0	$498,180	$499,700	$0	$499,700	$501,220	$132,905	$634,125	$502,645	$156,845	$659,490
4	Supplies and Drugs	$45,470	$45,698	$0	$45,698	$45,835	$0	$45,835	$45,926	$12,177.91	$58,104	$46,064	$14,373.74	$60,438
5	Depreciation and Amortization	$0	$0	$0	$0	$0	$0	$0		$0	$0			$0
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0		$0	$0			$0
7	Interest Expense	$0	$0	$0	$0	$0	$0	$0		$0	$0			$0
8	Malpractice Insurance Cost	$0	$0	$0	$0	$0	$0	$0		$0	$0			$0
9	Lease Expense	$162,000	$185,143	$0	$185,143	$194,400	$0	$194,400	$204,120	$289,683	$493,803	$214,326	$289,683	$504,009
10	Other Operating Expenses	$628,103	$620,567	$0	$620,567	$637,486	$0	$637,486	$639,525	$359,825	$999,349	$648,643	$382,379	$1,031,022
	TOTAL OPERATING EXPENSES	$1,775,999	$1,799,398	$0	$1,799,398	$1,840,725	$0	$1,840,725	$1,867,994	$1,271,794	$3,139,788	$1,903,197	$1,334,800	$3,237,997
	INCOME/(LOSS) FROM OPERATIONS	$2,961,887	$2,697,481	$0	$2,697,481	$2,656,154	$0	$2,656,154	$2,642,375	$312,512	$2,954,887	$2,620,704	$479,761	$3,100,465
	NON-OPERATING INCOME	$0	$0	$0	$0			$0			$0			$0
	Income before provision for income taxes	$2,961,887	$2,697,481	$0	$2,697,481	$2,656,154	$0	$2,656,154	$2,642,375	$312,512	$2,954,887	$2,620,704	$479,761	$3,100,465
	Provision for income taxes[c]	$0	$0	$0	$0			$0			$0			$0
	NET INCOME	$2,961,887	$2,697,481	$0	$2,697,481	$2,656,154	$0	$2,656,154	$2,642,375	$312,512	$2,954,887	$2,620,704	$479,761	$3,100,465
C.	Retained Earnings, beginning of year	$0	$0	$0	$0			$0			$0			$0
	Retained Earnings, end of year	$0	$0	$0	$0			$0			$0			$0
	Principal Payments	$0	$0	$0	$0			$0			$0			$0
D.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	62.5%	60.0%	0.0%	60.0%	59.1%	0.0%	59.1%	58.6%	19.7%	48.5%	57.9%	26.4%	48.9%
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%
3	Hospital Total Margin	62.5%	60.0%	0.0%	60.0%	59.1%	0.0%	59.1%	58.6%	19.7%	48.5%	57.9%	26.4%	48.9%
E.	FTEs	2	2	0	2	2		2	2	2	4	2	2	4
F.	VOLUME STATISTICS[d]													
1	Inpatient Discharges	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Outpatient Visits	5,189	5,244	0	5,244	5,260	0	5,260	5,276	1,399	6,675	5,291	1,651	6,942
	TOTAL VOLUME	5,189	5,244	0	5,244	5,260	0	5,260	5,276	1,399	6,675	5,291	1,651	6,942

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]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.
[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d]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.

22000

Connecticut Department of Public Health

Supplemental CON Application Form

Acquisition of Equipment

Conn. Gen. Stat. § 19a-638(a)(10),(11)

Applicant: Orthopaedic & Neurosurgery Specialists, P.C.

Project Name: Acquisition of 1.5 Tesla MRI by a Private Physician Practice

Affidavit

Applicant: Orthopaedic & Neurosurgery Specialists, P.C.

Project Title: Acquisition of 1.5 Tesla MRI by a Private Physician Practice

I, Seth Miller, M.D., President
(Name) (Position – CEO or CFO)

of Orthopaedic + Neurosurgery Specialists 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 1-15-16
Date

Subscribed and sworn to before me on JAN. 15, 2016

Pat C. Pedersen
Notary Public/Commissioner of Superior Court

My commission expires: AUG. 31, 2019

Pat C Pedersen
NOTARY PUBLIC
State of Connecticut
My Commission Expires
August 31, 2019

1. **Project Description: Acquisition of Equipment**

   a. Provide the manufacturer, model and number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).

Response:

The proposed scanner is a Siemens Aera 1.5 Tesla (1.5T) MRI ("Proposed Scanner").

   b. List each of the Applicant's sites and the imaging modalities currently offered by location.

Response:

Orthopaedic & Neurosurgery Specialists, P.C. ("ONS") currently operates a fixed 1.5 Tesla (1.5T) Magnetom Espree Open Bore MRI scanner (the "Existing Scanner") authorized pursuant to Docket Number 08-31150-CON at its office practice at 6 Greenwich Office Park, Greenwich, CT. ONS also offers x-ray, ultrasound and fluoroscopy services at its practice location.

2. **Clear Public Need**

   a. Complete **Table A** for each piece of equipment of the type proposed currently operated by the Applicant at each of the Applicant's sites.

TABLE A
EXISTING EQUIPMENT OPERATED BY THE APPLICANT

Provider Name/Address	Service*	Days/Hours of Operation **	Utilization***
Orthopaedic & Neurosurgery Specialists, P.C. 6 Greenwich Office Park, Greenwich 5 High Ridge Road Stamford	MRI	Monday – Friday 7am to 9pm; Saturday 7am to 5pm; Sunday 7am to 1pm	5,189[1]

*Include equipment strength (e.g. slices, tesla strength), whether the unit is open or closed (for MRI)
**Days of the week unit is operational, and start and end time for each day
***Number of scans/exams performed on each unit for the most recent 12-month period (identify period).

[1] FY 2014.

00080

b. Provide the rationale for locating the proposed equipment at the proposed site;

Response:

The scanner is proposed for ONS's office where it treats its patients. The proposed location is at ONS's practice which facilitates communication and collaboration of care between radiologists, technical personnel and ONS's providers. ONS patients also benefit from the current location due to its familiarity with a private practice setting.

3. Actual and Projected Volume

a. Complete the following tables 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 proposed pieces of equipment (of the type proposed, at the proposed location only). In **Table B**, report the units of service by piece of equipment, and in **Table C**, report the units of service by type of exam (e.g. if specializing in orthopedic, neurosurgery, or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners).

Response:

See Table B and Table C.

TABLE B

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY EQUIPMENT UNIT

Equipment***	Actual Volume (Last 3 Completed FYs)[2]			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[3]	FY 2017	FY 2018	FY 2019
Existing MRI	4,565	4,800	5,189	5,244[4]	5,474[5]	3,338	3,471	3,515
Proposed MRI	-	-	-	-	-	3,337	3,471	3,514
Total	**4,565**	**4,800**	**5,189**	**5,244**	**5,474**	**6,675**	**6,942**	**7,029**

[2] Calendar Year.
[3] FY 2016 represents Existing MRI only; Proposed MRI will not be in service until of FY 2017.
[4] FY 2015 volume represents annualized volume, which is based on 9 months of actual volume (January 1, 2015 to September 30, 2015).
[5] Due to CON approval time and build out time, the Proposed MRI is not anticipated to be in service until FY 2017.

*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 six months, report actual volume and identify the period covered.
**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.
***Identify each scanner separately and add lines as necessary. Also break out inpatient/outpatient/ED volumes if applicable.
****Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

TABLE C

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY TYPE OF SCAN/EXAM

Service***	Actual Volume (Last 3 Completed FYs)[6]			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Orthopedic	2,557	2,669	2,991	2,901	3,028	3,693	3,840	3,888
Arthogram	254	254	280	240	251	305	318	322
Spine	1,652	1,785	1,814	2,001	2,089	2,547	2,649	2,682
Head and Neck	82	68	68	76	79	97	101	102
Chest	1	7	19	10	10	13	13	13
MRA	19	17	15	16	17	20	21	21
Total	**4,565**	**4,800**	**5,189**	**5,244[7]**	**5,474[8]**	**6,675**	**6,942**	**7,029**

*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 six months, report actual volume and identify the period covered.
**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.
***Identify each type of scan/exam (e.g., orthopedic, neurosurgery or if there are scans/exams that can be performed on the proposed piece of equipment that the Applicant is unable to perform on its existing equipment) and add lines as necessary.
****Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume by scanner and scan type.

Response:

The assumptions used are based on historical utilization and growth of ONS in terms of the addition of doctors as well as number of patients.

c. Explain any increases and/or decreases in the volume reported in the tables above.

Response:

[6] Calendar Year.
[7] All FY 2015 volume represents annualized volume, which is based on 9 months of actual volume (January 1, 2015 to September 30, 2015).
[8] Due to CON approval time and build out time, the Proposed MRI is not anticipated to be in service until FY 2017.

00082

Increases in volume over the years is due to increase in the number of physicians employed by ONS and the utilization of services by the growing patient population.

d. Provide a breakdown, by town, of the volumes provided in **Table D** for the most recently completed FY.

TABLE D
UTILIZATION BY TOWN

Equipment*	Town	Utilization FY 2014
Existing Scanner	Greenwich	1,154
	Stamford	572
	Darien	257
	New Canaan	250
	Old Greenwich	207
	Riverside	194
	Cos Cob	182
	Wilton	105
	Westport	104
	Norwalk	90
	Fairfield	53
	Weston	49
	Ridgefield	40
	Redding	19
	Bridgeport	16
	Newtown	12
	Danbury	11
	Trumbull	11
	Southport	10
	Oxford	6
	Stratford	4
	Branford	4
	Easton	4
	New Fairfield	4
	New Milford	4
	Shelton	4
	Bethel	3
	Milford	3
	Monroe	3
	Guilford	2
	Hamden	2
	Madison	2

	Milford	2
	Sandy Hook	2
	Ansonia	1
	Avon	1
	Baltic	1
	Botsford	1
	Cheshire	1
	Danielson	1
	Derby	1
	Farmington	1
	Litchfield	1
	Mystic	1
	New Haven	1
	Orange	1
	Plainville	1
	Rocky Hill	1
	Roxbury	1
	Salisbury	1
	Southbury	1
	Uncasville	1
	Washington Depot	1
	Waterbury	1
	West Haven	1
	Woodbridge	1
	Woodbury	1
	Westport	
	Other Towns and Cities outside of Connecticut	1,781
	TOTAL	5,189

*Identify each scanner separately and add lines as necessary. Also, break out inpatient/outpatient/ED volumes if applicable and include equipment strength (e.g., slices, tesla strength), whether the unit is open or closed (for MRI).
**Fill in year

Greer, Leslie

From: Veyberman, Alla
Sent: Friday, February 19, 2016 2:26 PM
To: Greer, Leslie
Subject: FW: Docket No. 15-32063 CON Completeness questions
Attachments: 16-32063 Completeness Letter 1.docx; Minor Towns_Service Area.xls

Sorry-forgot to copy you on this one

From: Veyberman, Alla
Sent: Friday, February 19, 2016 2:07 PM
To: 'michelevolpe@aol.com' <michelevolpe@aol.com>
Cc: Riggott, Kaila <Kaila.Riggott@ct.gov>; Greci, Laurie <Laurie.Greci@ct.gov>
Subject: Docket No. 15-32063 CON Completeness questions

Dear Attorney Volpe:

Please see the attached completeness questions for Docket No. 15-32063 CON. Please acknowledging receipt

Thank you.

Alla

Alla Veyberman, MS
Health Care Analyst
CT Department of Public Health
Office of Health Care Access (OHCA)
Phone: 860.418.7007
Fax: 860.418.7053
Email: Alla.Veyberman@ct.gov

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

February 19, 2016 Via Email Only

michelevolpe@aol.com
Attorney Michele M. Volpe
Attorney, Bershtein, Volpe & McKeon, P.C.
105 Court Street
New Haven, CT 06511

RE: Certificate of Need Application Docket Number: 16-32063-CON
Orthopaedic & Neurosurgery Specialists, P. C.
Acquisition of Magnetic Resonance Imaging Scanner
Certificate of Need Completeness Letter

Dear Ms. Volpe:

On January 21, 2016, OHCA received the Certificate of Need application for Orthopaedic & Neurosurgery Specialists, P.C.'s proposal for the acquisition of a MRI unit. 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 question 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, 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 85** and reference "**Docket Number: 16-32063-CON**."

Please note that pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request no later than sixty days from the date of this email transmission. Therefore, please provide your written responses to OHCA no later than **Tuesday, April 19, 2016**, otherwise your application will be automatically considered withdrawn.

Please email your responses to all of the following email addresses: **OHCA@ct.gov, laurie.greci@ct.gov, *alla.veyberman@ct.gov*, *kaila.riggott@ct.gov* .**

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
Affirmative Action/Equal Opportunity Employer

1. Page 14 of the application states that the number of practice physicians increased from 17 in 2012 to 23 physicians in 2015. Provide the number of physicians, by specialty, for these years.

Year	Number of Physicians	Specialty	Month each new physician started
2012			
2013			
2014			
2015			

2. Page 17 of the application states that the existing scanner is operating over capacity and has been for several years. Provide additional information, methodology and documentation to support this statement. Include statistics with supporting documentation. Explain how the 85% utilization of the existing MRI scanner was determined.

3. Revise Table 8 on pages 26-27 of the application by providing a breakdown of utilization by town, for FY2015, the most recently completed fiscal year. Include only the incorporated town names. (*see attached*)

4. Resubmit Attachment F on page 75 of the application to reflect 2015 actual information.

5. Update Table B on page 81 of the application to include actual FY2015 utilization.

6. In reference to the Financial Worksheet submitted on page 77, provide the following:
    a. Projections for FY2016-FY2019, and
    b. Replace *FY2014 Actual Results* (Column 1) with the actual twelve month FY2015 information.

7. Does the Applicant provide services to indigent and/or Medicaid recipients? If indigent and/or Medicaid recipients require services, how will the treatment of these patients be handled?

8. Confirm that the proposed scanner will be located in the Greenwich office.

9. Report the month that the proposed scanner is expected to become operational in FY2017.

10. Explain the payer "NY-Gov" listed on page 33 of the application.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7070.

Sincerely,

Alla Veyberman
Healthcare Analyst

Attachment

Town	Community
Andover	Andover
Ansonia	Ansonia
Ashford	Ashford
Ashford	Warrenville
Avon	Avon
Barkhamsted	Barkhamsted
Barkhamsted	Pleasant Valley
Barkhamsted	Riverton
Beacon Falls	Beacon Falls
Berlin	Berlin
Berlin	East Berlin
Berlin	Kensington
Bethany	Bethany
Bethel	Bethel
Bethlehem	Bethlehem
Bloomfield	Bloomfield
Bolton	Bolton
Bozrah	Bozrah
Bozrah	Fitchville
Bozrah	Gilman
Branford	Branford
Branford	Short Beach
Branford	Stony Creek
Bridgeport	Bridgeport
Bridgewater	Bridgewater
Bristol	Bristol
Bristol	Forestville
Brookfield	Brookfield
Brookfield	Brookfield Center
Brooklyn	Brooklyn
Brooklyn	East Brooklyn
Burlington	Burlington
Canaan	South Canaan
Canaan	Falls Village
Canterbury	Canterbury
Canterbury	Packer
Canton	Canton
Canton	Canton Center
Canton	Collinsville
Canton	North Canton
Chaplin	Chaplin
Cheshire	Cheshire
Cheshire	West Cheshire
Chester	Chester
Clinton	Clinton
Colchester	Colchester
Colchester	North Westchester
Colebrook	Colebrook
Columbia	Chestnut Hill
Columbia	Columbia
Cornwall	Cornwall
Cornwall	Cornwall Bridge
Cornwall	West Cornwall
Coventry	Coventry
Coventry	South Coventry
Cromwell	Cromwell
Danbury	Candlewood Isle

Danbury	Danbury
Darien	Darien
Darien	Noroton
Darien	Noroton Heights
Derby	Derby
Durham	Durham
Durham	Durham Center
Eastford	Eastford
East Granby	East Granby
East Haddam	East Haddam
East Haddam	Moodus
East Hampton	Cobalt
East Hampton	East Hampton
East Hampton	Middle Haddam
East Hampton	Westchester
East Hartford	Burnside
East Hartford	East Hartford
East Haven	East Haven
East Lyme	Black Point
East Lyme	East Lyme
East Lyme	Flanders
East Lyme	Niantic
Easton	Easton
East Windsor	Broad Brook
East Windsor	East Windsor
East Windsor	Melrose
East Windsor	Warehouse Point
East Windsor	Windsorville
Ellington	Ellington
Enfield	Enfield
Enfield	Hazardville
Enfield	Thompsonville
Essex	Centerbrook
Essex	Essex
Essex	Ivoryton
Fairfield	Fairfield
Fairfield	Southport
Farmington	Farmington
Farmington	Unionville
Franklin	Franklin
Franklin	North Franklin
Glastonbury	East Glastonbury
Glastonbury	Glastonbury
Glastonbury	South Glastonbury
Goshen	Goshen
Goshen	West Goshen
Granby	Granby
Granby	North Granby
Granby	West Granby
Greenwich	Byram
Greenwich	Cos Cob
Greenwich	Glenville
Greenwich	Greenwich
Greenwich	Old Greenwich
Greenwich	Riverside
Griswold	Glasgo
Griswold	Griswold
Griswold	Hopeville

Griswold	Jewett City
Groton	Groton
Groton	Mystic
Groton	Noank
Groton	Poquonock Bridge
Groton	West Mystic
Guilford	Guilford
Guilford	North Guilford
Haddam	Haddam
Haddam	Haddam Neck
Haddam	Higganum
Hamden	Hamden
Hamden	Mount Carmel
Hamden	Whitneyville
Hampton	Hampton
Hartford	Hartford
Hartland	East Hartland
Hartland	Hartland
Hartland	West Hartland
Harwinton	Harwinton
Hebron	Amston
Hebron	Hebron
Kent	Kent
Kent	South Kent
Killingly	Attawaugan
Killingly	Ballouville
Killingly	Danielson
Killingly	Dayville
Killingly	East Killingly
Killingly	Goodyear
Killingly	Killingly
Killingly	Rogers
Killingly	South Killingly
Killingworth	Killingworth
Lebanon	Exeter
Lebanon	Lebanon
Ledyard	Gales Ferry
Ledyard	Ledyard
Lisbon	Lisbon
Litchfield	Bantam
Litchfield	East Litchfield
Litchfield	Litchfield
Litchfield	Milton
Litchfield	Northfield
Litchfield	South Litchfield
Lyme	Hadlyme
Lyme	Hamburg
Lyme	Lyme
Madison	East River
Madison	Madison
Manchester	Buckland
Manchester	Manchester
Mansfield	Eagleville
Mansfield	Mansfield
Mansfield	Mansfield Center
Mansfield	Mansfield Depot
Mansfield	Merrow
Mansfield	Storrs

Marlborough	Marlborough
Meriden	Meriden
Meriden	South Meriden
Middlebury	Middlebury
Middlefield	Middlefield
Middlefield	Rockfall
Middletown	Middletown
Middletown	Westfield
Milford	Devon
Milford	Milford
Milford	Woodmont
Monroe	Monroe
Monroe	Stepney Depot
Monroe	Stevenson
Montville	Chesterfield
Montville	Massapeag
Montville	Montville
Montville	Oakdale
Montville	Uncasville
Morris	East Morris
Morris	Lakeside
Morris	Morris
Naugatuck	Naugatuck
Naugatuck	Union City
New Britain	New Britain
New Canaan	New Canaan
New Fairfield	New Fairfield
New Hartford	Bakersville
New Hartford	New Hartford
New Hartford	Pine Meadow
New Haven	Fair Haven
New Haven	New Haven
New Haven	Westville
Newington	Newington
New London	New London
New Milford	Gaylordsville
New Milford	New Milford
Newtown	Botsford
Newtown	Hawleyville
Newtown	Newtown
Newtown	Sandy Hook
Norfolk	Norfolk
North Branford	North Branford
North Branford	Northford
North Canaan	East Canaan
North Canaan	North Canaan
North Haven	Clintonville
North Haven	North Haven
North Stonington	North Stonington
Norwalk	East Norwalk
Norwalk	Norwalk
Norwalk	Rowayton
Norwalk	South Norwalk
Norwalk	West Norwalk
Norwich	Greenville
Norwich	Norwich
Norwich	Norwichtown
Norwich	Occum

Norwich	Taftville
Norwich	Yantic
Old Lyme	Old Lyme
Old Lyme	South Lyme
Old Saybrook	Fenwick
Old Saybrook	Old Saybrook
Old Saybrook	Saybrook
Old Saybrook	Saybrook Point
Orange	Orange
Oxford	Oxford
Plainfield	Central Village
Plainfield	Moosup
Plainfield	Plainfield
Plainfield	Wauregan
Plainville	Plainville
Plymouth	Pequabuck
Plymouth	Plymouth
Plymouth	Terryville
Pomfret	Abington
Pomfret	Pomfret
Pomfret	Pomfret Center
Pomfret	Rogers
Portland	Gildersleeve
Portland	Portland
Preston	Long Society
Preston	Poquetanuck
Preston	Preston
Prospect	Prospect
Putnam	Putnam
Redding	Redding
Redding	Redding Ridge
Redding	West Redding
Ridgefield	Ridgefield
Rocky Hill	Rocky Hill
Roxbury	Roxbury
Salem	Salem
Salisbury	Lakeville
Salisbury	Lime Rock
Salisbury	Salisbury
Salisbury	Taconic
Deep River	Deep River
Scotland	Scotland
Seymour	Seymour
Sharon	Sharon
Shelton	Huntington
Shelton	Shelton
Sherman	Sherman
Simsbury	Simsbury
Simsbury	Tariffville
Simsbury	Weatogue
Simsbury	West Simsbury
Somers	Somers
Somers	Somersville
Southbury	South Britain
Southbury	Southbury
Southington	Marion
Southington	Milldale
Southington	Plantsville

Southington	Southington
South Windsor	East Windsor Hill
South Windsor	South Windsor
South Windsor	Wapping
Sprague	Baltic
Sprague	Hanover
Sprague	Sprague
Sprague	Versailles
Stafford	Stafford
Stafford	Stafford Springs
Stafford	Staffordville
Stafford	West Stafford
Stamford	Glenbrook
Stamford	North Stamford
Stamford	Springdale
Stamford	Stamford
Sterling	Oneco
Sterling	Sterling
Stonington	Mystic
Stonington	Old Mystic
Stonington	Pawcatuck
Stonington	Stonington
Stratford	Oronoque
Stratford	Stratford
Suffield	Suffield
Suffield	West Suffield
Thomaston	East Thompson
Thomaston	Thomaston
Thompson	Fabyan
Thompson	Grosvenordale
Thompson	Mechanicsville
Thompson	North Grosvenordale
Thompson	Quinebaug
Thompson	Thompson
Thompson	Wilsonville
Tolland	Tolland
Torrington	Burrville
Torrington	Drakeville
Torrington	Torrington
Trumbull	Long Hill
Trumbull	Nichos
Trumbull	Trumbull
Union	Union
Vernon	Rockville
Vernon	Talcottville
Vernon	Vernon
Voluntown	Voluntown
Wallingford	Tracey
Wallingford	Wallingford
Wallingford	Yalesville
Warren	Warren
Washington	Marble Dale
Washington	Marble Dale/Woodville
Washington	New Preston
Washington	Shepaug
Washington	Washington
Washington	Washington Depot
Washington	Woodville

Waterbury	Waterbury
Waterbury	Waterville
Waterford	Quaker Hill
Waterford	Waterford
Watertown	Oakville
Watertown	Watertown
Westbrook	Westbrook
West Hartford	Elmwood
West Hartford	West Hartford
West Haven	Allingtown
West Haven	West Haven
Weston	Weston
Westport	Greens Farms
Westport	Saugatuck
Westport	Westport
Wethersfield	Wethersfield
Willington	South Willington
Willington	West Willington
Willington	Willington
Wilton	Cannondale
Wilton	Georgetown
Wilton	Wilton
Winchester	Winchester
Winchester	Winchester Center
Winchester	Winsted
Windham	North Windham
Windham	South Windham
Windham	Willimantic
Windham	Windham
Windham	Windham Center
Windsor	Poquonock
Windsor	Wilson
Windsor	Windsor
Windsor Locks	Windsor Locks
Wolcott	Wolcott
Woodbridge	Woodbridge
Woodbury	Hotchkissville
Woodbury	North Woodbury
Woodbury	Woodbury
Woodstock	East Woodstock
Woodstock	North Woodstock
Woodstock	South Woodstock
Woodstock	West Woodstock
Woodstock	Woodstock
Woodstock	Woodstock Valley

Community	Town
Abington	Pomfret
Allingtown	West Haven
Amston	Hebron
Andover	Andover
Ansonia	Ansonia
Ashford	Ashford
Attawaugan	Killingly
Avon	Avon
Bakersville	New Hartford
Ballouville	Killingly
Baltic	Sprague
Bantam	Litchfield
Barkhamsted	Barkhamsted
Beacon Falls	Beacon Falls
Berlin	Berlin
Bethany	Bethany
Bethel	Bethel
Bethlehem	Bethlehem
Black Point	East Lyme
Bloomfield	Bloomfield
Bolton	Bolton
Botsford	Newtown
Bozrah	Bozrah
Branford	Branford
Bridgeport	Bridgeport
Bridgewater	Bridgewater
Bristol	Bristol
Broad Brook	East Windsor
Brookfield	Brookfield
Brookfield Center	Brookfield
Brooklyn	Brooklyn
Buckland	Manchester
Burlington	Burlington
Burnside	East Hartford
Burrville	Torrington
Byram	Greenwich
South Canaan	Canaan
Candlewood Isle	Danbury
Cannondale	Wilton
Canterbury	Canterbury
Canton	Canton
Canton Center	Canton
Centerbrook	Essex
Central Village	Plainfield
Chaplin	Chaplin
Cheshire	Cheshire
Chester	Chester
Chesterfield	Montville
Chestnut Hill	Columbia
Clinton	Clinton
Clintonville	North Haven
Cobalt	East Hampton
Colchester	Colchester
Colebrook	Colebrook
Collinsville	Canton
Columbia	Columbia
Cornwall	Cornwall

Cornwall Bridge	Cornwall
Cos Cob	Greenwich
Coventry	Coventry
Cromwell	Cromwell
Danbury	Danbury
Danielson	Killingly
Darien	Darien
Dayville	Killingly
Deep River	Deep River
Derby	Derby
Devon	Milford
Drakeville	Torrington
Durham	Durham
Durham Center	Durham
Eagleville	Mansfield
East Berlin	Berlin
East Brooklyn	Brooklyn
East Canaan	North Canaan
East Glastonbury	Glastonbury
East Granby	East Granby
East Haddam	East Haddam
East Hampton	East Hampton
East Hartford	East Hartford
East Hartland	Hartland
East Haven	East Haven
East Killingly	Killingly
East Litchfield	Litchfield
East Lyme	East Lyme
East Morris	Morris
East Norwalk	Norwalk
East River	Madison
East Thompson	Thomaston
East Windsor	East Windsor
East Windsor Hill	South Windsor
East Woodstock	Woodstock
Eastford	Eastford
Easton	Easton
Ellington	Ellington
Elmwood	West Hartford
Enfield	Enfield
Essex	Essex
Exeter	Lebanon
Fabyan	Thompson
Fair Haven	New Haven
Fairfield	Fairfield
Falls Village	Canaan
Farmington	Farmington
Fenwick	Old Saybrook
Fitchville	Bozrah
Flanders	East Lyme
Forestville	Bristol
Franklin	Franklin
Gales Ferry	Ledyard
Gaylordsville	New Milford
Georgetown	Wilton
Gildersleeve	Portland
Gilman	Bozrah
Glasgo	Griswold

Glastonbury	Glastonbury
Glenbrook	Stamford
Glenville	Greenwich
Goodyear	Killingly
Goshen	Goshen
Granby	Granby
Greens Farms	Westport
Greenville	Norwich
Greenwich	Greenwich
Griswold	Griswold
Grosvenordale	Thompson
Groton	Groton
Guilford	Guilford
Haddam	Haddam
Haddam Neck	Haddam
Hadlyme	Lyme
Hamburg	Lyme
Hamden	Hamden
Hampton	Hampton
Hanover	Sprague
Hartford	Hartford
Hartland	Hartland
Harwinton	Harwinton
Hawleyville	Newtown
Hazardville	Enfield
Hebron	Hebron
Higganum	Haddam
Hopeville	Griswold
Hotchkissville	Woodbury
Huntington	Shelton
Ivoryton	Essex
Jewett City	Griswold
Kensington	Berlin
Kent	Kent
Killingly	Killingly
Killingworth	Killingworth
Lakeside	Morris
Lakeville	Salisbury
Lebanon	Lebanon
Ledyard	Ledyard
Lime Rock	Salisbury
Lisbon	Lisbon
Litchfield	Litchfield
Long Hill	Trumbull
Long Society	Preston
Lyme	Lyme
Madison	Madison
Manchester	Manchester
Mansfield	Mansfield
Mansfield Center	Mansfield
Mansfield Depot	Mansfield
Marble Dale	Washington
Marble Dale/Woodville	Washington
Marion	Southington
Marlborough	Marlborough
Massapeag	Montville
Mechanicsville	Thompson
Melrose	East Windsor

Meriden	Meriden
Merrow	Mansfield
Middle Haddam	East Hampton
Middlebury	Middlebury
Middlefield	Middlefield
Middletown	Middletown
Milford	Milford
Milldale	Southington
Milton	Litchfield
Monroe	Monroe
Montville	Montville
Moodus	East Haddam
Moosup	Plainfield
Morris	Morris
Mount Carmel	Hamden
Mystic	Groton
Mystic	Stonington
Naugatuck	Naugatuck
New Britain	New Britain
New Canaan	New Canaan
New Fairfield	New Fairfield
New Hartford	New Hartford
New Haven	New Haven
New London	New London
New Milford	New Milford
New Preston	Washington
Newington	Newington
Newtown	Newtown
Niantic	East Lyme
Nichos	Trumbull
Noank	Groton
Norfolk	Norfolk
Noroton	Darien
Noroton Heights	Darien
North Branford	North Branford
North Canaan	North Canaan
North Canton	Canton
North Franklin	Franklin
North Granby	Granby
North Grosvenordale	Thompson
North Guilford	Guilford
North Haven	North Haven
North Stamford	Stamford
North Stonington	North Stonington
North Westchester	Colchester
North Windham	Windham
North Woodbury	Woodbury
North Woodstock	Woodstock
Northfield	Litchfield
Northford	North Branford
Norwalk	Norwalk
Norwich	Norwich
Norwichtown	Norwich
Oakdale	Montville
Oakville	Watertown
Occum	Norwich
Old Greenwich	Greenwich
Old Lyme	Old Lyme

Old Mystic	Stonington
Old Saybrook	Old Saybrook
Oneco	Sterling
Orange	Orange
Oronoque	Stratford
Oxford	Oxford
Packer	Canterbury
Pawcatuck	Stonington
Pequabuck	Plymouth
Pine Meadow	New Hartford
Plainfield	Plainfield
Plainville	Plainville
Plantsville	Southington
Pleasant Valley	Barkhamsted
Plymouth	Plymouth
Pomfret	Pomfret
Pomfret Center	Pomfret
Poquetanuck	Preston
Poquonock	Windsor
Poquonock Bridge	Groton
Portland	Portland
Preston	Preston
Prospect	Prospect
Putnam	Putnam
Quaker Hill	Waterford
Quinebaug	Thompson
Redding	Redding
Redding Ridge	Redding
Ridgefield	Ridgefield
Riverside	Greenwich
Riverton	Barkhamsted
Rockfall	Middlefield
Rockville	Vernon
Rocky Hill	Rocky Hill
Rogers	Killingly
Rogers	Pomfret
Rowayton	Norwalk
Roxbury	Roxbury
Salem	Salem
Salisbury	Salisbury
Sandy Hook	Newtown
Saugatuck	Westport
Saybrook	Old Saybrook
Saybrook Point	Old Saybrook
Scotland	Scotland
Seymour	Seymour
Sharon	Sharon
Shelton	Shelton
Shepaug	Washington
Sherman	Sherman
Short Beach	Branford
Simsbury	Simsbury
Somers	Somers
Somersville	Somers
South Britain	Southbury
South Coventry	Coventry
South Glastonbury	Glastonbury
South Kent	Kent

South Killingly	Killingly
South Litchfield	Litchfield
South Lyme	Old Lyme
South Meriden	Meriden
South Norwalk	Norwalk
South Willington	Willington
South Windham	Windham
South Windsor	South Windsor
South Woodstock	Woodstock
Southbury	Southbury
Southington	Southington
Southport	Fairfield
Sprague	Sprague
Springdale	Stamford
Stafford	Stafford
Stafford Springs	Stafford
Staffordville	Stafford
Stamford	Stamford
Stepney Depot	Monroe
Sterling	Sterling
Stevenson	Monroe
Stonington	Stonington
Stony Creek	Branford
Storrs	Mansfield
Stratford	Stratford
Suffield	Suffield
Taconic	Salisbury
Taftville	Norwich
Talcottville	Vernon
Tariffville	Simsbury
Terryville	Plymouth
Thomaston	Thomaston
Thompson	Thompson
Thompsonville	Enfield
Tolland	Tolland
Torrington	Torrington
Tracey	Wallingford
Trumbull	Trumbull
Uncasville	Montville
Union	Union
Union City	Naugatuck
Unionville	Farmington
Vernon	Vernon
Versailles	Sprague
Voluntown	Voluntown
Wallingford	Wallingford
Wapping	South Windsor
Warehouse Point	East Windsor
Warren	Warren
Warrenville	Ashford
Washington	Washington
Washington Depot	Washington
Waterbury	Waterbury
Waterford	Waterford
Watertown	Watertown
Waterville	Waterbury
Wauregan	Plainfield
Weatogue	Simsbury

West Cheshire	Cheshire
West Cornwall	Cornwall
West Goshen	Goshen
West Granby	Granby
West Hartford	West Hartford
West Hartland	Hartland
West Haven	West Haven
West Mystic	Groton
West Norwalk	Norwalk
West Redding	Redding
West Simsbury	Simsbury
West Stafford	Stafford
West Suffield	Suffield
West Willington	Willington
West Woodstock	Woodstock
Westbrook	Westbrook
Westchester	East Hampton
Westfield	Middletown
Weston	Weston
Westport	Westport
Westville	New Haven
Wethersfield	Wethersfield
Whitneyville	Hamden
Willimantic	Windham
Willington	Willington
Wilson	Windsor
Wilsonville	Thompson
Wilton	Wilton
Winchester	Winchester
Winchester Center	Winchester
Windham	Windham
Windham Center	Windham
Windsor	Windsor
Windsor Locks	Windsor Locks
Windsorville	East Windsor
Winsted	Winchester
Wolcott	Wolcott
Woodbridge	Woodbridge
Woodbury	Woodbury
Woodmont	Milford
Woodstock	Woodstock
Woodstock Valley	Woodstock
Woodville	Washington
Yalesville	Wallingford
Yantic	Norwich

Greer, Leslie

From: Veyberman, Alla
Sent: Friday, February 19, 2016 5:40 PM
To: 'Kathleen Gedney'; User, OHCA; Greci, Laurie; Riggott, Kaila
Cc: Michele Volpe; Jennifer O'Donnell
Subject: RE: CON Docket Number 16-32063 (Orthopaedic & Neurosurgery Specialists, P.C., Acquisition of Magnetic Resonance Scanner) - Confirmation of Receipt of February 19, 2016 Completeness Letter

Thank you for the confirmation.

Alla

Alla Veyberman, MS
Health Care Analyst
CT Department of Public Health
Office of Health Care Access (OHCA)
Phone: 860.418.7007
Fax: 860.418.7053
Email: Alla.Veyberman@ct.gov

From: Kathleen Gedney [mailto:kgg@bvmlaw.com]
Sent: Friday, February 19, 2016 5:05 PM
To: User, OHCA <OHCA@ct.gov>; Greci, Laurie <Laurie.Greci@ct.gov>; Veyberman, Alla <Alla.Veyberman@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>
Cc: Michele Volpe <michelemvolpe@aol.com>; Jennifer O'Donnell <jlo@bvmlaw.com>
Subject: CON Docket Number 16-32063 (Orthopaedic & Neurosurgery Specialists, P.C., Acquisition of Magnetic Resonance Scanner) - Confirmation of Receipt of February 19, 2016 Completeness Letter

All:

In accordance with OHCA's request to confirm delivery of the Completeness Letter dated February 19, 2016 regarding Certificate of Need Application Docket Number 16-32063 (Orthopaedic & Neurosurgery Specialists, P.C., Acquisition of Magnetic Resonance Scanner), we hereby acknowledge its receipt.

Please note that Michele Volpe's email was incorrect on OHCA's Completeness Letter. The correct email address is michelemvolpe@aol.com.

Thank you,

Kathleen Gedney-Tommaso

Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Wednesday, March 30, 2016 10:49 AM
To: User, OHCA; laurie.greci@ct.gov; Veyberman, Alla; Riggott, Kaila
Cc: Michelemvolpe@aol.com; Jennifer O'Donnell
Subject: Docket No. 16-32063-CON - Completeness Response
Attachments: ONS - Completeness Response - Docket No. 16-32063-CON (3.29.16).pdf; ONS - Completeness Response - Docket No. 16-32063-CON (3.29.16).docx; Attachment K-ONS - Completeness Response - Docket No. 16-32063-CON (3.29.16).xlsx; Attachment K -ONS - Completeness Response - Docket No. 16-32063-CON (3.29.16).pdf

Good Morning All:

Attached please find Orthopaedic & Neurosurgery Specialists, P.C.'s response to OHCA's Certificate of Need completeness letter dated February 19, 2016 in connection to Docket No. 16-32063-CON. We have attached a Word and PDF copy of the responses as well as an Excel and PDF copy of the revised Financial Worksheet.

Please do not hesitate to contact either Michele Volpe (203-777-6995) or I (203-859-6238) with any questions.

Regards,

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
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On February 19, 2016, Orthopaedic & Neurosurgery Specialists, P.C., ("ONS" or the "Applicant") received correspondence from the Office of Health Care Access ("OHCA") requesting additional information regarding the Applicant's Certificate of Need application proposal for the acquisition of a MRI unit (Docket No. 16-32063-CON). The Applicant's responses are provided below:

1. Page 14 of the application states that the number of practice physicians increased from 17 in 2012 to 23 in 2015. Provide the number of physicians, by specialty, for these years.

Year	Number of Physicians	Specialty	Month each new physician started
2012	19	Dr. Mark Vitale- orthopedics Dr. Tamar Kessel – physiatrist	Sept 1, 2012 Sept 1, 2012
2013	21	Dr. Demetris Delos – orthopedics Dr. Sean Penden - orthopedics	Sept 1, 2013 Sept 15, 2013
2014	21		
2015	23	Dr. Marc Kowalsky - orthopedics Dr. David Wei – orthopedics	March 15, 2015 Sept 21, 2015

2. Page 17 of the application states that the existing scanner is operating over capacity and has been for several years. Provide additional information, methodology and documentation to support this statement. Include statistics with supporting documentation. Explain how the 85% utilization of the existing MRI scanner was determined.

The Existing Scanner's utilization percentage is a calculation based on the number of slots utilized in a year divided by the number of slots available. A slot time is 40 minutes. The number of slots available is based on the capacity of the machine during the hours ONS is open (adjusted for snow emergencies, service and holidays). Currently, ONS offers approximately 21 slots each day Monday through Friday, 15 slots on Saturdays and 8 slots on Sundays. As previously stated, ONS has had to add additional business hours to accommodate patient need. Sunday hours started in 2014.

Slots are lost each year due to service, weather and holidays. In 2015, ONS lost 45 slots to service, 44 slots to weather and 159 slots to holidays. The total 2015 actual slots available was approximately 6,300 and the number of slots used was 5,813. This resulted in a 92%

utilization. In 2014, ONS lost 42 slots to service, 50 slots to weather and 141 slots to holidays. In 2014, the total number of slots available was approximately 6,276 and the number of slots used was 5,719. This resulted in a 91% utilization.

Please note that certain MRI scans requiring a longer scan time require the use of two or more slots. Therefore, the number of slots utilized is not equal to the volume of scans performed.

The 85% utilization standard derives from OHCA's Statewide Health Care Facilities and Services Plan at page 61.

3. Revise Table 8 on pages 26-27 of the application by providing a breakdown of utilization by town, for FY 2015, the most recently completed fiscal year. Include on the incorporated town names (see attached).

Please see revised Table 8 attached hereto as <u>Attachment H</u>.

4. Resubmit Attachment F on page 75 of the Application to reflect 2015 actual information.

Please see revised Attachment F attached hereto as <u>Attachment I</u>.

5. Update Table B on page 81 of the Application to include action FY 2015 utilization.

Please see updated Table B attached hereto as <u>Attachment J</u>.

6. In reference to the Financial Worksheet submitted on page 77, provide the following:
    a. Projections for FY 2016 – FY 2019, and
    b. Replace FY 2014 Actual Results (Column 1) with the actual twelve-month FY 2015 information.

Please see revised Financial Worksheet attached hereto as <u>Attachment K</u>.

7. Does the Applicant provide services to indigent and/or Medicaid recipients? If indigent and/or Medicaid recipients require services, how will the treatment of these patients be handled?

The Applicant does not participate with Medicaid. The Applicant is dedicated to ensuring that thorough follow up care occurs with its patients regardless of financial status. On a case by case basis, the Applicant works with patients who may be unable to pay all or part of their bills. The medical services for such patients are treated in the same manner as all ONS patients. For example, if a colleague requests that ONS see a patient who has a financial hardship, ONS will try and accommodate that patient and that patient's financial needs.

8. Confirm that the proposed scanner will be located in the Greenwich office.

The proposed scanner will be located in the Greenwich office.

9. Report the month that the proposed scanner is expected to become operational in FY 2017.

The exact month the Proposed Scanner is expected to become operational in FY 2017 cannot be determined as it is contingent on the date of OHCA approval.

10. Explain payor "NY-Gov" listed on page 33 of the Application.

"NY Gov" are patients who are State employees covered by New York state's United/Oxford insurance contract. This is a commercial insurer providing insurance to state employees.

Attachment H
Updated Table 8

TABLE 8

UTILIZATION BY TOWN

Town	Utilization FY 2015
Connecticut Towns:	
Greenwich	1,647
Stamford	600
New Canaan	282
Darien	261
Norwalk	228
Wilton	114
Westport	109
Weston	59
Fairfield	55
Ridgefield	44
Redding	15
Danbury	10
Bridgeport	9
Brookfield	8
Stratford	8
Newtown	8
Monroe	7
Easton	6
Milford	5
Bethel	4
East Haven	4

New Fairfield	4
Orange	4
Oxford	4
New Milford	3
Shelton	3
Cheshire	2
Darien	2
Derby	2
Hartford	2
New Haven	2
Plainville	2
Southbury	2
Avon	1
Killingly	1
Farmington	1
Lisbon	1
Washington	1
East Lyme	1
Norwich	1
Seymour	1
Sherman	1
Vernon	1
Wethersfield	1
Connecticut Total	**3,526**
Other Towns and Cities outside of Connecticut	1,736
TOTAL	**5,262**

Attachment I
Revised Attachment F

ONS MRI: Pro-Forma P&L	
2015 Actual	
	2015
Volume	**5,262**
Revenue	
Collections	**$ 4,591,328**
Expenses:	
Salaries	
Employee Salaries	368,721
Employee Benefits	81,113
Total Employee Expense	**449,834**
Other Expenses:	
Radiologists Fee *(@$95/Read)*	499,890
Billing Fees *(6.2% of Collections)*	284,662
Occupancy Fee *(Rent 10% of total)*	119,016
MRI Machine Lease -*Siemens*	186,143
Other Equipment -Other IS	203,172
MRI Supplies	46,750
Transcription	29,401
Licenses & Permits	975
Other Misc	2,200
Total Other Expenses	**1,372,209**
Total Expenses	**1,822,044**
Net Gain/Loss	**$ 2,769,284**
% Margin	60%

Attachment J
Updated Table B

TABLE B

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY EQUIPMENT UNIT

Equipment***	Actual Volume (Last 3 Completed FYs) [1]				**CFY Volume***	**Projected Volume (First 3 Full Operational FYs)****		
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[2]	FY 2017	FY 2018	FY 2019
Existing MRI	4,565	4,800	5,189	5,262	5,474[3]	3,338	3,471	3,515
Proposed MRI	-	-	-		-	3,337	3,471	3,514
Total	**4,565**	**4,800**	**5,189**	**5,262**	**5,474**	**6,675**	**6,942**	**7,029**

[1] The Applicant's Fiscal Year is the Calendar Year.
[2] Proposed 2016 Volume. FY 2016 represents Existing MRI only; Proposed MRI will not be in service until FY 2017.
[3] Due to CON approval time and build out time, the Proposed MRI is not anticipated to be in service until FY 2017.

Attachment K
Revised Financial Worksheet

NON-PROFIT

Applicant:

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:

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY Projected W/out CON	(3) FY Projected Incremental	(4) FY Projected With CON	(5) FY Projected W/out CON	(6) FY Projected Incremental	(7) FY Projected With CON	(8) FY Projected W/out CON	(9) FY Projected Incremental	(10) FY Projected With CON	(11) FY Projected W/out CON	(12) FY Projected Incremental	(13) FY Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue				$0			$0			$0			$0
2	Less: Allowances				$0			$0			$0			$0
3	Less: Charity Care				$0			$0			$0			$0
4	Less: Other Deductions				$0			$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare				$0			$0			$0			$0
6	Medicaid				$0			$0			$0			$0
7	CHAMPUS & TriCare				$0			$0			$0			$0
8	Other				$0			$0			$0			$0
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers				$0			$0			$0			$0
10	Uninsured				$0			$0			$0			$0
11	Self Pay				$0			$0			$0			$0
12	Workers Compensation				$0			$0			$0			$0
13	Other				$0			$0			$0			$0
	Total Non-Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts				**$0**			**$0**			**$0**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue				**$0**			**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions				**$0**			**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages				$0			$0			$0			$0
2	Fringe Benefits				$0			$0			$0			$0
3	Physicians Fees				$0			$0			$0			$0
4	Supplies and Drugs				$0			$0			$0			$0
5	Depreciation and Amortization				$0			$0			$0			$0
6	Provision for Bad Debts-Other[b]				$0			$0			$0			$0
7	Interest Expense				$0			$0			$0			$0
8	Malpractice Insurance Cost				$0			$0			$0			$0
9	Lease Expense				$0			$0			$0			$0
10	Other Operating Expenses				$0			$0			$0			$0
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	NON-OPERATING REVENUE				**$0**			**$0**			**$0**			**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

NON-PROFIT

Applicant:

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:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2014	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	Principal Payments				$0			$0			$0			$0
C.	**PROFITABILITY SUMMARY**													
1	Hospital 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%
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%
3	Hospital Total 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%
D.	**FTEs**				0			0			0			0
E.	**VOLUME STATISTICS**[c]													
1	Inpatient Discharges				0			0			0			0
2	Outpatient Visits				0			0			0			0
	TOTAL VOLUME	0	0	0	0	0	0	0	0	0	0	0	0	0

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]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.

[c]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.

FOR-PROFIT

Applicant Name: Orthopeadic & Neurosurgery Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics

Financial Worksheet (B) without, incremental to and with the CON proposal in the following reporting format:

		(2)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2018**	**FY 2018**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**										
1	Total Gross Patient Revenue	$4,591,328	$4,496,879	$0	$4,496,879	$4,510,370	$1,584,305	$6,094,675	$4,523,901	$1,814,561	$6,338,462
2	Less: Allowances	$0		$0	$0			$0			$0
3	Less: Charity Care	$0		$0	$0			$0			$0
4	Less: Other Deductions	$0		$0	$0			$0			$0
	Net Patient Service Revenue	**$4,591,328**	**$4,496,879**	$0	**$4,496,879**	**$4,510,370**	**$1,584,305**	**$6,094,675**	**$4,523,901**	**$1,814,561**	**$6,338,462**
5	Medicare	$0		$0	$0			$0			$0
6	Medicaid	$0		$0	$0			$0			$0
7	CHAMPUS & TriCare	$0		$0	$0			$0			$0
8	Other	$0		$0	$0			$0			$0
	Total Government	**$0**	**$0**	$0	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers	$0		$0	$0			$0			$0
10	Uninsured	$0		$0	$0			$0			$0
11	Self Pay	$0		$0	$0			$0			$0
12	Workers Compensation	$0		$0	$0			$0			$0
13	Other	$0		$0	$0			$0			$0
	Total Non-Government	**$0**	**$0**	$0	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts	$0	$0	$0	**$0**	$0	$0	**$0**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$4,591,328**	**$4,496,879**	**$0**	**$4,496,879**	**$4,510,370**	**$1,584,305**	**$6,094,675**	**$4,523,901**	**$1,814,561**	**$6,338,462**
15	Other Operating Revenue	$0	$0	$0	**$0**	$0	$0	**$0**			**$0**
17	Net Assets Released from Restrictions	$0	$0	$0	**$0**	$0	$0	**$0**			**$0**
	TOTAL OPERATING REVENUE	**$4,591,328**	**$4,496,879**	**$0**	**$4,496,879**	**$4,510,370**	**$1,584,305**	**$6,094,675**	**$4,523,901**	**$1,814,561**	**$6,338,462**
B.	**OPERATING EXPENSES**										
1	Salaries and Wages	$368,721	$379,757	$0	$379,757	$391,150	$391,150	$782,299	$402,884	$402,884	$805,768
2	Fringe Benefits	$81,113	$83,547	$0	$83,547	$86,053	$86,053	$172,107	$88,635	$88,635	$177,270
3	Physicians Fees	$499,890	$499,700	$0	$499,700	$501,220	$132,905	$634,125	$502,645	$156,845	$659,490
4	Supplies and Drugs	$46,750	$45,835	$0	$45,835	$45,926	$12,177.91	$58,104	$46,064	$14,373.74	$60,438
5	Depreciation and Amortization	$0	$0	$0	$0		$0	$0			$0
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0		$0	$0			$0
7	Interest Expense	$0	$0	$0	$0		$0	$0			$0
8	Malpractice Insurance Cost	$0	$0	$0	$0		$0	$0			$0
9	Lease Expense	$186,143	$194,400	$0	$194,400	$204,120	$289,683	$493,803	$214,326	$289,683	$504,009
10	Other Operating Expenses	$639,426	$637,486	$0	$637,486	$639,525	$359,825	$999,349	$648,643	$382,379	$1,031,022
	TOTAL OPERATING EXPENSES	**$1,822,043**	**$1,840,725**	**$0**	**$1,840,725**	**$1,867,994**	**$1,271,794**	**$3,139,788**	**$1,903,197**	**$1,334,800**	**$3,237,997**
	INCOME/(LOSS) FROM OPERATIONS	**$2,769,285**	**$2,656,154**	**$0**	**$2,656,154**	**$2,642,375**	**$312,512**	**$2,954,887**	**$2,620,704**	**$479,761**	**$3,100,465**
	NON-OPERATING INCOME	**$0**			**$0**			**$0**			**$0**
	Income before provision for income taxes	**$2,769,285**	**$2,656,154**	**$0**	**$2,656,154**	**$2,642,375**	**$312,512**	**$2,954,887**	**$2,620,704**	**$479,761**	**$3,100,465**
	Provision for income taxes[c]	$0			**$0**			**$0**			**$0**
	NET INCOME	**$2,769,285**	**$2,656,154**	**$0**	**$2,656,154**	**$2,642,375**	**$312,512**	**$2,954,887**	**$2,620,704**	**$479,761**	**$3,100,465**
C.	**Retained Earnings, beginning of year**	**$0**			**$0**			**$0**			**$0**
	Retained Earnings, end of year	**$0**			**$0**			**$0**			**$0**
	Principal Payments	$0			**$0**			**$0**			**$0**
D.	**PROFITABILITY SUMMARY**										
1	Hospital Operating Margin	**60.3%**	**59.1%**	**0.0%**	**59.1%**	**58.6%**	**19.7%**	**48.5%**	**57.9%**	**26.4%**	**48.9%**
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%**
3	Hospital Total Margin	**60.3%**	**59.1%**	**0.0%**	**59.1%**	**58.6%**	**19.7%**	**48.5%**	**57.9%**	**26.4%**	**48.9%**
E.	**FTEs**	**2**	**2**		**2**	**2**	**2**	**4**	**2**	**2**	**4**
F.	**VOLUME STATISTICS[d]**										
1	Inpatient Discharges	0	0	0	**0**	0	0	**0**	0	0	**0**
2	Outpatient Visits	**5,262**	5,260	0	**5,260**	5,276	1,399	**6,675**	5,291	1,651	**6,942**
	TOTAL VOLUME	**5,262**	**5,260**	**0**	5,260	**5,276**	**1,399**	6,675	**5,291**	**1,651**	6,942

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]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.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]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.

FINANCIAL WORKSHEET DESCRIPTIONS

Financial Worsheet:

C– Sale of Non-Profit Hospital to For-Profit Entity

Cells Legend:

	Indicates input cell
	Indicates calculated cell

Columns 1,2,5,8 & 11: **Add Non-Profit data (without CON)**

Columns 3,4,6,7,9,10,12 & 13: **Add For-Profit data (with CON & incremental to CON)**

Sale of Non-Profit Hosptal to For-Profit Entity

Name Entity:

Financial Worsheet (C):

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:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue				$0			$0			$0			$0
2	Less: Allowances				$0			$0			$0			$0
3	Less: Charity Care				$0			$0			$0			$0
4	Less: Other Deductions				$0			$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare				$0			$0			$0			$0
6	Medicaid				$0			$0			$0			$0
7	CHAMPUS & TriCare				$0			$0			$0			$0
8	Other				$0			$0			$0			$0
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers				$0			$0			$0			$0
10	Uninsured				$0			$0			$0			$0
11	Self Pay				$0			$0			$0			$0
12	Workers Compensation				$0			$0			$0			$0
13	Other				$0			$0			$0			$0
	Total Non-Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts				**$0**			**$0**			**$0**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue				**$0**			**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions				**$0**			**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages				$0			$0			$0			$0
2	Fringe Benefits				$0			$0			$0			$0
3	Physicians Fees				$0			$0			$0			$0
4	Supplies and Drugs				$0			$0			$0			$0
5	Depreciation and Amortization				$0			$0			$0			$0
6	Provision for Bad Debts-Other[b]				$0			$0			$0			$0
7	Interest Expense				$0			$0			$0			$0
8	Malpractice Insurance Cost				$0			$0			$0			$0
9	Lease Expense				$0			$0			$0			$0
10	Other Operating Expenses				$0			$0			$0			$0
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Provision for Income Taxes[c]				**$0**			**$0**			**$0**			**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME / (LOSS) FROM OPERATIONS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Sale of Non-Profit Hosptal to For-Profit Entity

Name Entity:

Financial Worsheet (C):

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:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	NON-OPERATING INCOME / REVENUE				$0			$0			$0			$0
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C.	**Retained Earnings/ Net Assets, beginning of year**				$0			$0			$0			$0
	Retained Earnings / Net Assets, end of year				$0			$0			$0			$0
	Principal Payments				$0			$0			$0			$0
D.	**PROFITABILITY SUMMARY**													
1	Hospital 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%
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%
3	Hospital Total 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%
E.	**FTEs**				0			0			0			0
F.	**VOLUME STATISTICS**[d]													
1	Inpatient Discharges				0			0			0			0
2	Outpatient Visits				0			0			0			0
	TOTAL VOLUME	0	0	0	0	0	0	0	0	0	0	0	0	0

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]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.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]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.

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, April 29, 2016 4:10 PM
To: Greer, Leslie
Cc: Veyberman, Alla
Subject: FW: Second Completeness Letter, Docket Number: 16-32063-CON
Attachments: 16-32063-CON 2nd CL.docx

Please add to the record.

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: Lazarus, Steven
Sent: Friday, April 29, 2016 4:10 PM
To: Michele Volpe (mmv@bvmlaw.com)
Cc: Riggott, Kaila; Veyberman, Alla
Subject: Second Completeness Letter, Docket Number: 16-32063-CON

Dear Attorney Volpe:

Please see the attached 2nd completeness questions for Docket No. 16-32063 CON. Please acknowledging receipt

Thank you.

Alla

Alla Veyberman, MS
Health Care Analyst
CT Department of Public Health
Office of Health Care Access (OHCA)
Phone: 860.418.7007
Fax: 860.418.7053

Email: Alla.Veyberman@ct.gov

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

April 29, 2016

Via Email Only

michelevolpe@aol.com
Attorney Michele M. Volpe
Attorney, Bershtein, Volpe & McKeon, P.C.
105 Court Street
New Haven, CT 06511

RE: Certificate of Need Application Docket Number: 16-32063-CON
Orthopaedic & Neurosurgery Specialists, P. C.
Acquisition of Magnetic Resonance Imaging Scanner
Certificate of Need Completeness Letter

Dear Attorney Volpe:

On March 30, 2016, OHCA received responses to the first completeness letter in the above referenced matter. 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 as an attachment to a responding email. ***Please email your responses to each of the following email addresses: OHCA@ct.gov; alla.veyberman@ct.gov; and kaila.riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 93** and reference "**Docket Number: 16-32063-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
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 this request was transmitted. Therefore, please provide your written responses to OHCA no later than **Tuesday, June 28, 2016**, otherwise your application will be automatically considered withdrawn.

1. Provide the volume of new patients associated with each of the new physicians (increasing from 17 in 2012 to 23 in 2015) listed in the table provided in response to completeness question 1.

2. Provide an explanation of the impact of these additional physicians on volume projections provided in Table 6 on application page 32 and the assumptions used in the developing those projections.

3. Similarly, as indicated in the response to question e on application page 20, provide an explanation of the impact of the Applicant's "continually expanding its business to include new physicians" on Table 6 volume projections and the assumptions used in developing those projections.

If you have any questions concerning this letter, please feel free to me at (860) 418-7007.

Sincerely,
Alla Veyberman
Healthcare Analyst

Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Wednesday, May 11, 2016 5:02 PM
To: User, OHCA; Veyberman, Alla; Riggott, Kaila
Cc: Michele Volpe; Jennifer O'Donnell
Subject: Docket No. 16-32063-CON - Completeness Response
Attachments: Response to 4.29.16 Completeness Questions (BVM 5.11.16).pdf; Response to 4.29.16 Completeness Questions (BVM 5.11.16).docx

Good Afternoon:

Attached please find Orthopaedic & Neurosurgery Specialists, P.C.'s response to OHCA's Certificate of Need completeness letter dated April 29, 2016 in connection to Docket No. 16-32063-CON. We have attached a Word and PDF copy of the responses.

Please do not hesitate to contact either Michele Volpe (203-777-6995) or I (203-859-6238) with any questions.

Regards,

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

On April 29, 2016, Orthopaedic & Neurosurgery Specialists, P.C., ("ONS" or the "Applicant" or the "Practice") received correspondence from the Office of Health Care Access ("OHCA") requesting additional information regarding the Applicant's Certificate of Need application proposal for the acquisition of a MRI unit (Docket No. 16-32063-CON). The Applicant's responses are provided below:

1. Provide the volume of new patients associated with each of the new physicians (increasing from 17 in 2012 to 23 in 2015) listed in the table provided in response to completeness question 1.

New patient volume is not tracked by physician. However, patient visit volume is tracked by the practice as a whole. See below.

2012	42,082
2013	46,492
2014	49,370
2015	51,597
2016	18,888 (through April 2016) 56,664 (annualized)

2. Provide an explanation of the impact of these additional physicians on volume projections provided in Table 6 on application page 32 and the assumptions used in the developing those projections.

The impact of additional physicians on volume projections is based on the Applicant's continually expanding Practice. Expanding the Practice by adding new physicians increases its patient volume and therefore increases demand for MRI scans. Additionally, new physicians take years to ramp up to full patient rosters so it is anticipated that the physicians added in recent years will continue to increase patient load in the years to come.

The assumptions used in Table 6 are based on an average growth of approximately one (1) to two (2) additional physicians per year. From 2012 to 2015, ONS added approximately one (1) – two (2) physicians per year. ONS assumes a continued growth of one (1) to two (2) physicians per year for 2016 (approximately 23 physicians), 2017 (approximately 25 physicians), 2018 (approximately 26 physicians), and 2019 (approximately 27 physicians). In 2012, the average number of scans per physician was 267. With respect to years 2017-2019, a rate of 267 scans per physician is assumed.[1]

[1] With respect to the anticipated volume in 2016, because the New Scanner will not be in service in 2016, ONS does not have the current capacity to accommodate all physician needs and is limited by the capacity of its current scanner.

3. Similarly, as indicated in the response to question e on application page 20, provide an explanation of the impact of the Applicant's "continually expanding its business to include new physicians" on Table 6 volume projections and the assumptions used in developing those projections.

The impact of "continually expanding business to include new physicians" increases its patient volume and therefore increases demand for MRI scans. The assumptions used in Table 6 are the same as indicated in the response to Question 2 above.

Greer, Leslie

From: Lazarus, Steven
Sent: Monday, June 13, 2016 11:04 AM
To: Michele Volpe (mmv@bvmlaw.com)
Cc: Veyberman, Alla; Riggott, Kaila; Greer, Leslie
Subject: Docket Number: 16-32063-CON Deem Complete Letter
Attachments: 16-32063-CON Deem Complete.pdf

Good Morning Attorney Volpe,

Please see the attached letter deeming the CON application Complete. If you have any questions regarding this correspondence, please contact Alla Veyberman (alla.veyberman@ct.gov) or myself.

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 13, 2016

Via Email Only

michelevolpe@aol.com
Attorney Michele M. Volpe
Attorney, Bershtein, Volpe & McKeon, P.C.
105 Court Street
New Haven, CT 06511

RE: Certificate of Need Application Docket Number: 16-32063-CON
Orthopaedic & Neurosurgery Specialists, P. C.
Acquisition of Magnetic Resonance Imaging Scanner
Certificate of Need Completeness Letter

Dear Ms. Volpe:

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 June 10, 2016.

If you have any questions concerning this letter, please feel free to me at (860) 418-7007.

Sincerely,

Alla Veyberman
Healthcare Analyst

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
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Hartford, Connecticut 06134-0308
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Affirmative Action/Equal Opportunity Employer

Selectmen's Office

www.essexct.gov

Norman M. Needleman, First Selectman
Email: nneedleman@essexct.gov
Board of Selectmen:
Stacia R. Libby
Bruce M. Glowac

Essex Town Hall
29 West Avenue
Essex. Connecticut 06426
Telephone: 860-767-4340
Fax: 860-767-8509

June 15, 2016

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134=0308

Re: Certificate of Need Application for One Additional 1.5 Tesla MRI filed by Connecticut Orthopaedic Specialists, P.C.

Dear Ms. Martone,

I am writing in support of the application of Connecticut Orthopaedic Specialists, P.C. ("COS") to allow them to purchase a mobile 1.5 Tesla magnetic resonance imaging unit ("MRI"). Currently, COS has two MRI units: one in their surgery center in Branford, and the other in their Hamden office. However, COS has grown over the last few years with Shoreline Orthopedics & Sports Medicine, located here in Essex having recently joined forces with Connecticut Orthopaedic Specialists For many years the surgeons of Shoreline Orthopedics have been a valuable contributor to the Essex community. The merger of Shoreline Orthopedics with COS has allowed private, personalized orthopedic services to remain a vital piece of this region's healthcare delivery system.

I am told that COS is a leader in reimbursement reform and has established a number of bundled payment programs with major payers in the State. Due to the growth of its practice, especially in the Essex region, COS needs an additional MRI unit in order to continue to keep the quality of care at its best and to allow the members of our community to receive diagnostic services close to home. There are no other MRI units in our town and the MRI service in Madison, CT is no longer available to our residents.

I strongly urge the Office of Health Care Access to approve this application, which I believe will be a great enhancement to the healthcare available to residents of Essex.

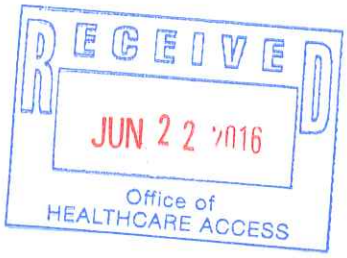
Sincerely,

Norman M. Needleman
First Selectman

Fax Message

Advanced Radiology Consultants,

Recipient:	*Deputy Commissioner Brancifort*	Pages:	*8*
Fax Number:	*860/418-7053*	Date / Time:	*06/22/2016 Wed / 13:14*
Subject:	*Docket No. 16-32063-CON*		



Advanced Radiology

◆ Advanced Radiology MRI Centers
◆ Advanced Interventional Radiology (AIR) Center
◆ Advanced Women's Imaging Center (AWIC)

June 21, 2016

Hon. Janet Brancifort, M.P.H.
Deputy Commissioner
Office of Health Care Access Division
Department of Public Health
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: Orthopaedic & Neurosurgery Specialists, P.C.
Acquisition of Magnetic Resonance Imaging Scanner
Docket No. 16-32063-CON

Dear Deputy Commissioner Brancifort:

Advanced Radiology Consultants, LLC ("Advanced Radiology") is a private radiology practice with office locations throughout Fairfield County, including an office at 1315 Washington Boulevard in Stamford. Advanced Radiology provides a full range of diagnostic imaging and interventional radiology services. The practice offers Magnetic Resonance Imaging ("MRI") at each of its locations. MRI services are provided at the practice's Stamford office with a 1.5 Tesla unit and we have filed a Certificate of Need ("CON") Application for the acquisition of a 3.0 Tesla unit for this location as well. Advanced Radiology provides services to all patients regardless of their ability to pay. The practice participates in the Medicaid program and serves many indigent patients in Stamford and elsewhere.

We are writing to request that OHCA deny the CON Application filed by Orthopaedic & Neurosurgery Specialists ("ONS") for the acquisition of a second MRI unit for use within its orthopedic practice (Docket No. 16-32063-CON). ONS has failed to meet several of the statutory criteria for issuance of a CON. Specifically, ONS has failed to establish that its proposal will improve the accessibility of services for Medicaid recipients and indigent persons (Conn. Gen. Stat. §19a-639(5)); rather ONS fails to provide access to MRI services for Medicaid recipients and indigent persons, without good cause for doing so (Conn. Gen. Stat. §19a-639 (10)). Its past and proposed practice is to exclude Medicaid recipients and many indigent persons from access to its MRI units (Conn. Gen. Stat. §19a-639(6)). ONS's failure to provide access for these patients is also inconsistent with the Statewide Healthcare Facilities and Services Plan ("SHP") mandate that a provider seeking to acquire an MRI unit not deny MRI services to any individual based upon the ability to pay or source of payment, including uninsured,

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underinsured and Medicaid patients (SHP, p. 62). In addition, ONS's proposal will result in the unnecessary duplication of existing healthcare services, which will adversely impact providers such as Advanced Radiology (Conn. Gen. Stat. §19a-639(9)).

Access for Medicaid Recipients & Indigent Persons

ONS does not participate with the Medicaid program (CON Application, p. 86). Based upon historic payer mix data provided to OHCA, the practice performed no MRI scans on Connecticut Medicaid beneficiaries in FY 2015 (CON Application, p. 33).[1] In addition, the practice's uninsured and self-pay MRI scans make up less than 1% of its MRI volume (CON Application, p. 33).[2] Projections for the existing and proposed second MRI unit show no change in this regard, with 0% Connecticut Medicaid and less than 1% uninsured and self-pay exams projected through 2019 (CON Application, p. 33). When asked to explain how Medicaid recipients and indigent persons will be handled by the practice, ONS reiterated that it does not participate in the Medicaid program (CON Application, p. 86). Further, ONS claims that it will "try and accommodate" patients with a financial hardships if requested by a colleague (CON Application, p. 86). Based on the practice's historically low percentages of uninsured and self-pay MRI scans (16 of 5,244 in FY 2015), this does not appear to happen often.

The CON statutes require that OHCA consider how a CON proposal impacts access to and the quality of care for Medicaid recipients and indigent persons. Section 19a-639(5) of the Connecticut General Statues requires an applicant to demonstrate how its proposal "will improve the quality, accessibility and cost effectiveness of healthcare delivery in the region, including … provision of … access to services for Medicaid recipients and indigent persons …" Similarly, Section 19a-639(6) requires OHCA to consider the applicant's "past and proposed provision of health care services to relevant patient populations and payer mix, including … access to services by Medicaid recipients and indigent persons." Section 19a-639(10) of the General Statutes states that an applicant who has "failed to provide" services to Medicaid recipients or indigent persons must "demonstrate 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." In addition, Section 19a-639(2) requires OHCA to consider the relationship of a CON proposal to the SHP and, as previously mentioned, the SHP prohibits a provider of MRI services from denying patients access to MRI based upon ability to pay or payer source (SHP, p. 62).

---

[1] ONS included "NY Gov" as a governmental payer in its initial CON submission (CON Application, p. 33). However when asked to clarify, ONS acknowledged that this is in fact commercial insurance provided to New York state employees and not state medical assistance provided to New York residents (CON Application, p. 87).

[2] Projected Medicaid and uninsured/self-pay percentages were similar in 2008, when ONS received approval to acquire its first MRI scanner (Docket No. 08-31120-CON, Final Decision, FF 20). However, at that time there were no specific CON decision criteria or SHP requirements around provision of access for these types of patients.

There is no question that ONS is denying Medicaid recipients access to its current MRI scanner and that it will continue to do the same if a second scanner is approved. Since the practice began providing MRI services in 2008, it does not appear that they have provided a single MRI scan to a Medicaid recipient (CON Application, p. 33; *see also* Docket No. 08-31120-CON, FF 20). No scans of Medicaid recipients are projected going forward.[3] In addition, only 16 of 5,244 MRI scans performed in FY 2015 were of uninsured or self-pay patients and the same percentage is projected through FY 2019 (CON Application, p. 33). Based on the foregoing, ONS's proposal does little, if anything, to improve the quality, accessibility or cost-effectiveness of care for Medicaid recipients and indigent persons. In fact, as discussed in greater detail below, it will adversely impact the area providers who *do* serve these patients. Moreover, ONS has not shown "good cause" for its failure to provide access to MRI services for Medicaid recipients and other individuals without ability to pay. It likely has to do with the low rates of reimbursement, which according to the CON statutes is not good cause to exclude these patients. Not to mention the SHP criteria – which represent a collaborative effort among OHCA and representatives of the healthcare industry in Connecticut – that expressly prohibit a provider requesting CON approval to acquire an MRI unit from denying services to Medicaid recipients or anyone based on ability to pay.

The fact that ONS does not care for Medicaid recipients or indigent persons in any appreciable numbers has a direct adverse impact on existing providers like Advanced Radiology. Because ONS does not treat Medicaid recipients in its practice, those patients are cared for by other physicians and referred to Advanced Radiology and local hospitals for MRI scans. Medicaid reimburses far less for MRI services than most commercial insurance plans. For example, at Advanced Radiology the average commercial insurance reimbursement for an MRI scan is more than twice what Medicaid pays for the same exam. Medicaid recipients accounted for 7.18% of all MRI scans at Advanced Radiology in FY 2015, and thanks to the Affordable Care Act ("ACA") Medicaid coverage in Connecticut has increased and will continue to increase in coming years. Uninsured/self-pay patients accounted for 3.09% of all MRI scan at Advanced Radiology in FY 2015. Combined these patients accounted for 10.26% of all MRI scans performed at Advanced Radiology in FY 2015, as compared with virtually none of ONS's MRI scans during the same time period. Note also that Advanced Radiology does not charge patients a facility fee, making it as cost-effective as ONS in this regard.

The number of Medicaid beneficiaries in the service area is expected to grow significantly in coming years due to ACA expansion efforts. Advanced Radiology will continue to accept these and other patients and, in fact, the practice is looking to acquire a second MRI

[3] Note that some individuals who will be covered by Medicaid in the coming years are now or were formally commercially insured. Some may have been patients of ONS in the past. Because ONS will not care for these individuals going forward, it is possible that the practice's MRI projections are overstated.

unit to allow it to serve an existing and growing patient base in the greater Stamford area. As discussed below, ONS's proposal to acquire an additional MRI unit will result in the loss of commercially insured scan volume at Advanced Radiology, which will further skew the practice's payer mix towards governmental payers that reimburse at far lower rates. As MRI payer mix shifts, it will threaten the viability of Advanced Radiology as a whole because the lion's share of the practice's profit margin comes from MRI services. This would compromise the practice's ability to provide a full range of imaging services to all patients, including the Medicaid and indigent patients that ONS rejects.

Unnecessary Duplication of Services & Adverse Impact on Existing Providers

The ONS Greenwich office and Advanced Radiology's Stamford office have largely overlapping service areas. ONS reports its Connecticut primary service area as Greenwich, Stamford, Darien, New Canaan, and Wilton (CON Application, p. 30). They also report a significant number of MRI scan on patients residing in Norwalk (CON Application, p. 88). The primary service area of the Stamford office of Advanced Radiology includes Stamford, Norwalk, Darien, New Canaan, and Greenwich.

Advanced Radiology receives referrals from ONS physicians for MRI scans that, for the most part, are performed at the practice's Stamford office. In FY 2015, ONS physicians referred 79 MRI scans to Advanced Radiology and our practice was reimbursed approximately $55,000 in connection with these scans. In the first quarter of FY 2016, ONS referred 20 MRI scans to Advanced Radiology.

Without a doubt, ONS's volume projections shows that the practice intends to take back a significant percentage of the MRI scans that its physicians refer to Advanced Radiology and other providers.[4] Although ONS claims that the growth it projects is a result of the addition of physicians to the practice, the numbers simply do not add up. Specifically, ONS has not accounted for a projected 22% increase in MRI scan volume between FY 2016 and FY 2017 (1,201 scans), the first year of operation of the proposed second unit (CON Application, p. 91).

Since FY 2012, ONS has seen growth in MRI scan volume of approximately 230 scans or 5% annually (CON Application, p. 91). As the table below demonstrates, even with the addition of 6 physicians between FYs 2012 and 2015, MRI scan volume grew by only 15% during this time (CON Application, pp. 85 & 91). Annually, MRI volume growth has not exceeded 8.1% and was as low as 1.4% between FY 2014 and FY 2015 (CON Application, p. 91).

[4] In the footnote on page 94 of the CON Application ONS concedes that it does not have the capacity to accommodate all of its physicians' MRI needs with a single scanner. This suggests that, if a second scanner is approved, ONS will have the capacity and will cease to refer cases to providers like Advanced Radiology.

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Number of Scans	4,565	4,800	5,189	5,262	5,474
Percent Increase Over Prior Year	--	**5.1%**	**8.1%**	**1.4%**	**4.0%**

When asked to explain how historic and anticipated future physician recruitment will impact MRI scan volume, ONS's responses was less than clear. It references a "per physician" scan volume of 267 scans based on FY 2012 data (CON Application, p. 94). However, this does not comport with the information provided by ONS in its completeness submissions. The table below shows lower scan-per-physician volume in FY 2012 and subsequent years (CON Application, pp. 85, 91 & 94).

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Number of Scans	4,565	4,800	5,189	5,262	5,474
Number of Physicians	19	21	21	23	23
Scans Per Physician	**240**	**229**	**247**	**229**	**238**

Moreover, even if year-to-year growth is attributable solely to the addition of new physicians, which is unlikely, each new physician has averaged only139 scans annually since FY 2012 (CON Application, pp. 85 & 91).

	FY 2013	FY 2014	FY 2015	FY 2016	Average
Number of New Physicians Over Prior Year	2	2	0	2	--
Scan Increase Over Prior Year	235	389	73	212	--
Scans Per New Physician	**117.5**	**194.5**	--	**106**	**139.3**

None of this accounts for the fact that ONS is projecting a 22% increase in MRI scan volume between FY 2016 and FY 2017 (CON Application, p. 91). The practice said it will recruit 2 new physicians that year, which means that each physician would need to order roughly 600 scans in his/her first year with the practice (CON Application, pp. 91 & 94). This is entirely

inconsistent with historic growth and the per-physician scan numbers provided by ONS (CON Application, pp. 85, 91 & 94). Even assuming some organic growth in MRI scans across ONS physicians, as well as growth attributable to newly recruited physicians, there are still a significant number of scans that will need to come from elsewhere. Practices like Advanced Radiology are already accommodating ONS's overflow scans, and will continue to do so despite our own capacity constraints. These are patients who have used Advanced Radiology for their imaging for many years and for whom we can ensure continuity and coordination of care. Because Advanced Radiology can and will continue to serve these patients, and any other patients who are referred by ONS physicians, ONS's acquisition of a second unit is an unnecessary duplication of MRI services.

Furthermore, ONS claims that providing its patients with MRI services in-office promotes quality, cost-effectiveness, timeliness, care coordination, and patient convenience (CON Application, pp. 18, 19 & 21). There are several flaws with ONS's reasoning. First, it is extremely unlikely that any ONS patient is receiving an MRI scan on the same day an ONS physician orders the scan (except in an emergency). Accordingly, having in-office MRI is not a "convenience" like having in-office x-ray where patients do, in fact, have exams in conjunction with office visits. Also, the "convenience" of having an MRI in a physician office setting, as opposed to a hospital, is the same whether that scan is performed in an orthopedist's office or a private radiology office such as Advanced Radiology.

In addition, the ability to coordinate care is no better when an orthopedic practice owns its own MRI unit. ONS still has to contract with a radiology practice to interpret the MRI scans. Presumably, the scans are not read by Greenwich Radiology physicians in real time. We suspect that the turnaround time is similar to the turnaround time for scans performed at Advanced Radiology's offices and interpreted by our subspecialist radiologists, with results communicated electronically to most referring providers. As far as cost is concerned, Advanced Radiology likely charges similar rates for MRI services and there is no facility fee involved. Moreover, because Advanced Radiology does not self-refer patients for studies, there is less risk of overutilization and increased costs for patients and payers.

When all is said and done, Advanced Radiology will be adversely impacted by ONS's acquisition of a second MRI unit, if approved by OHCA. In order to meet its generous volume projections, ONS physicians will need to refer all of their scans to practice-owned units. This will mean the loss by Advanced Radiology of a significant number of commercially insured scans each year. OHCA should not approve a proposal that adversely impacts an existing provider, particularly if that provider cares for all patients regardless of ability to pay and not just those select patients with commercial insurance or the financial means to pay the full cost of an MRI scan out of pocket.

Conclusion

For the foregoing reasons, ONS's request for permission to acquire a second MRI unit should be denied. ONS will stop referring scans to Advanced Radiology if it is approved for an additional unit. Because these patients are already well-served by existing providers, the proposed scanner is unnecessarily duplicative. In addition, by ONS's own admission, the MRI scanner will not be available to Medicaid recipients and services for indigent persons will be extremely limited.

MRI volume in lower Fairfield County is growing across all payers. This is why Advanced Radiology has applied for a second unit for its Stamford office. Rather than approving a limited-use MRI that excludes the most vulnerable patients in our service area, we urge OHCA to reject ONS's proposal. Advanced Radiology and other full-service providers can and will continue to serve any ONS patients in need.

Thank you for your consideration.

Very Truly Yours,

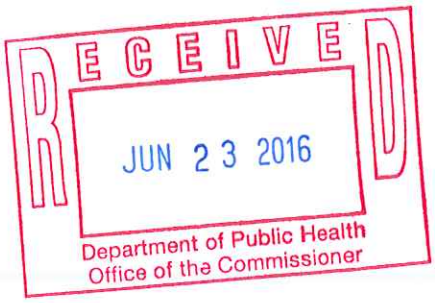
Terence W. Hughes, M.D.,
Chairman,
Advanced Radiology Consultants, LLC

cc: Seth R. Miller, M.D.,
President, ONS

Advanced Radiology

- Advanced Radiology MRI Centers
- Advanced Interventional Radiology (AIR) Center
- Advanced Women's Imaging Center (AWIC)

June 21, 2016



Hon. Janet Brancifort, M.P.H.
Deputy Commissioner
Office of Health Care Access Division
Department of Public Health
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: Orthopaedic & Neurosurgery Specialists, P.C.
Acquisition of Magnetic Resonance Imaging Scanner
Docket No. 16-32063-CON

Dear Deputy Commissioner Brancifort:

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---

[3] Note that some individuals who will be covered by Medicaid in the coming years are now or were formally commercially insured. Some may have been patients of ONS in the past. Because ONS will not care for these individuals going forward, it is possible that the practice's MRI projections are overstated.

unit to allow it to serve an existing and growing patient base in the greater Stamford area. As discussed below, ONS's proposal to acquire an additional MRI unit will result in the loss of commercially insured scan volume at Advanced Radiology, which will further skew the practice's payer mix towards governmental payers that reimburse at far lower rates. As MRI payer mix shifts, it will threaten the viability of Advanced Radiology as a whole because the lion's share of the practice's profit margin comes from MRI services. This would compromise the practice's ability to provide a full range of imaging services to all patients, including the Medicaid and indigent patients that ONS rejects.

Unnecessary Duplication of Services & Adverse Impact on Existing Providers

The ONS Greenwich office and Advanced Radiology's Stamford office have largely overlapping service areas. ONS reports its Connecticut primary service area as Greenwich, Stamford, Darien, New Canaan, and Wilton (CON Application, p. 30). They also report a significant number of MRI scan on patients residing in Norwalk (CON Application, p. 88). The primary service area of the Stamford office of Advanced Radiology includes Stamford, Norwalk, Darien, New Canaan, and Greenwich.

Advanced Radiology receives referrals from ONS physicians for MRI scans that, for the most part, are performed at the practice's Stamford office. In FY 2015, ONS physicians referred 79 MRI scans to Advanced Radiology and our practice was reimbursed approximately $55,000 in connection with these scans. In the first quarter of FY 2016, ONS referred 20 MRI scans to Advanced Radiology.

Without a doubt, ONS's volume projections shows that the practice intends to take back a significant percentage of the MRI scans that its physicians refer to Advanced Radiology and other providers.[4] Although ONS claims that the growth it projects is a result of the addition of physicians to the practice, the numbers simply do not add up. Specifically, ONS has not accounted for a projected 22% increase in MRI scan volume between FY 2016 and FY 2017 (1,201 scans), the first year of operation of the proposed second unit (CON Application, p. 91).

Since FY 2012, ONS has seen growth in MRI scan volume of approximately 230 scans or 5% annually (CON Application, p. 91). As the table below demonstrates, even with the addition of 6 physicians between FYs 2012 and 2015, MRI scan volume grew by only 15% during this time (CON Application, pp. 85 & 91). Annually, MRI volume growth has not exceeded 8.1% and was as low as 1.4% between FY 2014 and FY 2015 (CON Application, p. 91).

[4] In the footnote on page 94 of the CON Application ONS concedes that it does not have the capacity to accommodate all of its physicians' MRI needs with a single scanner. This suggests that, if a second scanner is approved, ONS will have the capacity and will cease to refer cases to providers like Advanced Radiology.

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Number of Scans	4,565	4,800	5,189	5,262	5,474
Percent Increase Over Prior Year	--	**5.1%**	**8.1%**	**1.4%**	**4.0%**

When asked to explain how historic and anticipated future physician recruitment will impact MRI scan volume, ONS's responses was less than clear. It references a "per physician" scan volume of 267 scans based on FY 2012 data (CON Application, p. 94). However, this does not comport with the information provided by ONS in its completeness submissions. The table below shows lower scan-per-physician volume in FY 2012 and subsequent years (CON Application, pp. 85, 91 & 94).

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Number of Scans	4,565	4,800	5,189	5,262	5,474
Number of Physicians	19	21	21	23	23
Scans Per Physician	**240**	**229**	**247**	**229**	**238**

Moreover, even if year-to-year growth is attributable solely to the addition of new physicians, which is unlikely, each new physician has averaged only139 scans annually since FY 2012 (CON Application, pp. 85 & 91).

	FY 2013	FY 2014	FY 2015	FY 2016	Average
Number of New Physicians Over Prior Year	2	2	0	2	--
Scan Increase Over Prior Year	235	389	73	212	--
Scans Per New Physician	**117.5**	**194.5**	--	**106**	**139.3**

None of this accounts for the fact that ONS is projecting a 22% increase in MRI scan volume between FY 2016 and FY 2017 (CON Application, p. 91). The practice said it will recruit 2 new physicians that year, which means that each physician would need to order roughly 600 scans in his/her first year with the practice (CON Application, pp. 91 & 94). This is entirely

inconsistent with historic growth and the per-physician scan numbers provided by ONS (CON Application, pp. 85, 91 & 94). Even assuming some organic growth in MRI scans across ONS physicians, as well as growth attributable to newly recruited physicians, there are still a significant number of scans that will need to come from elsewhere. Practices like Advanced Radiology are already accommodating ONS's overflow scans, and will continue to do so despite our own capacity constraints. These are patients who have used Advanced Radiology for their imaging for many years and for whom we can ensure continuity and coordination of care. Because Advanced Radiology can and will continue to serve these patients, and any other patients who are referred by ONS physicians, ONS's acquisition of a second unit is an unnecessary duplication of MRI services.

Furthermore, ONS claims that providing its patients with MRI services in-office promotes quality, cost-effectiveness, timeliness, care coordination, and patient convenience (CON Application, pp. 18, 19 & 21). There are several flaws with ONS's reasoning. First, it is extremely unlikely that any ONS patient is receiving an MRI scan on the same day an ONS physician orders the scan (except in an emergency). Accordingly, having in-office MRI is not a "convenience" like having in-office x-ray where patients do, in fact, have exams in conjunction with office visits. Also, the "convenience" of having an MRI in a physician office setting, as opposed to a hospital, is the same whether that scan is performed in an orthopedist's office or a private radiology office such as Advanced Radiology.

In addition, the ability to coordinate care is no better when an orthopedic practice owns its own MRI unit. ONS still has to contract with a radiology practice to interpret the MRI scans. Presumably, the scans are not read by Greenwich Radiology physicians in real time. We suspect that the turnaround time is similar to the turnaround time for scans performed at Advanced Radiology's offices and interpreted by our subspecialist radiologists, with results communicated electronically to most referring providers. As far as cost is concerned, Advanced Radiology likely charges similar rates for MRI services and there is no facility fee involved. Moreover, because Advanced Radiology does not self-refer patients for studies, there is less risk of overutilization and increased costs for patients and payers.

When all is said and done, Advanced Radiology will be adversely impacted by ONS's acquisition of a second MRI unit, if approved by OHCA. In order to meet its generous volume projections, ONS physicians will need to refer all of their scans to practice-owned units. This will mean the loss by Advanced Radiology of a significant number of commercially insured scans each year. OHCA should not approve a proposal that adversely impacts an existing provider, particularly if that provider cares for all patients regardless of ability to pay and not just those select patients with commercial insurance or the financial means to pay the full cost of an MRI scan out of pocket.

Conclusion

For the foregoing reasons, ONS's request for permission to acquire a second MRI unit should be denied. ONS will stop referring scans to Advanced Radiology if it is approved for an additional unit. Because these patients are already well-served by existing providers, the proposed scanner is unnecessarily duplicative. In addition, by ONS's own admission, the MRI scanner will not be available to Medicaid recipients and services for indigent persons will be extremely limited.

MRI volume in lower Fairfield County is growing across all payers. This is why Advanced Radiology has applied for a second unit for its Stamford office. Rather than approving a limited-use MRI that excludes the most vulnerable patients in our service area, we urge OHCA to reject ONS's proposal. Advanced Radiology and other full-service providers can and will continue to serve any ONS patients in need.

Thank you for your consideration.

Very Truly Yours,

Terence W. Hughes, M.D.,
Chairman,
Advanced Radiology Consultants, LLC

cc: Seth R. Miller, M.D.,
President, ONS

Greer, Leslie

From: Martone, Kim
Sent: Thursday, July 07, 2016 12:10 PM
To: Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Fernandes, David
Cc: Greer, Leslie
Subject: FW: Orthopaedic & Neurosurgery Specialists, P.C. 16-32063
Attachments: Response to A.R. Letter.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 Website: www.ct.gov/ohca

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Thursday, July 07, 2016 12:07 PM
To: Martone, Kim; Veyberman, Alla
Cc: 'Michele AOL'; Kathleen Gedney
Subject: Orthopaedic & Neurosurgery Specialists, P.C. 16-32063

Ms. Martone and Ms. Veyberman: Attached please find our response to Advanced Radiology's letter in connection with the above captioned matter. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

BERSHTEIN, VOLPE & McKEON, P.C.
ATTORNEYS AT LAW
105 COURT STREET—THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
TELEPHONE: (203) 777-5800
FACSIMILE: (203) 777-5806

Michele M. Volpe
mmv@bvmlaw.com
203-777-6995

VIA U.S. MAIL &
Email to Ms. Kimberly Martone and Ms. Alla Veyberman

July 7, 2016

Ms. Janet Brancifort, M.P.H.
Deputy Commissioner
Office of Health Care Access Division
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134-0308

Dear Ms. Brancifort:

Orthopaedic & Neurosurgery Specialists, P.C. ("ONS" or the "Applicant") is in receipt of a letter (the "Letter") from Advanced Radiology Consultants, LLC ("Advanced Radiology") with respect to ONS's Department of Public Health Division of Office of Health Care Access ("OHCA") Certificate of Need Application Docket No. 16-32063 (the "Application"). ONS respectfully requests that this correspondence be added to Docket No. 16-32063 to correct inaccurate and contradictory statements made by Advanced Radiology in the Letter. Advanced Radiology's conclusions in the Letter are conjecture and have no factual basis.

First, Advanced Radiology falsely states that ONS's Application does not meet the Statewide Health Plan ("SHP") criteria related to Medicaid. The SHP states that a "facility or provider shall not deny MRI scanner services to any individual based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients."[1] ONS has

[1] Statewide Health Plan at 62.

indisputably met this criterion as it does not deny MRI services to uninsured, underinsured and Medicaid patients. Advanced Radiology puts forth unfounded and inaccurate statements that ONS "excludes Medicaid recipients and indigent persons"[2] and that ONS is "denying Medicaid recipients."[3] Advanced Radiology presents no evidence of any specific circumstance or patient being denied MRI services based on payor status. In fact, ONS has repeatedly provided information to OHCA stating it is available to work one on one with patients who may be unable to pay part or all of the bill for any reason, including but not limited to insurance status or financial status.[4] ONS is dedicated to ensuring that thorough follow up care occurs with its patients regardless of financial status. The medical services for such patients are treated in the same manner as all ONS patients. Approval of ONS's Application will not impact access to Medicaid recipients or indigent persons nor reduce access to services by Medicaid recipients. Advanced Radiology's false statements are simply being used to bolster its own CON application.

Second, Advanced Radiology has inaccurately stated that approval of ONS's Application will result in unnecessary duplication of existing health care services.[5] This is false as ONS has proved its specific need for MRI services in the Application. Further, there is an undisputed need for additional MRI services in Fairfield County. According to Advanced Radiology's own research as detailed in its recent Certificate of Need application to acquire an additional in-office MRI filed with OHCA on June 14, 2016 ("Advanced Radiology CON"), nearly every provider of MRI services is operating over capacity, including ONS.[6] Advanced Radiology states "there is a document need for additional MRI capacity" based on over utilization of its own existing scanner,[7] one of the same reasons ONS Application satisfies the requirement that it will not result in unnecessary duplication of existing health care services. It is contradictory for Advanced Radiology to state that an additional MRI in the service area will result in unnecessary duplication of existing health care services while applying for an additional MRI itself. As such, the assertion that approval of ONS's Application will result in unnecessary duplication of existing health care services is not truthful and must be dismissed.

Third, approval of ONS's Application will not adversely affect providers such as Advanced Radiology. As stated above, there is an undisputed need for additional MRI services in Fairfield County and specifically at ONS. ONS has established in its Application the MRI need for its own practice patients which will not have an adverse effect on other MRI providers in the service area. Advanced Radiology asserts a certain number of patients are referred to Advanced Radiology annually.[8] However, ONS cannot verify the accuracy of this statement.

---

[2] Letter at 1.
[3] Letter at 3.
[4] Advanced Radiology has a similar policy. However, based on its CON it does not appear that Advanced Radiology has offered any charity care in the past year nor does it anticipate providing any charity care in the future. See Financial Worksheet B, Advanced Radiology CON at 134.
[5] Letter at 2.
[6] Advanced Radiology CON at 34. ("[a] majority of MRI units in the service area are also operating near or above optimal capacity...").
[7] Advanced Radiology CON at 35.
[8] Letter at 4.

Even assuming Advanced Radiology's figure was correct, these referred patients only account for less than 1% of annual MRI volume at the Stamford Office of Advances Radiology. Advanced Radiology has multiple MRI scanners so the impact to Advanced Radiology as a whole will be a small fraction of 1%. Further, ONS only represents one of 500 referral sources for Advanced Radiology.[9] Based on these facts, there is no merit behind Advanced Radiology's accusation that it will be adversely affected by a fraction of 1% of MRI volume by just one referral sources out of 500. Further, patients are given the choice of MRI providers; ONS does not control patient choice and thus cannot control referral numbers. Any anticipated adverse effect asserted by Advanced Radiology is not accurate.

ONS respectfully requests that OHCA dismiss the statements presented by Advanced Radiology in the Letter as they have no factual basis and are contradictory to statements provided in Advanced Radiology's own CON Application. Please do not hesitate to contact me with any questions. Thank you for your consideration.

Regards,

Michele M. Volpe
Bershtein, Volpe & McKeon, P.C.

Cc: Kimberly Martone, Director of Operations, OHCA
Alla Veyberman, Health Care Analyst, OHCA

S:\doc\03 2201-2250\032228 Orthopaedic & Neurosurgery Specialists, PC-Gen Corp\MRI\Acquisition of 2nd MRI (2015)\Advanced Radiology Letter\Response to A.R. letter (MMV 7.5.16).docx

[9] Advanced Radiology CON at 13.

BERSHTEIN, VOLPE & McKEON, P.C.
ATTORNEYS AT LAW
105 COURT STREET—THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
TELEPHONE: (203) 777-5800
FACSIMILE: (203) 777-5806

Michele M. Volpe
mmv@bvmlaw.com
203-777-6995

VIA U.S. MAIL &
Email to Ms. Kimberly Martone and Ms. Alla Veyberman

July 7, 2016

Ms. Janet Brancifort, M.P.H.
Deputy Commissioner
Office of Health Care Access Division
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134-0308

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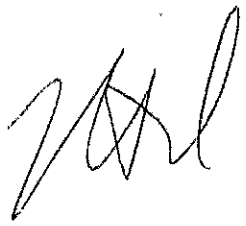
Regards,



Michele M. Volpe
Bershtein, Volpe & McKeon, P.C.

Cc: Kimberly Martone, Director of Operations, OHCA
Alla Veyberman, Health Care Analyst, OHCA

S:\doc\03 2201-2250\032228 Orthopaedic & Neurosurgery Specialists, PC-Gen Corp\MRI\Acquisition of 2nd MRI (2015)\Advanced Radiology Letter\Response to A.R. letter (MMV 7.5.16).docx

[9] Advanced Radiology CON at 13.

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 M.D., M.P.H., Commissioner

DATE: July 25, 2016

RE: Certificate of Need Application; Docket Number: 16-32063-CON
Orthopaedic & Neurosurgery Specialists, P. C.
Acquisition of Magnetic Resonance Imaging Scanner

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.

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Greer, Leslie

From: Greer, Leslie
Sent: Friday, August 05, 2016 9:08 AM
To: michelemvolpe@aol.com
Cc: Lazarus, Steven; Veyberman, Alla; Fernandes, David; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara
Subject: DN: 16-32063-CON Hearing Notice and Order
Attachments: 32063 Hearing Notice.pdf; 32063 and 32093 Order.pdf

Attorney Volpe,
Attached is the hearing notice for Orthopaedic & Neurosurgery Specialists, P.C. and the Order by the Department of Public Health, Office of Health Care Access dated August 5, 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

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

August 5, 2016

Michele Volpe, Esq.
Bershtein, Volpe & McKeon, PC
105 Court Street, Third Floor
New Haven, CT 065111

RE: Certificate of Need Applications Docket Number 16-32063-CON
Orthopedic and Neurosurgery Specialists, PC
Proposal to Acquire a Second Magnetic Resonance Imaging Scanner
Applicant Hearing Notice

Dear Attorney Volpe,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Orthopedic and Neurosurgery Specialists, PC. ("Applicant") on June 10, 2016 the Office of Health Care Access ("OHCA") has initiated its review of the CON application 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)

Applicant:	Orthopedic and Neurosurgery Specialists, PC
Docket Number:	16-32063-CON
Proposal:	Acquisition of a Second Magnetic Resonance Imaging Scanner

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: August 30, 2016

Time: 10:00 a.m.

Place: Department of Public Health, Office of Health Care Access
470 Capitol Avenue, Conference Room A/B
Hartford, CT 06134

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 Advocate* pursuant to General Statutes § 19a-639a (f).

All Applicants and Intervenors are reminded that The Office of Health Care Access division of the Department of Public Health follows the Rules of Practice under section 19a-9-1, et seq., of the Regulations of Connecticut State Agencies.

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:AV:SWL: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

August 5, 2016 P.O. #54772

The Advocate
75 Tresser Boulevard
Stamford, CT 06904

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 **Monday, August 8, 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,

Kimberly R. Martone
Director of Operations

Attachment
cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association
KRM:DF:JSH:RC;lmg

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

The Advocate August 5, 2016
Notice of Public Hearing, Docket Number 16-32063-CON and 16-32093-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

Statute Reference:	19a-638
Applicant(s):	Orthopedic and Neurosurgery Specialists, PC Advanced Radiology MRI Centers
Town:	Stamford
Docket Number(s):	16-32063-CON and 16-32093-CON
Proposal:	Acquisition of a Second Magnetic Resonance Imaging Scanner
Date:	August 30, 2016
Time:	10:00 a.m.
Place:	Department of Public Health, Office of Health Care Access 470 Capitol Avenue, Conference Room A/B Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than August 25, 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 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: Michele Volpe <michelemvolpe@aol.com>
Sent: Friday, August 05, 2016 9:15 AM
To: Greer, Leslie
Cc: Lazarus, Steven; Veyberman, Alla; Fernandes, David; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara
Subject: Re: DN: 16-32063-CON Hearing Notice and Order

Thank you Leslie.

Michele M. Volpe
Bershtein, Volpe & McKeon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

On Aug 5, 2016, at 9:07 AM, Greer, Leslie <Leslie.Greer@ct.gov> wrote:

> Attorney Volpe,
> Attached is the hearing notice for Orthopaedic & Neurosurgery Specialists, P.C. and the Order by the Department of Public Health, Office of Health Care Access dated August 5, 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*
> <image001.jpg>
>
> <32063 Hearing Notice.pdf>
> <32063 and 32093 Order.pdf>

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Friday, August 05, 2016 11:50 AM
To: Greer, Leslie
Subject: Re: Hearing Notices DN's 16-32063-CON and 16-32093-CON

Good day!

Thanks so much for your ad request.
We will be in touch shortly and look forward to serving you.

As a reminder, Graystone offers a wide range of diversity sources, don't hesitate to ask for options for this or future requests.

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.

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Graystone Group Advertising

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Bridgeport, CT 06604
Phone: 800-544-0005
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Date: Friday, August 5, 2016 at 8:55 AM
To: Ads Desk <ads@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: Hearing Notices DN's 16-32063-CON and 16-32093-CON

Please run the attached hearing notice in The Advocate by 8/8/16. 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

Greer, Leslie

From: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Friday, August 05, 2016 5:30 PM
To: Greer, Leslie
Cc: Olejarz, Barbara
Subject: FW: Hearing Notices DN's 16-32063-CON and 16-32093-CON
Attachments: 16-32063 and 16-32093 The Advocate.docx

Hello,

This notice is set to publish on Monday.
$180.91

Thanks,

Robert Taylor

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Date: Fri, 5 Aug 2016 11:49:32 -0400
To: Microsoft Office User <rtaylor@graystoneadv.com>
Subject: FW: Hearing Notices DN's 16-32063-CON and 16-32093-CON

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Friday, August 5, 2016 at 8:55 AM
To: Ads Desk <ads@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: Hearing Notices DN's 16-32063-CON and 16-32093-CON

Please run the attached hearing notice in The Advocate by 8/8/16. 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

SCOREBOARD

ON THE AIR

BASEBALL

▸▸ Little League World Series, Southeast Regional semifinal (ESPN) 7 p.m.

▸▸ Little League World Series, Southwest Regional (ESPN) 9 p.m.

HORSE RACING

▸▸ Cab Calloway Stakes (FS2) 4 p.m.

MAJOR LEAGUE BASEBALL

▸▸ San Francisco Giants at Miami Marlins (MLB) 7 p.m.

RIO SUMMER OLYMPICS

▸▸ Women's Field Hockey: U.S. vs. Australia; Women's Fencing; Women's Basketball: U.S. vs. Spain; Women's Fencing; Women's Rugby; Table Tennis; Women's Fencing; Archery; Men's Basketball: U.S. vs. Venezuela; Men's Water Polo; Weightlifting; Women's Volleyball; Boxing (NBCSN) 9 a.m.

▸▸ Equestrian; Table Tennis; Beach Volleyball; Women's Handball 9 a.m.

▸▸ Tennis (BRAVO) 9:30 a.m.

▸▸ Rowing; Men's Water Polo: U.S. vs. Spain; Swimming: Qualifying Heats; Canoe/Kayak; Women's Volleyball: U.S. vs. Netherlands; Men's Beach Volleyball: Gibb/Patterson (U.S.) vs. Huber/Seidl (Austria) (NBC) 10 a.m.

▸▸ Women's Beach Volleyball: Brazil vs. Argentina; Boxing; Basketball; Boxing (TELEMUNDO) 10:30 a.m.

▸▸ Beach Volleyball; Women's Volleyball; Men's Basketball; Men's Shooting; Judo; Sailing (MSNBC) Noon

▸▸ Volleyball; Men's Basketball: U.S. vs. Venezuela; Boxing (NBC UNIVERSO) 2 p.m.

▸▸ Men's Water Polo; Women's Rugby; Beach Volleyball; Table Tennis (CNBC) 5 p.m.

▸▸ Men's Diving; Men's Gymnastics: Team Gold Medal Finals; Swimming: Gold Medal finals: Men's 200m Freestyle & 100m Backstroke, Women's 100m Backstroke & 100m Breaststroke; Women's Beach Volleyball: Walsh Jennings/Ross (U.S.) vs. Wang/Yue (China) (NBC) 8 p.m.

▸▸ Canoe/Kayak: Whitewater qualifying (NBC) 12:35 a.m. (Tuesday)

Listings subject to change by station and networks

AUTO RACING

NASCAR-Sprint Cup

CHEEZ-IT 355

At Watkins Glen International
Watkins Glen, N.Y.
Lap length: 2.45 miles
(Start position in parentheses)

1. (6) Denny Hamlin, Toyota, 90.
2. (7) Joey Logano, Ford, 90.
3. (12) Brad Keselowski, Ford, 90.
4. (9) AJ Allmendinger, Chevrolet, 90.
5. (3) Tony Stewart, Chevrolet, 90.
6. (5) Kyle Busch, Toyota, 90.
7. (14) Martin Truex Jr., Toyota, 90.
8. (10) Jamie McMurray, Chevrolet, 90.
9. (32) Trevor Bayne, Ford, 90.
10. (4) Matt Kenseth, Toyota, 90.
11. (17) Kurt Busch, Chevrolet, 90.
12. (20) Casey Mears, Chevrolet, 90.
13. (16) Chase Elliott, Chevrolet, 90.
14. (21) Jeff Gordon, Chevrolet, 90.
15. (1) Carl Edwards, Toyota, 90.
16. (8) Ryan Newman, Chevrolet, 90.
17. (11) Michael McDowell, Chevrolet, 90.
18. (28) Clint Bowyer, Chevrolet, 90.
19. (19) Ryan Blaney, Ford, 90.
20. (23) Kasey Kahne, Chevrolet, 90.
21. (31) Danica Patrick, Chevrolet, 90.
22. (33) Paul Menard, Chevrolet, 90.
23. (40) Landon Cassill, Ford, 90.
24. (37) Boris Said, Ford, 90.
25. (27) Brian Scott, Ford, 90.
26. (39) Josh Wise, Chevrolet, 90.
27. (34) Aric Almirola, Ford, 90.
28. (22) Cole Whitt, Toyota, 90.
29. (2) Kyle Larson, Chevrolet, 89.
30. (25) Chris Buescher, Ford, 89.
31. (18) Austin Dillon, Chevrolet, 89.
32. (15) Kevin Harvick, Chevrolet, Accident, 83.
33. (26) David Ragan, Toyota, Accident, 83.
34. (35) Matt DiBenedetto, Toyota, Accident, 83.
35. (29) Regan Smith, Chevrolet, 77.
36. (36) Alex Kennedy, Chevrolet, Engine, 76.
37. (38) Michael Annett, Chevrolet, 74.
38. (30) Ricky Stenhouse Jr., Ford, Accident, 52.
39. (24) Greg Biffle, Ford, Accident, 52.
40. (13) Jimmie Johnson, Chevrolet, Accident, 52.

Race Statistics

Average Speed of Race Winner: 89.513 mph.; Time of Race: 2 Hrs, 27 Mins, 48 Secs. Margin of Victory: 2.065 Seconds.; Caution Flags: 8 for 20 laps.; Lead Changes: 9 among 8 drivers.

Leaders Summary (Driver, Times Lead, Laps Led): B. Keselowski 2 times for 28 laps; C. Edwards 1 time for 25 laps; D. Patrick 1 time for 11 laps; D. Hamlin 1 time for 10 laps; J. Logano 2 times for 8 laps; Kyle Busch 1 time for 4 laps; Kurt Busch 1 time for 3 laps; M. Truex Jr. 1 time for 1 lap.

Top 16 in Points: B. Keselowski, 727; K. Harvick, 718; Kurt Busch, 689; Kyle Busch, 670; C. Edwards, 653; J. Logano, 652; D. Hamlin, 620; M. Truex Jr., 612; M. Kenseth, 600; J. Johnson, 578; R. Newman, 562; C. Elliott- 561; A. Dillon, 559; J. Mcmurray, 550; K. Larson, 520; T. Bayne, 512.

BASEBALL

Atlantic League

FREEDOM DIVISION	W	L	Pct.	GB
Sugar Land	18	12	.600	—
York	17	12	.586	½
Lancaster	13	17	.433	5
Southern Md.	12	18	.400	6

LIBERTY DIVISION	W	L	Pct.	GB
Long Island	16	12	.571	—
Bridgeport	17	13	.567	—
Somerset	14	15	.483	2½
New Britain	11	19	.367	6

Sunday's Results

Bridgeport 3, Long Island 1
New Britain 8, Lancaster 1
York 6, Southern Maryland 3
Somerset at Sugar Land, late

Today's Games

New Britain at York, 6 p.m.
Somerset at Long Island, 6 p.m.

AMERICA'S LINE

BASEBALL

Favorite	Odds	Underdog
American League		
BLUE JAYS	-$140 (9)	Rays
Astros	-$138 (9)	TWINS
Orioles	-$140 (8½)	A'S
MARINERS	-$107 (7½)	Tigers
National League		
MARLINS	-$150 (6½)	Giants
BREWERS	-$165 (9)	Braves
CARDINALS	-$185 (9)	Reds
DODGERS	-$200 (8)	Phillies
Interleague		
Rangers	-$120 (10½)	ROCKIES

NOTE: The number inside the bracket is the over/under run total for the game.

NFL PRESEASON

Favorite	Points	Underdog
Open Current O/U		
Thursday		
WASHINGTON	3 3 (37)	Falcons
EAGLES	3 3 (37½)	Buccaneers
JETS	1½ 2½ (36½)	Jaguars
RAVENS	1 1 (36½)	Panthers
PATRIOTS	4 3½ (39½)	Saints
BEARS	1½ 1½ (35)	Broncos
Friday		
GIANTS	3 3 (36½)	Dolphins
STEELERS	4 3½ (35½)	Lions
BENGALS	3 3 (35)	Vikings
PACKERS	NL NL (NL)	Browns
CARDINALS	3 3 (37½)	Raiders
Saturday		
CHIEFS	1½ 2½ (35½)	Seahawks
BILLS	NL NL (NL)	Colts
RAMS	3 3½ (35½)	Cowboys
TITANS	3 3 (35½)	Chargers
Sunday		
49ERS	3 3 (36)	Texans

OLYMPIC BASKETBALL

Favorite	Points (O/U)	Underdog
Serbia	6 (159½)	Australia
France	24½ (149½)	China
Usa	50½ (167)	Venezuela

Home Team in CAPS

GOLF

PGA

TRAVELERS CHAMPIONSHIP

At TPC River Highlands
Cromwell, Conn.
Purse: $6.6 million
Yardage: 6,841; Par: 70
Final

Russell Knox, $1,188,000	67-67-64-68—266
Jerry Kelly, $712,800	64-70-69-64—267
Patrick Rodgers, $382,800	68-66-66-68—268
Justin Thomas, $382,800	68-69-69-62—268
Daniel Berger, $231,825	66-67-62-74—269
Jim Furyk, $231,825	73-66-72-58—269
Robert Garrigus, $231,825	67-67-68-67—269
T. Van Aswegen), $231,825	67-66-65-71—269
Brooks Koepka, $184,800	67-70-64-69—270
Marc Leishman, $184,800	65-68-71-66—270
Alex Cejka, $135,300	68-69-69-65—271
Russell Henley, $135,300	68-65-65-73—271
Spencer Levin, $135,300	69-67-68-67—271
Patrick Reed, $135,300	70-67-68-66—271
Shawn Stefani, $135,300	71-68-67-65—271
D. Summerhays, $135,300	68-69-65-69—271
Paul Casey, $83,490	68-67-66-71—272
Andres Gonzales, $83,490	70-68-65-69—272
Tyrrell Hatton, $83,490	71-65-70-66—272
Matt Kuchar, $83,490	69-67-71-65—272
Ryan Moore, $83,490	70-66-66-70—272
Louis Oosthuizen, $83,490	68-71-67-66—272
Carlos Ortiz, $83,490	66-71-69-66—272
Brendan Steele, $83,490	70-69-69-64—272
Blayne Barber, $47,227	71-64-70-68—273
Keegan Bradley, $47,227	67-72-67-67—273
Tony Finau, $47,227	69-68-69-67—273
Charley Hoffman, $47,227	69-68-69-67—273
Si Woo Kim, $47,227	69-70-67-67—273
Henrik Norlander, $47,227	71-68-70-64—273
Scott Brown, $47,227	68-70-67-68—273
Jon Rahm, $47,227	65-70-69-69—273
Bubba Watson, $47,227	67-70-68-68—273
Aaron Baddeley, $34,815	73-65-67-69—274
Jason Kokrak, $34,815	70-66-73-65—274
Webb Simpson, $34,815	70-67-69-68—274
Cameron Smith, $34,815	69-67-67-71—274
Derek Ernst, $25,740	68-69-70-68—275
Lucas Lee, $25,740	68-69-72-66—275
Seung-Yul Noh, $25,740	69-70-68-68—275
Rod Pampling, $25,740	69-68-72-66—275
Chris Stroud, $25,740	70-69-66-70—275
Brian Stuard, $25,740	70-65-69-71—275
Hudson Swafford, $25,740	67-71-68-69—275
Vaughn Taylor, $25,740	64-71-70-70—275
Gary Woodland, $25,740	67-70-67-71—275
Greg Chalmers, $16,573	69-69-72-66—276
Ernie Els, $16,573	72-67-70-67—276
Retief Goosen, $16,573	69-69-69-69—276
Stuart Appleby, $16,573	68-68-69-71—276
Bryson DeChambeau, $16,573	72-66-68-70—276
Zach Johnson, $16,573	67-71-68-70—276
Francesco Molinari, $16,573	71-67-65-73—276
Cameron Percy, $16,573	69-69-67-71—276
Chez Reavie, $16,573	70-67-70-69—276
Abraham Ancer, $14,718	68-68-68-73—277
Miguel A. Carballo, $14,718	73-66-71-67—277
Bryce Molder, $14,718	69-70-66-72—277
Rory Sabbatini, $14,718	67-72-73-65—277
John Senden, $14,718	69-68-72-68—277
Vijay Singh, $14,718	67-68-71-71—277
Zac Blair, $14,190	70-68-69-71—278
Martin Laird, $14,190	68-69-68-73—278
Padraig Harrington, $13,794	70-69-65-75—279
Matt Jones, $13,794	69-69-71-70—279
Soren Kjeldsen, $13,794	68-69-69-73—279
Nick Taylor, $13,794	68-71-68-72—279
Ricky Barnes, $13,464	68-71-69-72—280
Scott Pinckney, $13,332	68-67-74-72—281
Bud Cauley, $13,068	68-71-69-74—282
Sung Kang, $13,068	70-67-75-70—282
Hunter Mahan, $13,068	68-71-76-67—282
David Toms, $12,804	67-71-70-75—283

Champions Tour

3M CHAMPIONSHIP

Sunday
At TPC Twin Cities
Blaine, Minn.
Purse: $1.75 million
Yardage: 7,114; Par 72
Final
(x-won on first playoff hole)

x-Joe Durant, $262,500	70-64-63—197-19
Miguel Angel Jimenez, $154,000	67-63-67—197-19
Bernhard Langer, $115,063	67-68-64—199-17
Kevin Sutherland, $115,063	67-64-68—199-17
Glen Day, $76,563	65-67-68—200-16
David Frost, $76,563	70-64-66—200-16
Woody Austin, $59,500	67-68-66—201-15
Jeff Maggert, $59,500	66-67-68—201-15
Jose Coceres, $49,000	70-65-67—202-14
Mike Goodes, $40,250	69-67-67—203-13
Colin Montgomerie, $40,250	66-67-70—203-13
Steve Pate, $40,250	69-68-66—203-13
Jeff Sluman, $40,250	71-65-67—203-13
Stephen Ames, $32,375	68-69-67—204-12
Mark O'Meara, $32,375	68-66-70—204-12
Olin Browne, $29,750	71-67-67—205-11
Michael Allen, $22,641	72-69-65—206-10
Scott Dunlap, $22,641	67-70-69—206-10
Paul Goydos, $22,641	69-69-68—206-10
Mike Grob, $22,641	69-70-67—206-10
Mark Brooks, $22,641	68-68-70—206-10
Bart Bryant, $22,641	67-69-70—206-10
Todd Hamilton, $22,641	69-68-69—206-10
Scott Hoch, $22,641	68-69-69—206-10
Michael Bradley, $14,919	69-68-70—207 -9
Brad Bryant, $14,919	71-71-65—207 -9
Marco Dawson, $14,919	72-67-68—207 -9
Carlos Franco, $14,919	67-70-70—207 -9
Doug Garwood, $14,919	73-62-72—207 -9
Lee Janzen, $14,919	69-71-67—207 -9
Brandt Jobe, $14,919	69-65-73—207 -9
Wes Short, Jr., $14,919	71-71-65—207 -9
Tommy Armour III, $11,288	73-69-66—208 -8
Russ Cochran, $11,288	72-69-67—208 -8
Tom Pernice Jr., $11,288	73-66-69—208 -8
Jean-Francois Remesy, $11,288	67-70-71—208 -8
Jay Haas, $8,925	70-70-69—209 -7
Jeff Hart, $8,925	71-68-70—209 -7
Wayne Levi, $8,925	69-70-70—209 -7
Larry Mize, $8,925	68-69-72—209 -7
Kenny Perry, $8,925	73-68-68—209 -7
Steve Schneiter, $8,925	68-69-72—209 -7
Rod Spittle, $8,925	66-74-69—209 -7
Joey Sindelar, $6,825	73-67-70—210 -6
Mike Small, $6,825	71-69-70—210 -6
Esteban Toledo, $6,825	72-69-69—210 -6
Duffy Waldorf, $6,825	73-70-67—210 -6
Willie Wood, $6,825	73-70-67—210 -6
Jay Don Blake, $5,250	73-69-69—211 -5
Steve Lowery, $5,250	70-70-71—211 -5
Rocco Mediate, $5,250	69-66-76—211 -5
Gene Sauers, $5,250	71-71-69—211 -5
Clark Dennis, $4,113	73-68-71—212 -4
John Inman, $4,113	71-73-68—212 -4
Larry Nelson, $4,113	68-70-74—212 -4
Kirk Triplett, $4,113	73-71-68—212 -4
Tom Byrum, $3,500	75-70-68—213 -3
Scott McCarron, $3,500	72-68-73—213 -3
Jesper Parnevik, $3,500	69-71-73—213 -3
Billy Andrade, $2,888	69-72-73—214 -2
Tom Lehman, $2,888	73-73-68—214 -2
Loren Roberts, $2,888	75-71-68—214 -2
Hal Sutton, $2,888	71-73-70—214 -2
Jean Van de Velde, $2,450	72-69-74—215 -1
Scott Verplank, $2,275	76-71-69—216 E
Jerry Smith, $2,100	73-70-74—217 +1
Neal Lancaster, $1,715	74-68-76—218 +2
Craig Parry, $1,715	70-71-77—218 +2
Tom Purtzer, $1,715	72-73-73—218 +2
Bob Tway, $1,715	73-74-71—218 +2
John Daly, $1,383	72-72-75—219 +3
John Harris, $1,383	76-71-72—219 +3
Dan Forsman, $1,190	71-77-72—220 +4
Gil Morgan, $1,190	76-71-73—220 +4
Mike Springer, $1,085	76-72-73—221 +5

European Tour

PAUL LAWRIE MATCH PLAY

At Archerfield Links Golf Club
North Berwick, Scotland
Purse: $1.11 million
Yardage: 6,978; Par: 72
Championship

Anthony Wall, England, def. Alex Noren, Sweden, 1 up.

Third Place

James Morrison, England, def. Oliver Fisher, England, 4 and 2.

NFL

Preseason Schedule

Sunday's Game

Green Bay vs. Indianapolis at Canton, Ohio, ccd., field conditions

Thursday's Games

Washington at Atlanta, 7 p.m.
Tampa Bay at Philadelphia, 7 p.m.
Carolina at Baltimore, 7:30 p.m.
New Orleans at New England, 7:30 p.m.
Jacksonville at New York Jets, 7:30 p.m.
Denver at Chicago, 8 p.m.

Friday's Games

Miami at New York Giants, 7 p.m.
Detroit at Pittsburgh, 7 p.m.
Minnesota at Cincinnati, 7:30 p.m.
Cleveland at Green Bay, 8 p.m.
Oakland at Arizona, 10 p.m.

Saturday's Games

Seattle at Kansas City, 4:30 p.m.
Indianapolis at Buffalo, 7 p.m.
Dallas at Los Angeles, 8 p.m. (ESPN)
San Diego at Tennessee, 8 p.m.

Sunday, Aug. 14

Houston at San Francisco, 7 p.m.

SOCCER

MLS

Sunday's Results

Portland 3, Sporting Kansas City 0
Seattle 3, Orlando City 1
New York at Los Angeles, late

Friday's Game

San Jose at Vancouver, 11 p.m.

OLYMPICS ROUNDUP

Winds affect day 2

ASSOCIATED PRESS

RIO DE JANEIRO — The whipping gusts that disrupted athletes and spectators alike were just a prelude to the winds of change that roared through Rio de Janeiro on Sunday night: Serena and Venus Williams lost an Olympic doubles match for the first time.

Day two of the Rio Games proved quite the breeze for some athletes and much too windy for others. The gusts ripped apart a large decorative panel on the swimming venue and even shut down shopping at the megastore — essentially an enormous tent — inside the Olympic Park.

Then, the tempest: the Williams sisters were stunned in the opening round by the Czech Republic's Lucie Safarova and Barbora Strycova 6-3, 6-4 after entering Sunday's match with a 15-0 mark in the Olympics.

China won yet another medal in air rifle on a day nasty winds sent the clay targets in the trap event bobbing and bouncing through the air, forced delays on the tennis courts and whipped up treacherous waves in the Rodrigo de Freitas Lagoon.

The rowing regatta was called off after a two-hour delay when the choppy seas didn't let up. Race officials said winds gusting up to 34 mph pushed buoys into the lanes and capsized two boats during morning practice.

There were 14 golds up for grabs, including four swimming finals, where Katie Ledecky is the overwhelming favorite in the 400-meter freestyle.

Other highlights from Day 2 of the Rio Games:

▸▸ **KOSOVO FIRST:** Majlinda Kelmendi won Kosovo's first Olympic medal, taking gold in the women's 52-kilogram judo division.

▸▸ **BAD BREAK:** A day after gruesomely breaking his left leg while vaulting during men's preliminaries, French gymnast Samir Air Said posted a Facebook video from his hospital bed on Sunday thanking people for their support and pledging to shoot for Tokyo in 2020.

Today's best

RIO DE JANEIRO — Day 3 of the Rio Games features medal action in gymnastics, swimming, fencing, women's rugby, judo and more. Here are some things to watch (all times local):

▸▸ **SWIMMING: Michael Phelps** swims in preliminaries of the men's 200 meter butterfly. He holds the world and Olympic records in the event.

▸▸ **BASKETBALL:** After routing Senegal and setting Olympic records in points, margin of victory and assists, the U.S. women's team faces Spain. The USA men's basketball team takes on Venezuela.

▸▸ **FENCING:** History will be made as U.S. team member **Ibtihaj Muhammad** becomes the first American to compete in the Olympics wearing a hijab.

—ASSOCIATED PRESS

SUMMER OLYMPICS

Medal Table

11 of 14 Sunday's medal events
23 of 306 total medal events

Nation	G	S	B	Tot
China	3	2	3	8
United States	1	5	2	8
Italy	2	3	2	7
Japan	1	0	6	7
Australia	3	0	2	5
South Korea	2	2	1	5
Russia	1	2	2	5
Hungary	2	0	0	2
Sweden	1	1	0	2
Taiwan	1	0	1	2
Thailand	1	0	1	2
Canada	0	1	1	2
Kazakhstan	0	1	1	2
Uzbekistan	0	0	2	2
Argentina	1	0	0	1
Netherlands	1	0	0	1
Belgium	1	0	0	1
Kosovo	1	0	0	1
Vietnam	1	0	0	1
Brazil	0	1	0	1
Denmark	0	1	0	1
Indonesia	0	1	0	1
North Korea	0	1	0	1
Philippines	0	1	0	1
New Zealand	0	1	0	1
Greece	0	0	1	1
Poland	0	0	1	1
Spain	0	0	1	1

PUBLIC NOTICES

ADVERTISEMENT FOR BID

Sealed bids will be received in triplicate by the Housing Authority of the City of Stamford d/b/a Charter Oak Communities for **MODERNIZATION WORK for BOILER ROOM IMPROVEMENTS Including Hot Water Storage Tank Replacement at STAMFORD MANOR**, 26 Main St., Stamford, CT., until **2:00 PM, Thursday, September 8, 2016** at its offices at 22 Clinton Ave., Stamford, CT., 06901, at which time and place all bids will be publicly opened and read aloud.

A satisfactory Bid Bond executed by the bidder and sureties in the amount equal to five percent (5%) of the total bid or a certified check equivalent to five percent (5%) of the total bid shall be submitted with each bid. The successful bidder will be required to furnish Performance and Payment Bonds in the full amount of the contract.

The Housing Authority is exempt from all Federal, State, and Municipal taxes. The Housing Authority of the City of Stamford reserves the right to reject any or all bids and to waive any informality in bids, when such action is deemed to be in the best interest of the Authority. All Bid Documents must be completely filled in when submitted. Bidders will note requirements of minimum wage rates, Section 3, nondiscrimination/equal opportunity rules (Executive Order 11246) and related provisions in the General Conditions.

Plans and Specifications are on file and can be obtained on/or after 8/11/2016 at the Housing Authority Office at 22 Clinton Ave., Stamford, CT 06901, upon depositing Fifty dollars ($50.00) for each set obtained. Plans and Specifications are also available electronically by e-mail by contacting Peter Stothart, at Pstothart@charteroakcommunities.org or calling 203-977-1400 x3322 , 8:30 – 4:30 M-F.

Pre-bid inspection: The Housing Authority will conduct **a pre-bid inspection tour** of the work area on **Thursday, August 18, 2016, at 11:00 AM**. All parties will meet at 26 Main St., Stamford, CT. It is highly recommended that all prospective bidders attend.

No bid may be withdrawn for a period of ninety (90) days subsequent to the opening of bids without the consent of the Housing Authority of the City of Stamford. The Housing Authority is an equal opportunity employment contractor. Minority and women owned business enterprises are encouraged to participate.

HOUSING AUTHORITY OF THE CITY OF STAMFORD
d/b/a CHARTER OAK COMMUNITIES
VINCENT J. TUFO
Executive Director & CEO

Office of Health Care Access Public Hearings

Statute Reference:	19a-638
Applicant(s):	Orthopedic and Neurosurgery Specialists, PC Advanced Radiology MRI Centers
Town:	Stamford
Docket Number(s):	16-32063-CON and 16-32093-CON
Proposal:	Acquisition of a Second Magnetic Resonance Imaging Scanner
Date:	August 30, 2016
Time:	10:00 a.m.
Place:	Department of Public Health, Office of Health Care Access 470 Capitol Avenue, Conference Room A/B Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than August 25, 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 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.

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Benefits available
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Stamford, CT 06097

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for Milford law office. Heavy client contact, ability to work independently.Please email resume to: isable@haflaw.com

RECEPTIONIST
FT/PT for busy veterinary hospital in Norwalk. Must have excellent phone, computer and customer service skills. Exp. preferred. Please email resumes to nvhsusanm@yahoo.com or fax to 203-838-8423

RECEPTIONIST
P/T pos. at front desk in Dental Office. Computer skills req.
860-927-4430 or mail resume to:
P.O. box 40 Kent, CT 06757.

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and Dishwasher F/T with experi - ence. Cookhouse, New Milford.
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

IN THE MATTERS OF:

Orthopaedic & Neurosurgery Specialists, P. C. Docket Number: 16-32063-CON
Advanced Radiology MRI Centers Limited Partnership Docket Number: 16-32093-CON

ORDER

Pursuant to Conn. Gen. Stat. § 19a-639a(f), the above-referenced Dockets are hereby consolidated for purposes of conducting a public hearing. All other proceedings pertaining to the Dockets shall remain separate, including the issuance of a decision in each Docket.

8/5/16
Date

Kevin T. Hansted
Hearing Officer

An Equal Opportunity Employer
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688
Fax: (860) 418-7053

Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Monday, August 08, 2016 2:59 PM
To: User, OHCA; Veyberman, Alla; Riggott, Kaila; Lazarus, Steven; Fernandes, David
Cc: Michele Volpe; Jennifer O'Donnell
Subject: Docket No. 16-32063 and Docket No. 16-32093
Attachments: 201608081453.pdf

Please see the attached request in regards to the above-captioned matters.

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

DEPARTMENT OF PUBLIC HEALTH	:	
DIVISION OF OFFICE OF	:	
HEALTH CARE ACCESS	:	
	:	
IN RE: ORTHOPAEDIC & NEUROSURGERY	:	**DOCKET NO. 16-32063-CON**
SPECIALISTS, P.C.	:	
ACQUISITION OF MAGNETIC	:	
RESONANCE IMAGING SCANNER	:	
	:	
IN RE: ADVANCED RADIOLOGY MRI	:	**DOCKET NO. 16-32093-CON**
CENTERS LIMITED PARTNERSHIP	:	
ACQUISITION OF MRI UNIT FOR	:	
STAMFORD OFFICE	:	**AUGUST 8, 2016**

REQUEST TO RECEIVE COPIES OF ALL CORRESPONDENCE

Orthopaedic & Neurosurgery Specialists, P.C. ("ONS") and Advanced Radiology MRI Centers Limited Partnership (the "ARC"), the applicants in the above-captioned matters, are subject to a consolidated hearing on August 30, 2016. As ONS and ARC are subject to a consolidated hearing, ONS respectfully requests the Department of Public Health division of Office of Health Care Access grant ONS the right to receive a copy of any and all correspondence with respect to ARC Docket No. 16-32093-CON.

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

BY: _____

Its Attorney: Michele Volpe, Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511
Tel. No. 20 3 777-5800
Fax No. 203 777-5806

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via electronic mail, this 8th day of August, 2016 to the following:

Jennifer Groves Fusco
Attorney
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510
jfusco@uks.com

Michele M. Volpe
Bershtein, Volpe & McKeon P.C.

User, OHCA

From: Veyberman, Alla
Sent: Wednesday, August 10, 2016 9:15 AM
To: Michele Volpe; 'Kathleen Gedney'
Cc: User, OHCA; Riggott, Kaila; Lazarus, Steven; Fernandes, David; Greer, Leslie
Subject: Docket # 16-32063 CON: Request for Prefiled Testimony & Issues
Attachments: Request for Prefiled Testimony and Issues 16-32063.pdf

Dear Attorney Volpe,

Find attached a request for Prefiled Testimony and Issues related to the August 30, 2016 public hearing on the above referenced matter.

If you have any questions, please contact Steve Lazarus at Steven.Lazarus@ct.gov or me.

Sincerely,

Alla Veyberman, MS
CT Department of Public Health
Office of Health Care Access (OHCA)
Phone: 860.418.7007
Fax: 860.418.7053
Email: Alla.Veyberman@ct.gov

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

August 10, 2016

Via Email Only

Michele M. Volpe, Esq.
Bershtein, Volpe & McKeon, P.C.
105 Court Street
New Haven, CT 06511

RE: Certificate of Need Application Docket Number: 16-32063-CON
Acquisition of Magnetic Resonance Imaging Scanner

Dear Attorney Volpe:

The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket number on August 30, 2016. The hearing is at 10:00 a.m. at the Department of Public Health, Office of Health Care Access, 470 Capitol Avenue, Conference Room A/B in Hartford, CT 06134. 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. OHCA requests that Orthopaedic & Neurosurgery Specialists, P.C. ("Applicant") submit prefiled testimony by 4:00 p.m. on **August 23, 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.

Additionally, please find attached OHCA's Issues. Please respond to the attached Issues in writing to OHCA by 4:00 p.m. on **August 23, 2016.**

DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Please contact Alla Veyberman or Steven W. Lazarus at (860) 418-7001 if you have any questions concerning this request.

Sincerely,

Kevin T. Hansted
Hearing Officer

Attachment

ISSUES

Office of Health Care Access

Public Hearing Issues

Docket Number: 16-32063-CON: Acquisition of a 1.5 Tesla Magnetic Resonance Imaging Scanner by Othopaedic & Neurosurgery Specialists, P.C.

The Applicant should be prepared to present and discuss supporting evidence on the following issues:

- The clear public need for proposal
- Patient population and payor mix
- Referral patterns for ONS
- MRI capacity/availability (including all existing providers in this service area)

Provide a written response as an attachment to the Hospital's pre-file testimony:

- An updated annual utilization (Jan-July) for the existing MRI scanner
- The information below for 2015:

Total # of patients	# of MRI exams required	# of MRI exams performed at the applicant's location

When responding to the issues above, please refer to the links below:

1. http://www.ct.gov/dph/lib/dph/ohca/hc_facilities_advisory_body/inventory/2014/table_8_(mri).xlsx
2. http://www.ct.gov/dph/cwp/view.asp?a=3902&q=557562
3. http://www.ct.gov/dph/cwp/view.asp?a=3902&q=469574

Greer, Leslie

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Wednesday, August 10, 2016 10:51 AM
To: Fernandes, David; Veyberman, Alla; Lazarus, Steven
Cc: User, OHCA; Michele Volpe (mmv@bvmlaw.com); Michelemvolpe@aol.com
Subject: Docket Nos. 16-32063-CON & 16-32093-CON -- Objection to Request to Receive Copies of All Correspondence
Attachments: Objection to Request for Copies of Correspondence .pdf

Attached please find Advanced Radiology MRI Centers Limited Partnership's Objection to Orthopaedic and Neurosurgery Specialists, P.C.'s Request to Receive Copies of Correspondence, dated August 8, 2016.

Thanks,
Jen

Jennifer Groves Fusco, Esq.
Principal
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510
Office (203) 786.8316
Cell (203) 927.8122
Fax (203) 772.2037
www.uks.com

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: ADVANCED RADIOLOGY MRI CENTERS LIMITED PARTNERSHIP ACQUISITION OF MRI UNIT FOR STAMFORD OFFICE	)	DOCKET NO. 16-32093-CON
IN RE: ORTHOPAEDIC & NEUROSURGERY SPECIALISITS, P.C. ACQUISTION OF MAGENTIC RESONANCE IMAGING SCANNER	)	DOCKET NO. 16-32063-CON
	)	AUGUST 10, 2016

OBJECTION TO REQUEST TO RECEIVE COPIES OF ALL CORRESPONDENCE

Advanced Radiology MRI Centers Limited Partnership ("ARC) hereby objects to Orthopaedic & Neurosurgery Specialists, P.C.'s ("ONS") Request to Receive Copies of All Correspondence, dated August 8, 2016. The Office of Healthcare Access ("OHCA") has consolidated the above-referenced dockets for hearing purposes only and a joint public hearing is scheduled for August 30, 2016. ONS has requested the right to receive copies of "any and all correspondence" with respect to Docket No. 16-32093-CON, ARC's request for permission to acquire a second MRI unit for its Stamford office. ONS has provided no legal basis for its request and it should, therefore, be denied.

ARC and ONS have filed Certificate of Need ("CON") applications for the acquisition of MRI units to be located in Stamford and Greenwich, respectively. On August 5, 2016, OHCA issued an Order, pursuant to Conn. Gen. Stat. § 19a-693a(f), consolidating the dockets for purposes of conducting a public hearing. Section 19a-639a(f) allows OHCA to "hold hearings

on applications of a similar nature at the same time" in the interest of efficiency. However as OHCA's Order clearly states, "[a]ll other proceedings pertaining to the Dockets shall remain separate, including the issuance of a decision in each Docket."

Consolidation of the ONS and ARC CON applications for hearing purposes only does not confer special rights on either applicant. The mere fact that two CON applications are heard jointly does not entitle either applicant to receive information or participate in any way in the other applicant's docket. The right to participate, which typically includes the right to receive copies of correspondence through the issuance of a Final Decision, is reserved for intervenors and parties to a proceeding. Without being designated a party or intervenor, ONS has no greater right of access to the information in Docket No. 16-32093-CON than the general public.

In addition, all public documents in Docket No. 16-32093-CON will be available to ONS, either on the OHCA website or through the filing of a Freedom of Information Act request, in advance of the August 30th hearing. An order that ARC share these documents is, therefore, unnecessary. If however OHCA does order that ARC share documents from Docket No. 16-32093-CON with ONS, ARC requests that its obligation to provide copies of "any and all correspondence" be limited to standard hearing submissions (i.e. appearances, written testimony, responses to hearing issues, etc.). Moreover, if ARC is ordered to share documents with ONS then ARC requests identical access to information from Docket No. 16-32063-CON.

Respectfully Submitted,

ADVANCED RADIOLOGY MRI CENTERS LIMITED PARTNERSHIP

By: _____

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.
265 Church Street
One Century Tower
New Haven, CT 06510
Tel: (203) 786-8300
Fax (203) 772-2037

CERTIFICATION

This is to certify that a copy of the foregoing was sent via electronic mail this 10th day of August, 2016 to the following parties:

Michele M. Volpe, Esq,
Bershtein, Volpe & McKeon, P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
michelemvolpe@aol.com

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: ADVANCED RADIOLOGY MRI CENTERS LIMITED PARTNERSHIP ACQUISITION OF MRI UNIT FOR STAMFORD OFFICE	DOCKET NO. 16-32093-CON
IN RE: ORTHOPAEDIC & NEUROSURGERY SPECIALISITS, P.C. ACQUISTION OF MAGENTIC RESONANCE IMAGING SCANNER	DOCKET NO. 16-32063-CON
	AUGUST 10, 2016

OBJECTION TO REQUEST TO RECEIVE COPIES OF ALL CORRESPONDENCE

Advanced Radiology MRI Centers Limited Partnership ("ARC) hereby objects to Orthopaedic & Neurosurgery Specialists, P.C.'s ("ONS") Request to Receive Copies of All Correspondence, dated August 8, 2016. The Office of Healthcare Access ("OHCA") has consolidated the above-referenced dockets for hearing purposes only and a joint public hearing is scheduled for August 30, 2016. ONS has requested the right to receive copies of "any and all correspondence" with respect to Docket No. 16-32093-CON, ARC's request for permission to acquire a second MRI unit for its Stamford office. ONS has provided no legal basis for its request and it should, therefore, be denied.

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on applications of a similar nature at the same time" in the interest of efficiency. However as OHCA's Order clearly states, "[a]ll other proceedings pertaining to the Dockets shall remain separate, including the issuance of a decision in each Docket."

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In addition, all public documents in Docket No. 16-32093-CON will be available to ONS, either on the OHCA website or through the filing of a Freedom of Information Act request, in advance of the August 30th hearing. An order that ARC share these documents is, therefore, unnecessary. If however OHCA does order that ARC share documents from Docket No. 16-32093-CON with ONS, ARC requests that its obligation to provide copies of "any and all correspondence" be limited to standard hearing submissions (i.e. appearances, written testimony, responses to hearing issues, etc.). Moreover, if ARC is ordered to share documents with ONS then ARC requests identical access to information from Docket No. 16-32063-CON.

Respectfully Submitted,

ADVANCED RADIOLOGY MRI CENTERS
LIMITED PARTNERSHIP

By: _____

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.
265 Church Street
One Century Tower
New Haven, CT 06510
Tel: (203) 786-8300
Fax (203) 772-2037

CERTIFICATION

This is to certify that a copy of the foregoing was sent via electronic mail this 10th day of August, 2016 to the following parties:

Michele M. Volpe, Esq,
Bershtein, Volpe & McKeon, P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
michelemvolpe@aol.com

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.

Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Tuesday, August 23, 2016 3:36 PM
To: Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Fernandes, David; Greer, Leslie; User, OHCA
Cc: Michele Volpe; Jennifer O'Donnell; jfusco@uks.com
Subject: Docket No. 16-32063 - Pre-File Testimony for Aug 30, 2016 Hearing
Attachments: Docket No. 16-32063 - Notice of Appearance - M.Volpe.pdf; Docket No. 16-32063 - Pre-File Testimony of Applicant.pdf

All:

With respect to the above-captioned matter, attached please find:

1) Notice of Appearance for Michele Volpe on behalf of the Applicant.
2) Applicant's Pre-File testimony which includes the responses to OHCA's Issue List as attachments.

Regards,

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

DEPARTMENT OF PUBLIC HEALTH	:	
DIVISION OF OFFICE OF	:	
HEALTH CARE ACCESS	:	**DOCKET NO. 16-32063-CON**
	:	
IN RE: ORTHOPAEDIC & NEUROSURGERY	:	
SPECIALISTS, P.C.	:	
ACQUISITION OF MAGNETIC	:	
RESONANCE IMAGING SCANNER	:	**AUGUST 23, 2016**

NOTICE OF APPEARANCE

In accordance with §19a-9-28 of the Conn. Agencies Reg., please enter the appearance of Michele Volpe, of Bershtein, Volpe & McKeon, P.C., on behalf of Othopaedic & Neurosurgery Specialists, P.C. in the above-captioned matter.

I will attend and participate in the hearing on August 30, 2016 on behalf of Othopaedic & Neurosurgery Specialists, P.C.

Respectfully Submitted,

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

BY: _____

Michele M. Volpe, Juris No. 412124
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511
Tel. No. 20 3 777-5800
Fax No. 203 777-5806
mmv@bvmlaw.com
Its Attorney

DEPARTMENT OF PUBLIC HEALTH	**:**	
DIVISION OF OFFICE OF	**:**	
HEALTH CARE ACCESS	**:**	**DOCKET NO. 16-32063-CON**
	:	
IN RE: ORTHOPAEDIC & NEUROSURGERY	**:**	
SPECIALISTS, P.C.	**:**	
ACQUISITION OF MAGNETIC	**:**	
RESONANCE IMAGING SCANNER	**:**	**AUGUST 23, 2016**

PRE-FILE TESTIMONY OF MARK CAMEL, M.D.

My name is Mark Camel, M.D. and I am the Vice President of Othopaedic & Neurosurgery Specialists, P.C., the applicant in the above-captioned matter ("ONS" or the "Applicant"). I am here today to speak in support of the Certificate of Need ("CON") application in the above-captioned matter (the "Application") to add a second MRI unit to our practice. My professional background is outlined in the Curriculum Vitae enclosed as Attachment A to my testimony.

ONS is a growing orthopedic and neurosurgical physician practice with 23 physician providers with offices in Stamford and Greenwich. To accommodate its patients, deliver cost-effective care and to achieve coordination of care, ONS offers ancillary services such as advanced imaging services, fluoroscopy and x-rays, physical therapy and pain management. Because of the nature of ONS's professional services in orthopedics and neurosurgery, many patients of the Applicant require advanced imaging services such as MRI. ONS currently operates a fixed 1.5 Tesla (1.5T) Magnetom Espree Open Bore MRI scanner (the "Existing Scanner") authorized pursuant to Docket Number 08-31150-CON at its office practice at 6 Greenwich Office Park, Greenwich, CT. As outlined in the Application, ONS is seeking approval to acquire a second MRI - a Siemens Aera 1.5 Tesla (1.5T) MRI ("Proposed Scanner").

The Proposed Scanner will address unmet need while improving the quality, accessibility and cost-effectiveness of MRI services in the area. The existing MRI at ONS has reached its maximum capacity. Acquiring the Proposed Scanner will allow ONS to accommodate all its patients now and into the future.

My testimony will address how: (1) there is a clear public need for an additional MRI scanner for ONS; (2) the Application meets the requirements of the statewide health plan; (3) approval of the Application will positively impact the financial strength of the healthcare system; (4) approval of the Application will improve quality, accessibility and cost effectiveness of health care delivery in the region; (5) the Applicant does not deny MRI scans to patients based on Medicaid or indigent status; (6) approval of the Application will not create unnecessary duplication of health care services in the area and will not create underutilization; and (7) approval of the Application will result in greater choice and access for patients.

I. Clear Public Need for Additional MRI Services for ONS Patients

ONS has provided clear and convincing evidence based on its historic utilization and projected volume growth showing a need for an additional MRI. See Attachment B. ONS meets the need methodology in Chapter 5 of the Statewide Health Care Facilities and Services Plan.[1] Utilizing OHCA's standard of 4,000 scans, the capacity of the Existing Scanner was operating at 132% capacity for 2015.[2] ONS's internal capacity is also over DPH's suggested capacity of 85% utilization.[3] In 2014, the Existing Scanner was averaging an internal utilization of 91% and in 2015, the Existing Scanner averaged over 92% utilization based on the internal capacity of ONS alone. ONS's internal capacity is based on the number of scans that ONS can accommodate as

[1] Connecticut Department of Public Health, Office of Health Care Access, "*Statewide Health Care Facilities and Services Plan, October 2012*"; Supplemented 2014, at 61(hereinafter the "Statewide Health Plan").
[2] In 2015 ONS's Existing Scanner's volume was 5,262.
[3] Statewide Health Plan at 61.

determined by the number of MRI slots available. To meet current patient demand, ONS operates its scanner far beyond normal business hours which opens up availability more than OHCA's standard of 4,000 scans per year. Further, ONS has grown from 17 physicians in 2012 to 23 physicians in 2016 and ONS's patient population has grown from 42,082 in 2012 to an estimated 56,664 in 2016. ONS is continuing to add new physicians and patients. Under any methodology or formula applied by OHCA, ONS's current utilization is well over the 85% capacity threshold. An updated utilization analysis for January through July 2016 is provided on Attachment C.

Additionally, other providers in the Primary Service Area[4] cannot accommodate the anticipated need for ONS patients. Nearly all of the other Connecticut MRI scanners in the service area are operating above capacity.[5] Greenwich Hospital's main campus units are operating at 117% and 80% capacity; Stamford Hospital's main campus is operating at 161% capacity and the Tully Health Center is operating at 109% capacity; and Advanced Radiology is operating at 165% capacity; Norwalk Hospital Radiology & Mammography Center is operating at 82% capacity.[6]

ONS and additional other providers in the Primary Service Area cannot accommodate the anticipated need for ONS patients. ONS is continually expanding its business to include new physicians which has, in turn, increased its patient population and volume. See Attachment D for 2015 patient population analysis requested as an attachment to this pre-file testimony. ONS expects to continue to increase the number of providers in its practice and thus the number of

[4] The Primary Service Area has been identified in the Application as the Connecticut towns and cities of Greenwich, Stamford, New Canaan, Darien, Norwalk and Wilton, Connecticut as well as Port Chester and Rye, New York (the "Service Area" or "Primary Service Area").
[5] Statewide Healthcare Facilities and Services Inventory – 2014, Table 8 ("Magnetic Resonance Imaging (MRI) Scanning Providers") published by the Department of Public Health (2014) (hereinafter "Table 8"). http://www.ct.gov/dph/lib/dph/ohca/publications/2014/final_2014__facilities_plan_-_2_24_15.pdf
[6] Utilization capacity based on OHCA's 4,000 scans per year per MRI.

patients. ONS has grown from 17 physicians in 2012 to 23 physicians in 2016. ONS's growth cannot be accommodated by other scanners in the area as nearly all providers are operating at or above capacity. Other MRI providers in the area will not be able to absorb future ONS need. Specifically, Advanced Radiology, the other non-hospital provider of MRI services is operating at 165% capacity at its Stamford location. More important, Advanced Radiology MRI utilization does not factor into ONS patient population or MRI volume as ONS is less than one percent (1%) of Advanced Radiology's Stamford MRI volume.

ONS's acquisition of the Proposed Scanner will help avoid issues that may arise if the Existing Scanner is down for maintenance, service or any other reason. It is critical for ONS to have a backup for its patients as a second scanner will limit interruption to care and maintain consistent access. Approval of the Proposed Scanner will also avoid delays in diagnosis and treatment that may arise with inadequate MRI access.

II. The Application Meets the Requirements of the Statewide Health Plan

The approval of the Application aligns with all standards and guidelines enumerated in the Statewide Health Plan published by OHCA in October of 2012 and supplemented in 2014.

Consistent with the guiding principles enumerated on page two (2) of the Statewide Health Plan, the long term viability of ONS as a community based physician practice will be increased as it will be better equipped to adapt to the demands and needs of its patients. ONS patients will continue to receive the benefit of enhanced continuity of care, service, communication and coordination that in-office imaging provides. ONS provides all of its patients with copies and discs of their MRI images. Further, the proposal will maintain access to ONS's in-office MRI services as all ONS patients will be able to receive the benefit of in-office MRI services and accommodate the volume and demand fluctuations. ONS will be able to

accommodate all its patients for MRI services even if one of the MRI machines is down or is being serviced. Equitable access to ONS's MRI services will also benefit patients and their health plans' desire for outpatient office imaging.

The proposal supports the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner by having more ONS patients receive in-office imaging that delivers a more appropriate level of care than hospital-based or other off-site alternatives. The proposal will also maintain the quality of MRI services to ONS patients by allowing ONS to better track patient compliance. The proposal also promotes planning to contain costs by providing MRI services at a lower cost alternative to facility-based MRI. As a result of acquiring the Proposed Scanner, ONS will be better equipped to measure and monitor specific MRI needs among its patients.

In addition to meeting the guiding principles outlined in the CON statutes, regulations and Statewide Health Plan, the Application meets all the standards and guidelines specific to MRIs outlined in Chapter 5.[7] For MRI applications, the Statewide Health Plan requires that the applicant:

a. Identify the Primary Service Area;

The Primary Service Area has been identified in the Application as towns and cities of Greenwich, Stamford, New Canaan, Darien, Norwalk and Wilton Connecticut. ONS also provides services to patients in New York including the Port Chester and Rye, New York.

[7] Statewide Health Plan at 60.

b. Identify existing services (i) of the applicant, and (ii) of other providers in the Primary Service Area;

ONS has identified its current services and the other Connecticut providers of MRI services in the area, including three hospital-based providers. The other providers in the Connecticut Primary Service area include on-campus imaging at each Greenwich Hospital and Stamford Hospital as well as Greenwich Hospital's off-campus MRI in Stamford, Stamford Hospital's Tully Health Center MRI, Hospital for Special Surgery Stamford campus MRI, Norwalk Hospital and Norwalk Hospital's off campus Hospital Radiology & Mammography Center in Norwalk. Advanced Radiology also has an MRI in the Connecticut Primary Service Area.

c. Provide capacity of existing services identified in subsection (1)(b), if available;

ONS's internal capacity is over DPH's suggested capacity of 85% utilization.[8] In 2014, the Existing Scanner is averaging a utilization of 91% and in 2015, the Existing Scanner averaged over 92% utilization based on the number of slots available at ONS during its operating hours. Utilizing OHCA's standard of 4,000 scans per year, the capacity of the Existing Scanner was operating at 132% capacity for 2015. Additional providers in the Service Area cannot accommodate the existing MRI volume for ONS patients. As important, MRI providers in the area are not be able to absorb the future need of ONS patients. If all future ONS patients were not able to get scans at ONS, they could face long wait times and/or may be required to travel long distances to obtain an MRI.

[8] Statewide Health Plan at 61.

d. Explain the likely impact on existing services identified in subsection (1)(b);

The Proposed Scanner will not negatively impact other providers in the service area as ONS only provides MRI services to its own patients. Further, the Proposed Scanner will positively impact the diversity of patient choice and cost in the geographic region because more ONS patients will have a choice to receive MRI services at ONS's private practice setting.

e. Provide actual and proposed hours of operation for services;

Currently, ONS operates is Existing Scanner Monday through Friday from 7 am to 9 pm, Saturday from 7 am to 5 pm and Sunday from 7 am to 1 pm. Any changes to the current hours will depend on patient needs and ONS's ability to accommodate preferred patient scheduling times.

f. Provide 3-year projection of utilization, with reasonable assumptions on MRI scan volume and capacity; and

This information has been provided in the Application on page 32 and 91 and is as follows:

PROJECTED UTILIZATION BY SERVICE

	Projected Volume			
Service*	**FY 2016****	**FY 2017****	**FY 2018****	**FY 2019**
MRI Scans	5,474[9]	6,675	6,942	7,029
Total	**5,474**	**6,675**	**6,942**	**7,029**

[9] FY 2016 represents Existing MRI only; Proposed MRI will not be in service until of FY 2017.

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY EQUIPMENT UNIT

Equipment* **	Actual Volume (Last 3 Completed FYs) [10]				**CFY Volume***	**Projected Volume (First 3 Full Operational FYs)****		
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[11]	FY 2017	FY 2018	FY 2019
Existing MRI	4,565	4,800	5,189	5,262	5,474[12]	3,338	3,471	3,515
Proposed MRI	-	-	-		-	3,337	3,471	3,514
Total	**4,565**	**4,800**	**5,189**	**5,262**	**5,474**	**6,675**	**6,942**	**7,029**

g. Demonstrate need consistent with the need methodology in the Plan. The Applicant shall demonstrate that the proposed scanner meets either of the following criteria:

a. The applicant is expected to demonstrate that the Percent Utilization of Current Capacity in the Primary Service Area exceeds 85%.

b. If the applicant has an MRI scanner in the Primary Service Area, the applicant is expected to demonstrate that its Percent Utilization of Current Capacity exceeds 85%.

The Existing Scanners is operating above 85% capacity.[13] Based on ONS's internal capacity of 6,300 slots per year, the Existing Scanner averaged a utilization of 92% in 2015. ONS has to operate above what OHCA considers full time operation of a MRI scanner (4,000 scans per year) to meet patient demand. Utilizing the Statewide Health Plan maximum of 4,000 scans per year, ONS was operating at 132% capacity in 2015.

[10] The Applicant's Fiscal Year is the Calendar Year.
[11] Proposed 2016 Volume. FY 2016 represents Existing MRI only; Proposed MRI will not be in service until FY 2017.
[12] Due to CON approval time and build out time, the Proposed MRI is not anticipated to be in service until FY 2017.
[13] Application at 32; Application at 91.

The Plan requires that the Applicant must also demonstrate that the proposal meets the following criteria:

a) Hospital applicants shall be accredited by the Joint Commission on Accreditation of Healthcare Organizations or certified by Medicare directly or through a deeming agency;

Not applicable as ONS is a physician practice applicant and maintains accreditation by the American College of Radiology.

b) Non-hospital facilities shall obtain accreditation from the American College of Radiology within eighteen months of the date on which imaging activities are first conducted;

The Existing Scanner is fully-accredited by The American College of Radiology.[14] See Attachment E for ONS's current American College of Radiology accreditation. ONS will obtain accreditation for the Proposed Scanner.[15]

c) A full-time board certified radiologist, who is a member in good standing with the American College of Radiology, shall be responsible for managing the operation of the MRI scanner and for the written interpretation of the MRI scan;

ONS contracts with Greenwich Radiology for the provision of professional radiology services and will continue to do so with the Proposed Scanner.[16] Therefore, a full time, board certified radiologist who is in good standing with the American College of Radiology will continue to work with ONS to be responsible for maintaining the MRI scanner, its operations and interpreting images.

[14] Application at 14.
[15] Application at 15.
[16] Application at 14.

d) *Personnel shall be trained, consistent with guidance of the American College of Radiology, in the use of the MRI scanner and the safety procedures to follow in the event of an emergency;*

ONS follows the current American College of Radiology Guidelines and will continue to do so with the Proposed Scanner.[17] All of its personnel are trained consistent with such guidelines and safety procedures.

e) *When imaging is performed a physician must be available either on-site or with immediate access to remote viewing of images as they are acquired. The physician in this case must be qualified to interpret images, make adjustments to imaging parameters or protocols, make decisions regarding magnetic field strength risks, and consult with the technologists on technical factors related to the study acquisition. This physician must be board certified to perform and interpret the examinations so produced;*

ONS contracts with Greenwich Radiology for the provision of professional radiology services and will continue to do so with the Proposed Scanner.[18] A full time, board certified radiologist who is in good standing with the American College of Radiology will continue to interpret images, make adjustments to imaging parameters or protocols, make decisions regarding magnetic field strength risks, and consult with the technologists on technical factors related to the study acquisition and work with ONS to be responsible for maintaining the MRI scanner, its operations and interpreting images.

[17] Application at 16.
[18] Application at 14.

f) When contrast is administered, a physician capable of addressing any contrast reactions or adverse events must be on site and immediately physically available to assist in the imaging suite. This physician must be in proximity such that he/she can respond immediately if called. This is not intended to require the physical presence of a physician in the room or suite at all times;

Physicians are always on-site during contrast MRI scans and ONS will continue this practice with the Proposed Scanner.

g) The facility or provider must have a policy that explains what steps will be taken to respond in the event of a medical emergency for patients undergoing MRI scans, including the plan for responding to allergic reactions related to contrast media or other drugs or biologicals used in connection with the scan; and

The Applicant has emergency safety policies and protocols in place to respond to medical emergencies. Additionally, the Applicant maintains and employs safety and emergency policies and protocols to address certain medical conditions.

h) The facility or provider shall not deny MRI scanner services to any individual based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients.[19]

ONS has never denied an MRI to any patient based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients. ONS sees patients with Medicaid as their primary or secondary insurance. In 2015, ONS saw 23 patients with Medicaid as their primary insurance and 1,453 patients with Medicaid as their secondary insurance. ONS

[19] Plan at 62.

writes off care provided to these patients and such write off in 2015 was $87,868.81. ONS provides Medicaid neurosurgery care at its office.

Additionally, ONS works one on one with patients who may be unable to pay part or all of the bills. Based on the specific patient's circumstances, the patient may be offered a payment plan or a payment discount/adjustment. ONS has dedicated insurance specialists to assist patients with questions regarding out of network care, copays, deductibles and other insurance and financial need questions. In addition to the Medicaid patients above, in 2015, ONS saw 46 patients who had no health insurance or did not pay. ONS wrote of the cost of this care- $15,752.94. ONS also provides free care to the Medicaid population by participating in the Greenwich Hospital orthopedic clinic as further described below in Section V.

The Statewide Health Plan also requires the Applicant to demonstrate that it has sufficient capital to finance the project and provide projections concerning the revenue and expenses for the first three years of the proposal. The Statewide Health Plan additionally requires certain other factors for consideration which include:

a. The capabilities of the proposed MRI scanner as compared to existing scanners;

The Proposed Scanner offers new and unique MRI functionality on account of its enhanced software allowing for faster scan time and improved noise suppression.

b. The ability of the applicant to serve an underserved population and not jeopardize the financial viability of the project;

ONS is a financially strong physician practice and its financial viability will not be impacted if it has to accommodate certain ONS patients who have an issue affording an MRI scan.

c. The impact on existing services, including avoiding delays in timely diagnosis or treatment;

There will only be a positive impact on existing services offered by ONS to its patients. The Proposed Scanner will help ONS avoid delays for its patients in scheduling MRI scans because all ONS patients will have access to ONS's scanner in a timely manner.

d. The use of the scanner for clinical research;

ONS is committed to clinical research and has both completed research on and is in the process of researching several projects relating to orthopedic and neurological issues including the distal upper extremities, shoulders, knees, and brains. ONS works in conjunction with the ONS Foundation for Clinical Research and Education ("ONSF"), a charitable organization with an affiliation to Greenwich Hospital. This organization strives to improve standards of excellence for the treatment of musculoskeletal disorders through clinical research, physician and patient education, and community outreach programs. The MRI is utilized in ONS and ONSF research to track results. A summary of various completed and current clinical research projects utilizing the MRI are included as Attachment F. Without greater MRI capability and access, the clinical research through ONS and ONSF will be hindered.

e. The history of the applicant in running accredited, financially successful facilities;

ONS has operated a successful private physician practice for many years. ONS has successfully operated an MRI at its office since 2008 and has never been in jeopardy of losing its accreditation from the American College of Radiology.

f. The applicant's ability to make radiation dose exposure decisions; and

The Applicant is able to make radiation dose exposure decisions as it has been operating the Existing Scanner for almost ten (10) years without event. In addition, ONS has operated in-office x-ray and fluoroscopy for many years without a significant event.

As demonstrated above, ONS meets all applicable MRI standards and guidelines outlined in the Statewide Health Plan.

III. Approval of The Application Will Positively Impact the Financial Strength of the Healthcare System

This proposal will positively impact the financial strength of the state's health care system because ONS will be offering its patients more cost effective and collaborative MRI scans and the proposal will help maintain the viability of an independent community based physician practice.[20] Additionally, this proposal is financially feasible for the Applicant because ONS has the utilization volume numbers to support an additional scanner. There are no projected incremental losses from operations resulting from the implementation of the Proposed CON and the proposal shows a positive net income in the first year of operations.

IV. Approval of the Application Will Improve Quality, Accessibility and Cost Effectiveness of Health Care Delivery in The Region

The quality, accessibility and cost-effectiveness of health care in the region will be improved because more ONS patients will be able to receive MRI scans at their physician's office and thus benefit from the enhanced communication and coordination that physician based

[20] Connecticut has seen a massive influx of community-based providers be employed by hospitals and hospital-based systems. Intensive consolidation of providers leaves patients with little choice in many market places. ONS is an independent community based provider whose physicians are not employed by a health system. *See*, State of Connecticut Office of the Attorney General "*Report of the Connecticut Attorney General Concerning Hospital Physician Practice Acquisitions and Hospital-Based Facility Fees*" (April 16, 2014); http://www.ct.gov/ag/lib/ag/press_releases/2014/20140416_oag_report_hospitalmdacquisitions_hospitalbasedfacfee.doc200x.pdf.

in-office imaging provides. ONS contracts with highly qualified radiologists in the area to interpret its scans and maintain compliance with community and industry standards.

ONS will also be able to accommodate patients should the Existing Scanner be down for repairs or servicing. ONS will be able to accommodate all of its scan volume and projected future growth in a timelier manner.

ONS is an independent community based physician practice and as such, its patients will not be subject to additional facility fees. Hospital providers account for the majority of the scanners in the service area. Connecticut has seen a massive influx of community-based providers be employed by hospitals and hospital-based systems. Intensive consolidation of providers leaves patients with little choice in many market places. ONS is an independent community based provider whose physicians are not employed by a health system. With the Proposed Scanner, more patients will be given a choice to receive their MRI at ONS and potentially avoid additional costs for the MRI, facility charges or higher contracted rates.

V. The Applicant Does Not Deny Patients based on Medicaid or Indigent Status

As stated above, ONS sees patients with Medicaid as their primary or secondary insurance. In 2015, ONS saw 23 patients with Medicaid as their primary insurance and 1,453 patients with Medicaid as their secondary insurance. ONS writes off care provided to these patients. ONS writes off care provided to these patients and such write off in 2015 was $87,868.81. ONS provides Medicaid neurosurgery care at its office.

ONS also provides free services to patients in the Service Area. ONS provides a surgeon and Physician Assistant to the Greenwich Hospital Orthopedic Clinic one (1) day a week from 1-4 PM, three (3) weeks of each month. On average, ONS providers see twelve (12) patients in a day. These patients are either Medicaid, Medicare or uninsured. Services to these patients are

all provided pro bono including any surgeries that result from the visits. The surgery value alone of the free care to Medicaid patients in 2015 was in excess of $200,000. ONS is committed to serving the orthopedic needs of all residents of the Service Area.

ONS has a diverse patient population and dedicates resources to providing free care. As stated above in Section II, ONS has never denied an ONS patient an MRI based on the patient's ability to pay or source of payment. ONS works one on one with patients who may be unable to pay part or all of the bills. Based on the specific patient's circumstances, the patient may be offered a payment plan or a payment discount/adjustment. ONS has dedicated insurance specialists to assist patients with questions regarding out of network care, copays, deductibles and other insurance and financial questions. ONS works with many patient populations and payors including a 24% Medicare population.[21]

It should be noted that Fairfield County has a low Medicaid MRI population and there does not appear to be any access issues for the Medicaid population. This is evidenced by the fact that the Hospital for Special Surgery's ("HSS") significant efforts to attract Medicaid recipients to its Stamford MRI have only resulted in 1.9% percent of its total patient population.[22] With respect to is Stamford MRI, HSS has enrolled in Medicaid, sent letters to providers informing area providers of its Medicaid participation status, offered clinic hours, hosted community education events, and done many other steps to increase its Medicaid population. In spite of these efforts, HSS's Medicaid patient population remains under 2%. This indicates that the Medicaid need for MRI is low in Fairfield county.

[21] Application at 33.
[22] OHCA Docket No. 12-32780-CON, Attachment 6 to Agreed Settlement Annual Report dated April 15, 2016.

VI. Approval of the Application Will Not Create Unnecessary Duplication of MRI in The Area and Will Not Create Underutilization

Approval of the Application will not create unnecessary duplication of MRI services in the area because nearly all of MRI scanners in the area are operating at or over capacity or otherwise maintain high utilization. ONS's capacity is over DPH's suggested capacity of 85% utilization. In 2014, the Existing Scanner is averaging a utilization of 91% and in 2015, the Existing Scanner averaged over 92% utilization pursuant to ONS's own internal analysis. The Existing Scanner operated at 132% capacity in accordance with DPH's utilization criteria. Since there is a critical need for additional MRI services in the area based on all the current provider over-utilization, there will be no duplication of existing or approved health care services and no under-utilization. Further, ONS provides MRI services only to its own patients. Because of the limited clinical scope of services (e.g. patients with orthopedic and/or neurological needs), MRI activity at ONS has no effect on the MRI volume needed on other body systems. ONS can operate two scanners at appropriate utilization levels without decreasing utilization of other providers in the service area.

VII. Approval of the Application Will Result in Greater Choice for Patients and Will Not Adversely Affect Other Providers or Negatively Impact the Diversity of Health Care Providers and Patient Choice in the Geographic Region

Approval of the Proposed Scanner will positively impact the diversity of patient choice in the geographic region because more ONS patients will have a choice to receive MRI services at ONS's private practice setting. The Proposed Scanner will not negatively impact other providers in the service area as ONS only provides MRI services to its own patients. With the addition of the Proposed Scanner, ONS will be able to offer its expanding patient base the choice

to receive MRI services at its office based location. Approval of the Proposed Scanner will allow ONS to accommodate is projected patient volume in the years to come without affecting other MRI providers.

ONS has established in its Application need for a second MRI and that approval of this Application will have no adverse effect on other MRI providers in the service area. Of note, Advanced Radiology asserts a certain number of patients are referred from ONS to Advanced Radiology annually. However, ONS cannot verify the accuracy of this statement. Even assuming Advanced Radiology's figure is correct, these referred patients barely account for 1% of annual MRI volume at the Stamford Office of Advanced Radiology. Advanced Radiology has multiple MRI scanners so the impact to Advanced Radiology as a whole is extremely minimal and insignificant. Further, ONS only represents one of 500 referral sources for Advanced Radiology.[23] Based on these facts, there is no adverse effect to Advanced Radiology as ONS is a mere fraction of 1% of Advanced Radiology's MRI volume and just one out of 500 referral sources.

VIII. Conclusion

ONS has proven the clear public need for MRI, ONS meets the requirements of the statewide health plan, the MRI will positively impact the financial strength of the healthcare system, improve MRI quality, accessibility and cost effectiveness of health care delivery in the region, and ONS has never denied an MRI to a patient based on Medicaid or indigent status. Approving the MRI for the Applicant will not create unnecessary duplication of health care services in the area and will not create underutilization but rather result in greater access to cost

[23] Advanced Radiology CON at 13.

effective care delivered by community based physicians and surgeons. See Attachment G for additional information directly response to OHCA's Issue List dated August 10, 2016.

Attachment A
CV

CURRICULUM VITAE

MARK H. CAMEL, M.D.

Home Address	47 Beechcroft Road Greenwich, Connecticut 06830
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Work Address	Orthopaedic & Neurosurgery Specialists, PC 6 Greenwich Office Park Greenwich, Connecticut 06831
Work Telephone	(203) 869-1145 X 248
Personal	Married: Linda Chiswick, May 3, 1987 Children: Andrew, Matthew, Edward

EDUCATION AND PROFESSIONAL TRAINING

1977	Bachelor of Arts: Political Science and Biology University of Rochester Rochester, New York
1981	Doctor of Medicine Washington University School of Medicine Saint Louis, Missouri
1981-1982	Internship: General Surgery Barnes Hospital Saint Louis, Missouri
1982-1985	Resident: Neurological Surgery Barnes Hospital Saint Louis, Missouri
1985-1986	Chief Resident: Neurological Surgery Barnes Hospital Saint Louis, Missouri
1986-1987	Fellowship: Neurological Surgery Washington University School of Medicine

Saint Louis, Missouri

BOARD CERTIFICATION

1990 American Board of Neurological Surgery

LICENSURE

Missouri
Connecticut
New York

PROFESSIONAL EMPLOYMENTS

1987-1998 Neurological Surgeon
Private Practice
Stamford, Connecticut

1998-Present Neurological Surgeon
Private Practice
Greenwich, Connecticut

PROFESSIONAL SOCIETIES

Congress of Neurological Surgeons
American Association of Neurological Surgeons
The New England Neurosurgical Society
The Physician's Scientific Society

PROFESSIONAL ACTIVITIES

1995-1996 Vice President, Congress of Neurological Surgeons

1992-2000 Member, Executive Committee, Congress of Neurological Surgeons

1999-2000 Chairman, Strategic Financial Planning Committee,
Congress of Neurological Surgeons

1993-1995 Chairman, Membership Committee, Congress of Neurological Surgeons

1992-1995 Chairman, Exhibits Committee, Congress of Neurological Surgeons

1991-1992 Member, Editorial Board, Clinical Neurosurgery

1993-1995 Member, Professional Conduct Committee,
Congress of Neurological Surgeons

PROFESSIONAL ACTIVITIES (Continued)

1993-1994 Member, Guidelines and Outcomes Committee, American Association of Neurological Surgeons

1991-1992 Member, Executive Committee, Greenwich Hospital

1996-1997 Member, Credentials Committee, Greenwich Hospital

ACADEMIC AFFILIATIONS

2010-2011 Clinical Assistant Professor of Neurological Surgery, Weill Cornell Medical College

Attachment B
Clear Public Need Analysis

I.	**Need Analysis based on ONS Actual Capacity**	ONS is operating at **91%** Percent Utilization Capacity for the existing MRI
I.	**Need Analysis based on application of the Statewide Health Plan Chapter 5, Section 3(b)**	ONS is operating at **132%** Percent Utilization of Current Capacity for the existing MRI, well in excess of 85% pursuant to the Statewide Health Plan
II.	**Need Analysis based on application of the Statewide Health Plan Chapter 5, Section 3(a)** As Applied to Greenwich, Stamford, New Canaan, Darien, Norwalk and Wilton with all published utilization[24]	The Service Area is operating at **94%** Percent Utilization of Current Capacity

[24] Statewide Healthcare Facilities and Services Inventory – 2014, Table 8 ("Magnetic Resonance Imaging (MRI) Scanning Providers") published by the Department of Public Health (2014) (hereinafter "Table 8"). http://www.ct.gov/dph/lib/dph/ohca/publications/2014/final_2014__facilities_plan_-_2_24_15.pdf

I. Need Analysis from CON Application:

Application Filed 1.20.16

- The Existing Scanner is operating well over capacity based on numbers identified in the Statewide Health Care Facilities and Services Plan as well as internal capacity numbers of ONS. ONS has reached maximum capacity on its existing MRI under any analysis.
- ONS has had to extend its normal business hours to accommodate its patient need. Even with the extended hours, ONS cannot accommodate the needs and access of practice patients in the time frame the patients desire. Additionally, ONS is continually expanding its business to include new physicians which has also increased its patient volume and therefore increased demand for MRI scans.[25]
- The Applicant has established that the percent utilization of the current capacity of the Existing Scanner exceeds 85%. In 2014, the Existing Scanner had an average utilization of 91%. In 2015, the Existing Scanner is averaging a utilization of 92% and in September 2015, the Existing Scanner averaged over 94% utilization.[26]
- Annual volume increases and proposed annual volume increases are on account of ONS's patient base that is continually growing due to the addition of new providers to the practice. ONS had added an additional five (5) providers since 2012 and is continuing to grow.[27]

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY EQUIPMENT UNIT[28]

Equipment* **	Actual Volume (Last 3 Completed FYs)[29]			**CFY Volume***	**Projected Volume (First 3 Full Operational FYs)****			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[30]	FY 2017	FY 2018	FY 2019
Existing MRI	4,565	4,800	5,189	5,244 [31]	5,474[32]	3,338	3,471	3,515
Proposed MRI	-	-	-	-	-	3,337	3,471	3,514
Total	**4,565**	**4,800**	**5,189**	**5,244**	**5,474**	**6,675**	**6,942**	**7,029**

[25] OHCA Docket No. 16-32063, ONS Certificate of Need Application ("Application") at 14.
[26] Application at 17.
[27] Application at 27.
[28] Application at 81.
[29] Calendar Year.
[30] FY 2016 represents Existing MRI only; Proposed MRI will not be in service until FY 2017.
[31] FY 2015 volume represents annualized volume, which is based on 9 months of actual volume (January 1, 2015 to September 30, 2015).
[32] Due to CON approval time and build out time, the Proposed MRI is not anticipated to be in service until FY 2017.

Completeness Question Response Filed 3.30.16

- The Existing Scanner's utilization percentage is a calculation based on the number of slots utilized in a year divided by the number of slots available. A slot time is 40 minutes. The number of slots available is based on the capacity of the machine during the hours ONS is open (adjusted for snow emergencies, service and holidays). Currently, ONS offers approximately 21 slots each day Monday through Friday, 15 slots on Saturdays and 8 slots on Sundays. As previously stated, ONS has had to add additional business hours to accommodate patient need. Sunday hours started in 2014.

  Slots are lost each year due to service, weather and holidays. In 2015, ONS lost 45 slots to service, 44 slots to weather and 159 slots to holidays. The total 2015 actual slots available was approximately 6,300 and the number of slots used was 5,813. This resulted in a 92% utilization. In 2014, ONS lost 42 slots to service, 50 slots to weather and 141 slots to holidays. In 2014, the total number of slots available was approximately 6,276 and the number of slots used was 5,719. This resulted in a 91% utilization.

  Please note that certain MRI scans requiring a longer scan time require the use of two or more slots. Therefore, the number of slots utilized is not equal to the volume of scans performed.

  The 85% utilization standard derives from OHCA's Statewide Health Care Facilities and Services Plan at page 61.[33]

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY EQUIPMENT UNIT[34]

Equipment* **	Actual Volume (Last 3 Completed FYs) [35]				**CFY Volume***	**Projected Volume (First 3 Full Operational FYs)****		
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[36]	FY 2017	FY 2018	FY 2019
Existing MRI	4,565	4,800	5,189	5,262	5,474[37]	3,338	3,471	3,515
Proposed MRI	-	-	-		-	3,337	3,471	3,514
Total	**4,565**	**4,800**	**5,189**	**5,262**	**5,474**	**6,675**	**6,942**	**7,029**

Completeness Question Response Filed 5.11.16

- The impact of additional physicians on volume projections is based on the Applicant's continually expanding Practice. Expanding the Practice by adding new physicians increases its patient volume and therefore increases demand for MRI scans. Additionally, new physicians take years to ramp up to full patient rosters so it is anticipated that the

[33] Application at 85-86 (completeness response filed 3.30.16).
[34] Application at 91 (completeness response filed 3.30.16).
[35] The Applicant's Fiscal Year is the Calendar Year.
[36] Proposed 2016 Volume. FY 2016 represents Existing MRI only; Proposed MRI will not be in service until FY 2017.
[37] Due to CON approval time and build out time, the Proposed MRI is not anticipated to be in service until FY 2017.

physicians added in recent years will continue to increase patient load in the years to come.[38]

The assumptions used in Table 6 are based on an average growth of approximately one (1) to two (2) additional physicians per year. From 2012 to 2015, ONS added approximately one (1) – two (2) physicians per year. ONS assumes a continued growth of one (1) to two (2) physicians per year for 2016 (approximately 23 physicians), 2017 (approximately 25 physicians), 2018 (approximately 26 physicians), and 2019 (approximately 27 physicians). In 2012, the average number of scans per physician was 267. With respect to years 2017-2019, a rate of 267 scans per physician is assumed.[39]

[38] Application at 94 (completeness response filed 5.11.16).

[39] With respect to the anticipated volume in 2016, because the New Scanner will not be in service in 2016, ONS does not have the current capacity to accommodate all physician needs and is limited by the capacity of its current scanner.

II. Need Analysis from the Statewide Health Plan 3(b):

ONS meets the need methodology under 3(b) for an applicant that has an MRI scanner in the Primary Service Area as ONS has demonstrated that its MRI Percent Utilization of Current Capacity exceeds 85%. ONS performed 5,262 scans in 2015. Utilizing OHCA's standard of 4,000 scans, the capacity of the Existing Scanner was operating at 132% capacity for 2015. This is where the need analysis should end and the ONS CON application should be approved.

III. Need Analysis from the Statewide Health Plan 3(a):

Analysis under 3(a) of Chapter 5 of the SWHP is not required for ONS to receive approval from OHCA. However, even applying criteria under 3(a), the MRI Percent Utilization of Current Capacity in the Primary Service Area is over 85%. Based on a Connecticut service area of Greenwich, Stamford, New Canaan, Darien, Norwalk and Wilton the MRI Percent Utilization of Current Capacity is 94%.

"**Utilization Rate per Capita**" – none published by OHCA, BVM analysis indicates **0.144** (see below)*
"**Utilization Rate**" – 0.144 * 339,728= **48,921**
"**Current Estimated Capacity**" - 13*4,000 = **52,000**
"**Percent Utilization of Current Capacity**"- 48,921/ 52,000 = **94%** utilization

With 1 new scanner - 48,921/ 56,000 = **87% utilization**
With 2 new scanners – 48,921/ 60,000 **= 82% utilization**

Total Service Area Population[40]:

Greenwich	62,610
Stamford	128,278
New Canaan	20,314
Darien	21,689
Norwalk	88,145
Wilton	18,692
Total:	**339,728**

[40] Source: "ESTIMATED POPULATIONS IN CONNECTICUT AS OF JULY 1, 2014" published by the Department of Public Health http://www.ct.gov/dph/lib/dph/hisr/hcqsar/population/pdf/pop_towns2014.pdf (most recent).

Number of MRI in the Service Area and Utilization

		Actual 2013 Volume[41]	SWHP Available
Greenwich	1. Greenwich Hospital 1.5 2. Greenwich Hospital 3.0 3. ONS 1.5	4,693 3,218 4,800	4,000 4,000 4,000
Stamford	4. Stamford Hospital 1.5 5. Greenwich Hospital Off Campus 1.5 6. Stamford Hospital Tully Health Center 1.5 7. Advanced Radiology Consultants 1.5 8. Hospital for Special Surgery	6,427 1,991 4,360 6,705 1,981[42]	4,000 4,000 4,000 4,000 4,000
New Canaan	none	-	
Darien	9. Stamford Hospital Off Campus 1.5	1,827	4,000
Norwalk	10. Norwalk Hospital 1.5 11. Norwalk Hospital Radiology & Mammography Center 0.7 12. Norwalk Hospital Radiology & Mammography Center 1.5 (#1) 13. Norwalk Hospital Radiology & Mammography Center 1.5 (#2)	3,174 9,797 included in above included in above	4,000 12,000
Wilton	none		
Total:	**13**	**48,973[43]**	**52,000**

Utilization Rate Per Capita Calculation:
Number of Scans in Service Area/ Service Area Population = 48,973/ 339,728**= .144**

[41] Data from Table 8, Statewide Healthcare and Facilities Services Inventory - 2014 ("Magnetic Resonance Imaging (MRI) Scanning Providers) published by DPH (2014) (hereinafter referred to as "Table 8") unless otherwise indicated.
[42] Docket No. 12-31780-CON
[43] Utilization is likely to have gone up since data was collected in 2013 and published.

Attachment C

Current ONS Utilization

January 2016 through July 2016 - 3,280

Annualized volume should extrapolate to 5,623, however the Existing MRI is maxing out on its throughput.

Attachment D
2015 Patient Population Analysis

Total # of Patients	**# of MRI Scans Required**	**# of MRI Exams Performed at the Applicant's Location**
51,597[44]	6,769*	5,262[45]

* The number of scans required in our service area will always be more than the number of MRIs performed at ONS because some patients will require an MRI on a 3.0T or can only tolerate an open MRI and certain NY residents may choose to have an MRI scan closer to their home in New York, the same is true for other ONS Connecticut patients who work in New York. Certain ONS patients may not receive scans on ONS's scanner even if the Proposed Scanner is approved, such patients will continue to require scans at other providers for reasons including but not limited to scanner capability. Specifically, certain head injury patients, patients with varying kinds of embedded hardware, patients who require diffuse tensor imaging, and patients who cannot handle a longer duration scan may require scans performed on a 3.0T scanner. In addition, certain patients may receive scans on other MRIs based on commercial insurance participating provider status, for example, workers' compensation does not allow patients to be scanned at ONS. As stated above, some New York patients will receive scans at New York providers for reasons of geographic preference. Finally, some patients seek an MRI at another location because they are able to obtain an MRI scan closer to their home.

[44] CON Application page 94.
[45] CON Application page 89.

Attachment E
Current American College of Radiology Accreditation

ACR®
AMERICAN COLLEGE OF RADIOLOGY

American College of Radiology

Magnetic Resonance Imaging Services of

Orthopedic & Neurosurgery Specialists PC

6 Greenwich Office Park
40 Valley Drive
Greenwich, Connecticut 06831

were surveyed by the
Committee on MRI Accreditation of the
Commission on Quality and Safety

The following magnet was approved

Siemens ESPREE 32X8 2009

For

Head, Spine, Body, MSK, MRA

Accredited from:

May 10, 2016 through May 10, 2019

Anthony J. Scarlis, M.D.

CHAIRMAN, COMMITTEE ON MRI ACCREDITATION

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

MRAP# 05157-0

Attachment F
Summary of Clinical Research

Distal Upper Extremity:
Project #1: For patients undergoing corticosteroids injections to treat symptomatic basal joint arthritis of the thumb/wrist, controversy exists as to whether to selectively inject the trapezio-metacarpal (TM) joint or scaphotrapezoid-trapezial (STT) joint, and whether these are even different joints or confluent spaces. We plan to use a cadaveric model to selectively inject radiographic dye jn 8 specimens in the TM joint and 8 in the STT joint and use MRI arthrography to determine if these are in fact separate joints. Results will help doctors provide the most accurate corticosteroid injections for this problem.

Project #2: Controversy exists as to what the incidence of symptomatic extensor carpi ulnaris (ECU) subluxation is, since imaging may often reveal asymptomatic subluxation in patients without a snapping ECU. We plan to use clinical data in asymptomatic volunteers in 3 different forearm positions to determine the rate of incidental subluxation and determine the optimal forearm position for wrist MRIs to reduce the detection of false positives to reduce the rate of unnecessary treatment and surgery.

Shoulder
1. Assessment of rotator cuff repair anatomic outcome using double row repair published in Journal of Shoulder and Elbow.
2. Evaluation of vascularity, healing and integrity of superior capsule (shoulder) reconstruction.
(Allograft reinforcement of a large or massive rotator cuff tear to prevent the need for reverse total shoulder arthroplasty.)

Knee
Assessment of anterior cruciate ligament graft integration into femoral tunnel after anterior cruciate ligament injury.

Brain
Correlation of diffusion tensor imaging data with post-concussion symptom resolution to assess current return to contact sport guidelines in adolescent athletes.

Attachment G
Hearing Issue Responses

I. Clear Public Need:

- **a.** ONS has demonstrated clear and convincing need for an additional MRI based on historic utilization and projected growth in volume of MRIs.
- **b.** ONS meets the need analysis for a 2nd MRI based on the need methodology in chapter 5 of the Statewide Health Care Facilities and Services Plan ("SWHP").
- **c.** ONS's capacity is over DPH's suggested capacity based on the SWHP of 85% utilization.
  - **i.** In 2014 ONS was at 91% capacity[46]
  - **ii.** In 2015 ONS was at 92% capacity[47]
- **d.** Utilizing OHCA's standard of 4,000 scans per year, the capacity of the Existing Scanner is operating at 132% capacity for 2015.[48]
- **e.** ONS has grown from 17 physicians in 2012 to 23 physicians in 2016.[49]
- **f.** ONS's patient population has grown from 42,082 in 2012 to an estimated 56,664 in 2016.[50]
- **g.** ONS is continuing to add new physicians and patients.

II. There Is No Excess Capacity in The Market to Absorb ONS's Need

- **a.** Other providers in the Primary Service Area cannot accommodate the anticipated need for ONS patients. Nearly all of the other Connecticut MRI scanners in the service area are operating above capacity.[51]
  - **i.** Greenwich Hospital's main campus units are operating at 117% and 80% capacity[52]
  - **ii.** Stamford Hospital's main campus is operating at 161% capacity[53]
  - **iii.** The Tully Health Center is operating at 109% capacity[54]
  - **iv.** Advanced Radiology is operating at 167% capacity[55]
  - **v.** Norwalk Hospital is at 79% capacity.[56]
  - **vi.** Norwalk Hospital Radiology & Mammography Center is operating at 82% capacity among its three scanners.[57]

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[46] Application at 17; explanation of capacity analysis at Application at 85 (completeness response dated 3.30.16).
[47] *Id*.
[48] 2015 utilization was 5,262. 5,262/4,000 = 1.3155 or ~132%
[49] Application at 14; Application at 85 (completeness response dated 3.30.16).
[50] CON Application page 94 (completeness response dated 6.11.16).
[51] Data from *Table 8, Statewide Healthcare and Facilities Services Inventory - 2014* ("Magnetic Resonance Imaging (MRI) Scanning Providers) published by DPH (2014) (hereinafter referred to as "*Table 8*")
[52] Per Table 8, Greenwich Hospital utilization was 4,693 and 3,218. 4,693/4,000 = 1.17 or 117%; 3,218/4,000 = 0.8 or 80%.
[53] Per Table 8, Stamford Hospital utilization was 6,427. 6,427/4,000 = 1.60 or 160%
[54] Per Table 8, Tully Health Center utilization was 4,360. 4,360/4,000 = 1.09 or 109%
[55] Per Table 8, Advanced Radiology utilization was 6,705. 6,705/4,000 = 1.65 or 167%
[56] Per Table 8, Norwalk Hospital main campus utilization was 3,174. 3,174/4,000 = 0.79 or 79%.
[57] Per Table 8, Norwalk Hospital Radiology & Mammography Center utilization was 9,797 for its three scanners. 9,797/12,000 = 0.82 or 82%.

III. SWHP Analysis

a. Pursuant to section 3.b. of Chapter 5 of the SWHP, ONS meets the need criteria because its current scanner is operating over 85% capacity. The Percent Utilization of Current Capacity is 132% for 2015.[58]

b. Analysis under 3.a. of Chapter 5 of the SWHP is not required, however, the Percent Utilization of Current Capacity in the Primary Service Area is over 85%. Based on a service area of Greenwich, Stamford, New Canaan, Darien, Norwalk and Wilton the Percent Utilization of Current Capacity is 94-95%.[59]

c. Although not required or contemplated by the SWHP, further analysis would indicate that the projected Percent Utilization of Current Capacity with two additional scanners in the market would be 82% capacity.[60]

IV. Patient Population and Payor Mix:

a. ONS's 2014 patient population is found on page 34 of the application and is as follows:

UTILIZATION BY TOWN

Town	Utilization FY 2014
Connecticut Towns:	
Greenwich	1,154
Stamford	572
Darien	257
New Canaan	250
Old Greenwich	207
Riverside	194
Cos Cob	182
Wilton	105
Westport	104
Norwalk	90
Fairfield	53
Weston	49
Ridgefield	40
Redding	19
Bridgeport	16
Newtown	12
Danbury	11
Trumbull	11

[58] 2015 utilization was 5,262. 5,262/4,000 = 1.3155 or ~132%

[59] Utilizing only Table 8 data from 2013 produces a utilization rate of 94%. Replacing ONS and Advanced Radiology data with 2015 utilization data produces an 95% utilization rate.

[60] Utilizing only Table 8 data from 2013 produces a utilization rate of 82%. Replacing ONS and Advanced Radiology data with 2015 utilization data also produces an 82% utilization rate.

Southport	10
Oxford	6
Stratford	4
Branford	4
Easton	4
New Fairfield	4
New Milford	4
Shelton	4
Bethel	3
Milford	3
Monroe	3
Guilford	2
Hamden	2
Madison	2
Milford	2
Sandy Hook	2
Ansonia	1
Avon	1
Baltic	1
Botsford	1
Cheshire	1
Danielson	1
Derby	1
Farmington	1
Litchfield	1
Mystic	1
New Haven	1
Orange	1
Plainville	1
Rocky Hill	1
Roxbury	1
Salisbury	1
Southbury	1
Uncasville	1
Washington Depot	1
Waterbury	1
West Haven	1
Woodbridge	1
Woodbury	1
Westport	
Connecticut Total	3,408
Other Towns and Cities outside of Connecticut	1,781
TOTAL	**5,189**

b. ONS's 2015 patient population is found on page 88 of the application's completeness responses and is as follows:

UTILIZATION BY TOWN

Town	Utilization FY 2015
Connecticut Towns:	
Greenwich	1,647
Stamford	600
New Canaan	282
Darien	261
Norwalk	228
Wilton	114
Westport	109
Weston	59
Fairfield	55
Ridgefield	44
Redding	15
Danbury	10
Bridgeport	9
Brookfield	8
Stratford	8
Newtown	8
Monroe	7
Easton	6
Milford	5
Bethel	4
East Haven	4
New Fairfield	4
Orange	4
Oxford	4
New Milford	3
Shelton	3
Cheshire	2
Darien	2
Derby	2
Hartford	2
New Haven	2
Plainville	2
Southbury	2
Avon	1
Killingly	1

Farmington	1
Lisbon	1
Washington	1
East Lyme	1
Norwich	1
Seymour	1
Sherman	1
Vernon	1
Wethersfield	1
Connecticut Total	**3,526**
Other Towns and Cities outside of Connecticut	1,736
TOTAL	**5,262**

c. ONS's utilization volume for January through July of 2016 is provided in the pre-filed testimony and is 3,280 (or 5,623 annualized). Please note, however, that the MRI is maxing out on its capacity and throughput.

d. ONS's payor mix for annualized 2015 and anticipated 2016-2019 data was provided on page 33 of the application and is as follows:

APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2015**		Annualized FY 2015		Projected							
					FY 2016		FY 2017		FY 2018		FY 2019	
	Discharges[61]	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	930	24%	1,240	24%	1,294	24%	1,578	24%	1,642	24%	1,662	24%
Medicaid*	0		0		0		0		0		0	
CHAMPUS & TriCare	1	>1%	1	>1%	1	>1%	1	>1%	1	>1%	1	>1%
NY Gov	111	3%	148	3%	154	3%	188	3%	196	3%	199	3%
Total Government	**1,042**	**26%**	**1,389**	**26%**	1,450	**26%**	1,768	**26%**	1,839	**26%**	1,862	**26%**
Commercial Insurers	2,784	71%	3,712	71%	3,875	71%	4,725	71%	4,914	71%	4,976	71%
Uninsured/Self Pay	12	>1%	16	>1%	17	>1%	20	>1%	21	>1%	21	>1%
Private Pay	11	>1%	15	>1%	16	>1%	19	>1%	20	>1%	20	>1%
Workers Compensation	84	2%	112	2%	117	2%	143	2%	148	2%	150	2%
Total Non-Government	**2,891**	**73%**	**3,855**	**73%**	**4,024**	**73%**	**4,907**	**73%**	**5,103**	**73%**	**5,167**	**73%**
Total Payer Mix	**3,933**	**100%**	**5,244**	**100%**	**5,474**	**100%**	**6,675**	**100%**	**6,942**	**100%**	**7,029**	**100%**

V. Referral Patterns for ONS:

- ONS will be the only referral source for the Proposed MRI. ONS does not accept referrals from doctors or providers outside of ONS nor does it market the MRI services to providers.
- Due to the nature of ONS's physician services as an orthopedic practice, many patients require an MRI. Approximately 10% of all ONS patients receive an MRI.

Year	ONS Patient Volume[62]	ONS Scan Utilization	Percent of ONS Patients Who Receive a Scan
2012	42,082	4,565[63]	10.8%
2013	46,492	4,800[64]	10.3%
2014	49,370	5,189[65]	10.5%
2015	51,597	5,262[66]	10.2%

[61] Discharges from January 1, 2015 through September 30, 2015.
[62] CON Application page 94 (completeness response dated 5.11.16).
[63] CON Application page 32.
[64] *Id.*
[65] *Id.*
[66] CON Application page 89 (completeness response dated 3.30.16).

- ONS has grown its practice over the years. The number of practice physicians increased from 17 in 2012 to 23 in 2015.[67]

Year	Number of Physicians	Specialty	Month each new physician started
2012	19	Dr. Mark Vitale- orthopedics Dr. Tamar Kessel – physiatrist	Sept 1, 2012 Sept 1, 2012
2013	21	Dr. Demetris Delos – orthopedics Dr. Sean Penden - orthopedics	Sept 1, 2013 Sept 15, 2013
2014	21		
2015	23	Dr. Marc Kowalsky - orthopedics Dr. David Wei – orthopedics	March 15, 2015 Sept 21, 2015

VI. MRI Capacity/availability (including all existing providers in this service area):

- Other providers in the Primary Service Area cannot accommodate the anticipated need for ONS patients. Nearly all of the other Connecticut MRI scanners in the service area are operating above capacity.[68] As a whole, the scanners below are operating at 94-95% capacity.[69]

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	SWHP Inventory 2013[70]
Siemens Magnetom Espree Open Bore 1.5T	See above	n/a	ONS 40 Valley Drive Greenwich, CT	M-F 7:00am -9:00 pm Sat: 7:00am – 5pm Sun: 7:00 am – 1:00pm	4,800
1.5T MRI Fixed Closed	Not publicly available	Not publicly available	Greenwich Hospital 5 Perryridge Road, Greenwich, CT	M-F 7:30am to 7pm Sa-Su 7:30 am to 5:30pm	4,693
3.0T MRI Fixed Closed	Not publicly available	Not publicly available	Greenwich Hospital 5 Perryridge Road, Greenwich, CT	M-F 7:15am to 7pm Sa-Su 7am to 5pm	3,218
1.5T MRI Fixed Closed	Not publicly available	Not publicly available	Greenwich Hospital, Diagnostic Center 2015 West Main Street, Stamford, CT	M-F 7:30am to 5pm	1,991
1.5T MRI Fixed Closed	Not publicly available	Not publicly available	The Stamford Hospital 30 Shelburne Road, Stamford, CT	24 hours a day, 7 days a week	6,427
1.5T MRI Fixed Closed	Not publicly available	Not publicly available	The Stamford Hospital, Tully Health Center 32 Strawberry Hill Court, Stamford, CT	M-F 8am to 8pm Sa-Su 8am to 4pm	4,360
1.5T MRI Fixed	Not publicly available	Not publicly available	The Stamford Hospital, Darien Imaging Center	M, W,F 8am to 4pm Tu,Th 8am to 8pm	1,827

[67] CON Application page 85 (completeness response dated 3.30.16).
[68] *Statewide Healthcare Facilities and Services Inventory – 2014, Table 8 ("Magnetic Resonance Imaging (MRI) Scanning Providers")* published by the Department of Public Health (2014) (hereinafter "Table 8"). http://www.ct.gov/dph/cwp/view.asp?a=3902&q=557564&dphNav=|56694|
[69] Utilizing only Table 8 data from 2013 produces a utilization rate of 94%. Replacing ONS and Advanced Radiology data with 2015 utilization data produces an 95% utilization rate.
[70] *Table 8.*

Closed			6 Thorndale Circle Darien, CT	Sa-Su 8am to 12pm	
1.5T MRI Fixed Open	Not publicly available	Not publicly available	Advanced Radiology Consultants, LLC 1315 Washington Blvd, Stamford, CT	M-F 7am to 11pm Sa-Sun 7 am to 3:30pm	6,705 scans performed in 2013 6,617 scans performed in 2015[71]
1.5T MRI Fixed Closed	Not publicly available	Not publicly available	Hospital for Special Surgery 1 Blactchley Road Stamford, CT	Not publicly available	1,981 (for Feb 2015 through Jan 2016)[72]
Philips Ingenia 1.5 T Fixed/Closed	Not publicly available	Not publicly available	Norwalk Hospital Main Campus 24 Stevens Street Norwalk, CT	24 hours	3,174
G.E. HDX Twinspeed 8 Channel 1.5 T Fixed/Closed	Not publicly available	Not publicly available	Norwalk Hospital Radiology & Mammography Center 184 East Avenue Norwalk, CT	M-Th.- 7:15 am – 8:30 pm F - 7:15 am – 4:30 pm Sat.- 7:30 am – 11:45 am	9,797
G.E. HDX Openspeen Excite 0.7 T Fixed/Open	Not publicly available	Not publicly available	Norwalk Hospital Radiology & Mammography Center 184 East Avenue Norwalk, CT	M-Th.- 7:15 am – 8:30 pm F - 7:15 am – 4:30 pm Sat.- 7:30 am – 11:45 am	included in above
G.E. HDX Echospeed Channel 1.5 T Fixed/Closed	Not publicly available	Not publicly available	Norwalk Hospital Radiology & Mammography Center 184 East Avenue Norwalk, CT	M-Th.- 7:15 am – 8:30 pm F - 7:15 am – 4:30 pm Sat.- 7:30 am – 11:45 am	included in above

*Note that HSS indicated its internal capacity is only 2,540 scans per year.[73]

[71] Advanced Radiology Application at 40.
[72] Docket No. 12-31780.
[73] HSS application at 16.

Greer, Leslie

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Thursday, August 25, 2016 3:41 PM
To: User, OHCA; Fernandes, David; Lazarus, Steven; Riggott, Kaila; Hansted, Kevin; Greer, Leslie
Cc: Michele Volpe (mmv@bvmlaw.com); Kathleen Gedney <kgg@bvmlaw.com> (kgg@bvmlaw.com)
Subject: Orthopeadic & Neurosurgery Specialists, P.C. -- Docket No. 16-32063-CON
Attachments: Acquisition of MRI.PDF

Attached please find the following on behalf of Advanced Radiology Consultants, LLC:

1. Notice of Appearance of UKS;
2. Petition for Status;
3. Prefiled Testimony of Clark Yoder and Dr. Alan Kaye.

Should you require anything further, please don't hesitate to contact me.

Thanks,
Jen

Jennifer Groves Fusco, Esq.
Principal
Updike, Kelly & Spellacy, P.C.
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August 25, 2016

VIA ELECTRONIC & OVERNIGHT MAIL

Hon. Janet Brancifort, M.P.H.
Deputy Commissioner
Office of Health Care Access Division
Department of Public Health
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: Orthopaedic & Neurosurgery Specialists, P.C.
Acquisition of MRI Unit for Greenwich Office
Docket No. 16-32063-CON

Dear Deputy Commissioner Brancifort:

This office represents Advanced Radiology Consultants, LLC ("ARC"). Enclosed are an original and four (4) copies of the following:

- Notice of Appearance of Updike, Kelly & Spellacy, P.C.;
- Petition of Advanced Radiology Consultants, LLC To Be Designated As An Intervenor With Full Rights Including The Right of Cross-Examination;
- Prefiled Testimony of Clark G. Yoder, M.B.A., Chief Executive Officer, Advanced Radiology Consultants; and
- Prefiled Testimony of Alan D. Kaye, M.D., former Chief Executive Officer, Advanced Radiology Consultants.

These documents are being submitted in connection with the public hearing on the above matter scheduled for August 30, 2016 at 10:00 a.m. Mr. Yoder and Dr. Kaye will be present at the hearing to adopt their prefiled testimony under oath and for cross-examination.

Should you require anything further, please feel free to call me at (203) 786-8316.

Very truly yours,

Jennifer Groves Fusco

Enclosures

cc: Clark G. Yoder *(w/enc)*
Michele M. Volpe, Esq. *(w/enc)*

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: ORTHOPAEDIC & NEUROSURGERY SPECIALISITS, P.C. ACQUISTION OF MAGENTIC RESONANCE IMAGING SCANNER	)	DOCKET NO. 16-32063-CON
	)	AUGUST 25, 2016

NOTICE OF APPEARANCE

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Updike, Kelly & Spellacy, P.C. ("Firm") in the above-captioned proceeding on behalf of Advanced Radiology Consultants, LLC ("ARC"). The Firm will appear and represent ARC at the public hearing on this matter, scheduled for August 30, 2016.

Respectfully Submitted,

ADVANCED RADIOLOGY
CONSULTANTS, LLC

By: _____

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CERTIFICATION

This is to certify that a copy of the foregoing was sent via electronic mail this 25th day of August, 2016 to the following parties:

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: ORTHOPAEDIC & NEUROSURGERY SPECIALISITS, P.C. ACQUISTION OF MAGENTIC RESONANCE IMAGING SCANNER	)	DOCKET NO. 16-32063-CON
	)	AUGUST 25, 2016

PETITION OF ADVANCED RADIOLOGY CONSULTANTS, LLC TO BE DESIGNATED AS AN INTEVENOR WITH FULL RIGHTS INCLUDING THE RIGHT OF CROSS-EXAMINATION

In accordance with Section 4-177a of the Connecticut General Statutes and Section 19a-9-27 of the Regulations of Connecticut State Agencies, Advanced Radiology Consultants, LLC ("ARC"), a private radiology practice with multiple locations including an office at 1315 Washington Boulevard in Stamford, hereby petitions the Office of Health Care Access Division of the Department of Public Health ("OHCA") to be designated as an intervenor with full rights, including the right of cross-examination, in the Certificate of Need ("CON") proceeding under Docket No. 16-32063-CON. This proceeding concerns the request by Orthopaedic & Neurosurgery Specialists, P.C. ("ONS") for permission to acquire a second MRI unit for its Greenwich office.

As detailed herein and in the accompanying testimony of Clark G. Yoder, M.B.A., Chief Executive Officer ("CEO") of ARC, ONS's acquisition of a second scanner will result in the unnecessary duplication of services and will have an adverse financial impact on ARC. In order to

meet its generous volume projections and make the new unit profitable, ONS will need to direct a majority of its MRI referrals to that practice's scanners, a fact that they virtually concede in their submissions with reference to their intention to provide MRI access for all ONS patient in need of scans (Prefiled Testimony of Mark Camel, M.D., pp. 6 & 13). This means less scans referred to providers like ARC and the loss of associated revenue. Given that a majority of ONS's patients are commercially insured, the loss of this volume will further skew the payer mix of ARC towards governmental insurers who reimburse at far lower rates. In addition, ONS has not shown that its acquisition of a second MRI unit will increase access to MRI services for the state's most vulnerable patients, including Medicaid recipients and indigent persons. If anything, ONS's proposal has the potential to reduce access for these individuals. And as set forth in the testimony of and Alan D. Kaye, M.D., ARC's former CEO, the possibility of overutilization based on self-referral calls into question the validity of ONS's volume projections and the cost-effectiveness of the proposed MRI unit.

Background

ARC is a private radiology practice with more than 100 years of experience serving patients in Connecticut. The practice has six offices located in Orange, Shelton, Trumbull, Stratford, Fairfield, and Stamford. ARC has been serving the Stamford community at its 1315 Washington Boulevard office for more than 15 years. The practice provides a full range of diagnostic imaging and interventional radiology services, including MRI at each of its office locations. MRI services are provided at the practice's Stamford office with a 1.5 Tesla unit. ARC has filed a CON Application

for the acquisition of a 3.0 Tesla unit for this location as well (Docket No. 16-32093-CON). All ARC radiologists are subspecialty trained. The practice provides the highest-quality, accredited MRI services in a cost-effective private physician office setting. ARC receives referrals for MRI services from a broad array of providers including physicians of all specialties, podiatrists and chiropractors, none of whom has a financial interest in any ARC equipment. ONS has historically referred patients to ARC for MRI scans and these patients have been served primarily at ARC's Stamford office. ARC provides services to all patients regardless of their ability to pay. The practice participates in the Medicaid program and serves many indigent patients in Stamford and elsewhere.

ARC's Interests Will Be Adversely Affected by Approval of ONS's CON Request

ONS is asking OHCA to approve a CON for a second MRI unit to service patients of its orthopedic and neurosurgery practice. The unit will be located in ONS's Greenwich office, which is within the primary service area of ARC's Stamford office. In addition, ONS has a Stamford office located less than 5 miles from ARC's Stamford office and CON laws would not preclude ONS from relocating either MRI unit to Stamford at any time (CON Application, p. 86).

ONS claims it needs a second MRI unit to meet demand within its practice. Notably, ONS is projecting a significant incremental increase in scans with acquisition of the new unit, beyond normal year-to-year growth. ONS projects a 1,200 scan or 22% increase in MRI volume in the first year of operation of the second unit (CON Application, p. 32). ONS attributes this projected growth to the addition of physicians, but additional physician visits and associated MRI volume alone cannot

account for this significant an annual increase. By ONS's own admission its existing scanner cannot meet all current practice demand, which is why ONS needs a second unit (CON Application, p. 94).

It follows, therefore, that once ONS purchases a second scanner it will attempt to recapture all ONS-referred MRI volume. In its written testimony ONS concedes that it is looking to provide MRI access for all ONS patients in need of scans, subject to any physical or clinical limitations (Camel Testimony, pp. 6, 13 & 31). To be certain of this, the practice also reports that it must perform more than 1,000 incremental scans by FY 2017 just to break even on the acquisition of a second unit (CON Application, p. 17). As mentioned above, 1,200 incremental scans are projected for the first year of operation of the second unit (CON Application, p. 32). This is almost equal to the number of MRI scans ordered by ONS in FY 2015 that were referred to other providers (6,769 scans ordered – 5,262 scans performed by ONS = 1,507 scans referred to other providers (Camel Testimony, p. 31)).

In FY 2015, ARC performed 79 MRI scans referred by ONS physicians. The value of these services was approximately $55,000. In FY 2016 to date, ONS has referred 69 MRI scans to ARC valued at approximately $48,000. At this rate by year end ONS will have referred 110 MRI scans to ARC valued at $76,000. If ONS is authorized to acquire a second MRI unit ARC will likely lose some or all of these referrals to ONS. This will result in a loss of revenue for ARC. Although ONS downplays the amount of this loss, it is a financial loss nonetheless and therefore the CON proposal will adversely impact an existing provider of MRI services.

In addition, a majority of the scans referred to ARC by ONS were of commercially insured patients. Commercially insured scans generate the highest per-patient revenue for MRI services. The loss of this revenue will further skew ARC's payer mix towards Medicaid and other governmental

payers, which reimburse at much lower rates than commercial insurance. ARC relies on its commercially insured patients to generate the MRI revenues that support the practice's provision of all imaging services to its patients. The loss of ONS-referred scan volume and commercially insured revenue will undoubtedly have an adverse financial impact on ARC. ARC is entitled to participate in ONS's CON proceeding in order to protect its interests in this regard.

Moreover, because ONS does not participate in the Medicaid program providers like ARC and area hospitals are left to accommodate the MRI needs of this patient population (CON Application, p. 86). The availability of MRI services for Medicaid recipients is even more critical as this population increases due to Affordable Care Act-related program expansion in Connecticut. Authorizing the acquisition of a second MRI by ONS does nothing to enhance access for Medicaid program participants. Rather, it adds MRI capacity that for all intents and purposes excludes these individuals. ONS's second unit, like its first, will "skim the cream" – namely, commercially insured MRI scans – leaving other providers to care for the increasing number of patients who are governmentally insured or uninsured. The larger the number of Medicaid and indigent patients ARC cares for, the less financially viable the practice will become. Too significant a shift in payer mix can jeopardize the practice's existence. This in turn jeopardizes access to services at a provider that cares for all patients regardless of their financial means. ARC's interest in ensuring that the practice continues to exist to serve its patients justifies its participation in ONS's CON proceeding.

Lastly, ONS's status as a self-referral provider can have an adverse impact on healthcare consumers, payers and radiology providers such as ARC. As Dr. Kaye will testify, studies have shown that when providers have a financial interest in advanced imaging equipment they tend to refer

patients at higher rates, leading to over utilization, increased cost and, subsequently, decreased cost-effectiveness. Increased healthcare costs due to the performance of unnecessary services impact the healthcare system as a whole and every provider in it.

Summary of Evidence to Be Presented, Manner of Participation and Relief Sought

ARC will ask OHCA to deny ONS's request for permission to acquire a second MRI unit. ONS has failed to meet several of the statutory criteria for issuance of a CON. Specifically, ONS's proposal will result in the unnecessary duplication of existing healthcare services, which will adversely impact providers such as ARC (Conn. Gen. Stat. §19a-639(9)). This will be demonstrated through the presentation of evidence showing the number and value of scans historically referred to ARC by ONS providers. ARC will show that it has accommodated, and will continue to accommodate, ONS's overflow scans despite its own MRI capacity constraints, making the addition of a second unit unnecessarily duplicative. ARC will further show the adverse financial consequences to the practice of this loss of volume, which is primarily commercially insured. This is particularly relevant in light of the fact that ARC serves all patients regardless of ability to pay and expects to see an increase in Medicaid volume going forward, which could decrease its financial viability.

In addition, ONS has failed to establish that its proposal will improve the accessibility of services for Medicaid recipients and indigent persons (Conn. Gen. Stat. §19a-639(5)); rather ONS fails to provide access to MRI services for Medicaid recipients and many indigent persons, without good cause for doing so (Conn. Gen. Stat. §19a-639 (10)). Its past and proposed practice is to

exclude Medicaid recipients and many indigent persons from access to its MRI units (Conn. Gen. Stat. §19a-639(6)). ONS's failure to provide access for these patients is also inconsistent with the Statewide Healthcare Facilities and Services Plan ("SHP") mandate that a provider seeking to acquire an MRI unit not deny MRI services to any individual based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients (SHP, p. 62). ARC will present evidence regarding ONS's history, or lack thereof, of providing MRI service to these patient populations. This will be compared with ARC's history of providing services to Medicaid program participants and indigent persons. ARC will also present evidence to demonstrate the adverse impact on existing providers of the introduction of additional MRI capacity in the market that does ***not*** service all patients regardless of ability to pay.

Moreover, ARC will present evidence regarding the impact of self-referral on the need for, and cost-effectiveness of, MRI services. ARC will submit studies that show higher rates of referrals for imaging by providers with financial interests in the equipment on which the examinations are performed. ARC will show how this unnecessary utilization may be artificially inflating ONS's MRI volume and decreasing the cost-effectiveness of the service they are proposing to augment with the acquisition of a second MRI unit.

If ARC is granted status, it intends to present this and other evidence and legal arguments in support of its positions. The arguments are set forth in detail in the attached testimony of Mr. Yoder and Dr. Kaye. ARC respectfully requests that it be allowed to submit written testimony, present evidence and arguments at the August 30, 2016 public hearing on this matter, cross-examine witnesses, and inspect and copy records pertaining to the proceeding. ARC's participation will

furnish assistance to OHCA in determining the impact of this proposal on existing providers and access to MRI services for certain patient populations. ARC's participation will also assist OHCA in evaluating ONS's compliance with other statutory CON decision criteria (i.e. need and cost-effectiveness of services). ARC's participation is in the interest of justice and will not impair the orderly conduct of these proceedings.

WHEREFORE, for the foregoing reasons, ARC respectfully requests that its Petition to be Designated as an Intervenor With Full Rights be granted.

Respectfully Submitted,

ADVANCED RADIOLOGY CONSULTANTS, LLC

By: _____

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CERTIFICATION

This is to certify that a copy of the foregoing was sent via electronic mail this 25th day of August, 2016 to the following parties:

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: ORTHOPAEDIC & NEUROSURGERY SPECIALISITS, P.C. ACQUISTION OF MAGENTIC RESONANCE IMAGING SCANNER	)	DOCKET NO. 16-32063-CON
	)	AUGUST 25, 2016

PREFILED TESTIMONY OF CLARK G. YODER, M.B.A., CHIEF EXECUTIVE OFFICER OF ADVANCED RADIOLOGY CONSULTANTS, LLC, IN OPPOSITION TO THE CON REQUEST OF ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

Good morning Hearing Officer Hansted and members of the Office of Health Care Access ("OHCA") staff. My name is Clark Yoder and I am the Chief Executive Officer ("CEO") of Advanced Radiology Consultants, LLC ("ARC"). With me today is my colleague, Dr. Alan Kaye, ARC's former CEO. We thank you for this opportunity to testify in opposition to the Certificate of Need ("CON") Application filed by Orthopaedic & Neurosurgery Specialists, P.C. ("ONS") for a second MRI unit to use within its orthopedic and neurosurgery practice. ARC respectfully requests that ONS's CON request be denied. ONS's acquisition of a second, captive scanner would adversely impact ARC and other providers that accept all patients regardless of ability to pay. ONS's proposal does not enhance access to MRI services for our state's most vulnerable patients, including Medicaid program participants and indigent persons. Nor does it present the most cost-effective option for bringing additional MRI capacity to the Stamford area, as Dr. Kaye will testify.

ARC is a private radiology practice with office locations throughout Fairfield and New Haven Counties, including an office at 1315 Washington Boulevard in Stamford. ARC provides a full range of diagnostic imaging and interventional radiology services. The practice offers MRI at each of its locations. MRI services are provided at the practice's Stamford office with a 1.5 Tesla unit and, as OHCA knows, we have filed a CON Application for the acquisition of a 3.0 Tesla unit for this location as well (Docket No. 16-32093-CON). ARC provides services to all patients regardless of their ability to pay. The practice participates in the Medicaid program and serves many indigent patients in Stamford and elsewhere.

ONS has failed to meet several of the statutory criteria for issuance of a CON. Specifically, ONS has failed to establish that its proposal will improve the accessibility of services for Medicaid recipients and indigent persons (Conn. Gen. Stat. §19a-639(5)); rather ONS fails to provide access to MRI services for Medicaid recipients and many indigent persons, without good cause for doing so (Conn. Gen. Stat. §19a-639 (10)). Its past and proposed practice is to exclude Medicaid recipients from access to its scanners and provide MRI services to an extremely limited number of uninsured or self-pay patients (Conn. Gen. Stat. §19a-639(6)). ONS's failure to provide access for these patients is also inconsistent with the Statewide Healthcare Facilities and Services Plan ("SHP") mandate that a provider seeking to acquire an MRI unit not deny ***MRI services*** to any individual based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients (SHP, p. 62). In addition, ONS's proposal will result in the unnecessary duplication of existing healthcare services, which will adversely impact providers such as ARC (Conn. Gen. Stat. §19a-639(9)).

Access for Medicaid Recipients & Indigent Persons

ONS does not participate with the Medicaid program (CON Application, p. 86). Based upon historic payer mix data provided to OHCA, the practice performed no MRI scans on Connecticut Medicaid beneficiaries in FY 2015 (CON Application, p. 33).[1] In addition, the practice's uninsured and self-pay MRI scans make up less than 1% of its MRI volume (CON Application, p. 33).[2] Projections for the existing and proposed second MRI unit show no change in this regard, with 0% Connecticut Medicaid and less than 1% uninsured and self-pay exams projected through 2019 (CON Application, p. 33). When asked to explain how Medicaid recipients and indigent persons will be handled by the practice, ONS reiterated that it does not participate in the Medicaid program (CON Application, p. 86). Further, ONS claimed that it would "try and accommodate" patients with a financial hardships if requested by a colleague (CON Application, p. 86). Based on the practice's historically low percentages of uninsured and self-pay MRI scans (just 16 of 5,244 scans in FY 2015), this does not appear to happen often (CON Application, pp. 25 & 77).

The CON statutes require that OHCA consider how a CON proposal impacts access to and the quality of care for Medicaid recipients and indigent persons. Section 19a-639(5) of the Connecticut General Statues requires an applicant to demonstrate how its proposal "will improve the quality, accessibility and cost effectiveness of healthcare delivery in the region, including … provision of … and access to services for Medicaid recipients and indigent persons …" Similarly, Section 19a-639(6) requires OHCA to consider the applicant's "past and proposed

[1] ONS included "NY Gov" as a governmental payer in its initial CON submission (CON Application, p. 33). However when asked to clarify, ONS acknowledged that this is in fact commercial insurance provided to New York state employees and not state medical assistance provided to New York residents (CON Application, p. 87).
[2] Projected Medicaid and uninsured/self-pay percentages were similar in 2008, when ONS received approval to acquire its first MRI scanner (Docket No. 08-31120-CON, Final Decision, FF 20). However, at that time there were no specific CON decision criteria or SHP requirements around provision of access for these types of patients.

provision of health care services to relevant patient populations and payer mix, including … access to services by Medicaid recipients and indigent persons." Section 19a-639(10) of the General Statutes states that an applicant who has "failed to provide" services to Medicaid recipients or indigent persons must "demonstrate 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." In addition, Section 19a-639(2) requires OHCA to consider the relationship of a CON proposal to the SHP and, as previously mentioned, the SHP prohibits a CON applicant from denying ***MRI scanner services*** to patients based upon ability to pay or payer source (SHP, p. 62).

There is no question that ONS is denying Medicaid recipients access to its current MRI scanner and that it will continue to do the same if a second scanner is approved. As a threshold matter, ONS does not participate with the Medicaid program. ONS cannot provide Medicaid recipients with true access to MRI services if it does not participate with the Medicaid program. Since the practice began providing MRI services in 2008, it does not appear that they have provided a single MRI scan to a Medicaid recipient (CON Application, p. 33; *see also* Docket No. 08-31120-CON, FF 20). No scans of Medicaid recipients are projected going forward.[3] ONS claims it treated 23 Medicaid patients in FY 2015 and wrote off the cost of their care, but those appear to be physician office services and not the ***MRI scanner services*** to which the SHP refers (Camel Testimony, pp. 11-12).

In response to a letter submitted to OHCA by our Chairman Terrence Hughes, M.D., ONS's counsel calls ARC's claims about her client's treatment of Medicaid recipients "unfounded and inaccurate." She states that ARC has presented "no evidence of any specific

[3] Note that some individuals who will be covered by Medicaid in the coming years are now or were formally commercially insured. Some may have been patients of ONS in the past. Because ONS will not care for these individuals going forward, it is possible that the practice's MRI projections are overstated.

circumstance or patient being denied MRI services based on payor status." The reality is, because ONS does not participate in the Medicaid program their physicians do not, as a general rule, receive referrals of Medicaid patients. Because ONS physicians do not generally see Medicaid patients as part of their practices, there is little opportunity for Medicaid patients to be referred by these physicians to the ONS MRI unit.

Even when ONS does see Medicaid patients in its office practice (23 of 51,597 patients or .0004% of FY 2015 patient volume), it does not appear that they refer these patients to the ONS unit for MRI services (Camel Testimony, p. 11-12). ONS estimates that approximately 13% of their patients are referred for MRI scans (6,769 ÷ 51,597), with approximately 10% of all patients (78% of all referrals (5,262 ÷ 6,769)) going to the ONS scanner (5,262 ÷ 51,597) (Camel Testimony, p. 31). Based on these estimates, at least two of the Medicaid patients seen by ONS physicians in FY 2015 should have been referred to the ONS scanner for an MRI (23 x 10%), yet none were.

It is essentially denial of access by omission. You do not need to turn patients away at the door to deny them access; you simply choose not to participate with their health plan. ONS does not participate in the Medicaid program. And even simpler than that, on the rare occasion you come across a Medicaid patient in your office practice you opt not to self-refer that patient for MRI services (the only way a patient can obtain access to the ONS unit). ONS suggests that they have not denied any Medicaid beneficiary access to MRI services, but of the handful of Medicaid patients they treat, just a fraction of a percentage of their total patient volume, they have not self-referred a single MRI examination. To the extent that these patients required MRI services, ONS chose to refer them elsewhere. If a provider can opt not to participate with Medicaid or self-refer Medicaid patients for MRI services, yet still fulfill the CON statutory

decision criteria around access for Medicaid patients, then these statutes have very little meaning.

In addition, only 16 of 5,244 MRI scans performed by ONS in FY 2015 were of uninsured or self-pay patients and the same percentage is projected through FY 2019 (CON Application, p. 33). Compare this with ARC's Stamford MRI service, which provided 249 scans to uninsured and self-pay patients in FY 2015, more than 15 times as many uninsured and self-pay patients as ONS saw that same year. ARC's MRI service as a whole provided 908 scans to uninsured and self-pay patients in FY 2015, nearly 57 times as many uninsured and self-pay patients as ONS.

Based on the foregoing, ONS's proposal does little, if anything, to improve the quality, accessibility or cost-effectiveness of care for Medicaid recipients and indigent persons. In fact, as discussed in greater detail below, it will adversely impact the area providers who ***do*** serve these patients. Moreover, ONS has not shown "good cause" for its failure to provide access to MRI services for Medicaid recipients. It likely has to do with lower rates of reimbursement, which according to the CON statutes is not good cause to exclude these patients. Not to mention the SHP criteria – which represent a collaborative effort among OHCA and representatives of the healthcare industry in Connecticut – that expressly prohibit a provider requesting CON approval to acquire an MRI unit from denying MRI services to Medicaid recipients or anyone based on ability to pay. No matter how you look at it, a provider's decision not to participate in the Medicaid program, or to self-refer Medicaid patients for MRI scans, is a de facto denial of access to Medicaid beneficiaries.

The fact that ONS does not care for Medicaid recipients or indigent persons in any appreciable numbers has a direct adverse impact on existing providers like ARC. Because ONS

does not treat Medicaid recipients in its practice, those patients are cared for by other physicians and referred to ARC and local hospitals for their MRI scans. Medicaid reimburses far less for MRI services than most commercial insurance plans. For example, at ARC the average commercial insurance reimbursement for an MRI scan is more than twice what Medicaid pays for the same exam. Medicaid recipients accounted for 7.18% of all MRI scans at ARC in FY 2015, and thanks to the Affordable Care Act ("ACA") Medicaid coverage in Connecticut has increased and will continue to increase in coming years. Uninsured/self-pay patients accounted for 3.09% of all MRI scan at ARC in FY 2015. Combined these patients accounted for 10.26% of all MRI scans performed at ARC in FY 2015, as compared with virtually none of ONS's MRI scans during the same time period. Note also that ARC does not charge patients a facility fee, making it as cost-effective as ONS in this regard.

The number of Medicaid beneficiaries in the service area is expected to grow significantly due to ACA expansion efforts. According to a GE Study commissioned by ARC and excerpted here, the Medicaid population in the greater Stamford area is expected to grow by 14% over the next five years (Exhibit A). ARC will continue to accept these and other patients and, in fact, the practice is looking to acquire a second MRI unit to allow it to serve an existing and growing patient base in the greater Stamford area. As discussed below, ONS's proposal to acquire an additional MRI unit will result in the loss of commercially insured scan volume at ARC, which will further skew the practice's payer mix towards governmental payers that reimburse at far lower rates. As our MRI payer mix shifts, it can threaten the viability of ARC as a whole because the lion's share of the practice's profit margin comes from MRI services. This would compromise the practice's ability to provide a full range of imaging services to all

patients, including the Medicaid and indigent patients that ONS rejects. The same is true for the area's full-service acute-care hospitals, where Medicaid percentages can be even higher.

In December of 2013, OHCA approved a request by the Hospital for Special Surgery ("HSS") for permission to acquire an MRI unit for use in Stamford (Exhibit B). This approval, by way of Agreed Settlement, came six months after OHCA denied HSS's original proposal to acquire a scanner to serve its own commercially insured and private pay patients (Exhibit B). The request was ultimately approved because HSS agreed to expand the scope of its Stamford MRI service to all Connecticut residents, including Medicaid recipients and the uninsured (Exhibit B). In doing so OHCA impliedly acknowledged the importance of having any new equipment serve all individuals in a market regardless of payer source or ability to pay.

The Agreed Settlement included conditions requiring HSS to participate in the Connecticut Medicaid program, to conduct community outreach regarding the availability of its MRI services in Stamford, and to take all practical steps to achieve a payer mix that included 10% Medicaid and 2% uninsured in the unit's first year of operation (Exhibit B). Despite this mandate, OHCA received reports of physicians having difficulty referring Medicaid patients to HSS's Stamford location and only 27 of 1,981 scans (1.4%) for the first year were of Connecticut Medicaid beneficiaries (Exhibit B). Moreover, HSS only scanned 10 uninsured patients, representing .5% of its Stamford MRI volume for the year (Exhibit B). ONS claims that the former is evidence of a low Medicaid MRI population and need in Fairfield County (Camel Testimony, p. 16).[4] It is equally possible that HSS is focused on marketing to the highest-paying commercially insured MRI patients in the market, per its original proposal, leaving those with Medicaid, or without ability to pay, to be cared for in growing numbers by

[4] Statistics show that the Medicaid population in Fairfield County is not as low as ONS suggests. For example, Stamford has a 9% Medicaid population, which is projected to grow to 13% with Medicaid expansion (Exhibit C). Norwalk has an 11% Medicaid population, which is projected to grow to 15% with Medicaid expansion (Exhibit C).

ARC and area hospitals. As discussed below, a similar approach by ONS will adversely impact existing MRI providers and can ultimately create access issues for all area residents.

Unnecessary Duplication of Services & Adverse Impact on Existing Providers

The ONS Greenwich office and ARC's Stamford office have largely overlapping service areas. ONS reports its Connecticut primary service area as Greenwich, Stamford, Darien, New Canaan, and Wilton (CON Application, p. 30). They also report a significant number of MRI scans on patients residing in Norwalk (CON Application, p. 88). The primary service area of the Stamford office of ARC includes Stamford, Norwalk, Darien, New Canaan, and Greenwich.

ARC receives referrals from ONS physicians for MRI scans that, for the most part, are performed at the practice's Stamford office. In FY 2015, ONS physicians referred 79 MRI scans to ARC and our practice was reimbursed approximately $55,000 in connection with these scans. ARC has received 69 MRI referrals from ONS in FY 2016 to date, valued at approximately $48,500. At this rate ARC expects to receive around 110 MRI referrals from ONS physicians in FY 2016, valued at approximately $77,000.

Without a doubt, ONS's volume projections shows that the practice intends to take back a significant percentage of the MRI scans that its physicians refer to ARC and other providers.[5] Although ONS claims that the growth it projects is a result of the addition of physicians to the practice, the numbers simply do not add up. Specifically, ONS has not accounted for a projected ***22% increase*** in MRI scan volume between FY 2016 and FY 2017 (1,201 scans), the first year of operation of the proposed second unit (CON Application, p. 91).

[5] In the footnote on page 94 of the CON Application ONS concedes that it does not have the capacity to accommodate all of its physicians' MRI needs with a single scanner. Dr. Camel references the need to have sufficient MRI capacity to serve all ONS patients (Camel Testimony, pp. 6 & 13). If a second scanner is approved, ONS will have the capacity and will likely cease to refer cases to providers like ARC.

Since FY 2012, ONS has seen growth in MRI scan volume of approximately 230 scans or 5% annually (CON Application, p. 91). As the table below demonstrates, even with the addition of 6 physicians between FYs 2012 and 2015, MRI scan volume grew by only 15% during this time (CON Application, pp. 85 & 91). Annually, MRI volume growth has not exceeded 8.1% and was as low as 1.4% between FY 2014 and FY 2015 (CON Application, p. 91).

	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Number of Scans	4,565	4,800	5,189	5,262	5,474
Percent Increase Over Prior Year	--	**5.1%**	**8.1%**	**1.4%**	**4.0%**

When asked to explain how historic and anticipated future physician recruitment will impact MRI scan volume, ONS's response was less than clear. It references a "per physician" scan volume of 267 scans based on FY 2012 data (CON Application, p. 94). However, this does not comport with the information provided by ONS in its completeness submissions. The table below shows lower scan-per-physician volume in FY 2012 and subsequent years (CON Application, pp. 85, 91 & 94).

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Number of Scans	4,565	4,800	5,189	5,262	5,474
Number of Physicians	19	21	21	23	23
Scans Per Physician	**240**	**229**	**247**	**229**	**238**

Moreover, even if year-to-year growth is attributable solely to the addition of new physicians, which is unlikely, each new physician has averaged only139 scans annually since FY 2012 (CON Application, pp. 85 & 91).

	FY 2013	FY 2014	FY 2015	FY 2016	Average
Number of New Physicians Over Prior Year	2	2	0	2	--
Scan Increase Over Prior Year	235	389	73	212	--
Scans Per New Physician	**117.5**	**194.5**	--	**106**	**139.3**

None of this accounts for the fact that ONS is projecting a ***22% increase*** in MRI scan volume between FY 2016 and FY 2017 (CON Application, p. 91). The practice said it will recruit 2 new physicians that year, which means that each physician would need to order roughly 600 scans in his/her first year with the practice (CON Application, pp. 91 & 94). This is entirely inconsistent with historic growth and the per-physician scan numbers provided by ONS (CON Application, pp. 85, 91 & 94). ONS states that it must perform at least 1,071 incremental scans in FY 2017 to breakeven, which represents an increase of approximately 20% over FY 2016 volume (CON Application, p. 25). Even assuming some organic growth in MRI scans across ONS physicians, as well as growth attributable to newly recruited physicians, there are still a significant number of scans that will need to come from elsewhere in order to breakeven as projected.

Providers like ARC are already accommodating ONS's overflow scans, and we will continue to do so despite our own capacity constraints. These are patients who have used ARC for their imaging for many years and for whom we can ensure continuity and coordination of care. Because ARC can and will continue to serve these patients if they so choose, as well as any other patients referred by ONS physicians, ONS's acquisition of a second unit is an unnecessary duplication of MRI services.

Furthermore, ONS claims that providing its patients with MRI services in-office promotes quality, cost-effectiveness, timeliness, care coordination, and patient convenience (CON Application, pp. 18, 19 & 21). There are several flaws with ONS's reasoning. First, it is extremely unlikely that any ONS patient is receiving an MRI scan on the same day an ONS physician orders the scan (except in an emergency). Accordingly, having in-office MRI at an orthopedic practice is not a "convenience" like having in-office x-ray where patients do, in fact,

have exams in conjunction with office visits. Also, the "convenience" of having an MRI in a physician office setting, as opposed to a hospital, is the same whether that scan is performed in an orthopedist's office or a private radiology office such as ARC.

In addition, the ability to coordinate care is no better when an orthopedic practice owns its own MRI unit. ONS still has to contract with a radiology practice to interpret the MRI scans. Presumably, the scans are not read by Greenwich Radiology physicians in real time. We suspect that the turnaround time is similar to the turnaround time for scans performed at ARC's offices and interpreted by our subspecialist radiologists, with results communicated electronically to most referring providers within an hour of the scan being available to read. One difference is that our images and results are also accessible by physicians, and patients themselves, from virtually anywhere via ARC's image sharing network. As far as cost is concerned, ARC likely charges similar rates for MRI services and there is no facility fee involved.

Moreover, because ARC does not self-refer patients for studies, there is less risk of overutilization and increased costs for patients and payers. As Dr. Kaye will testify, studies have shown that providers who refer patients to scanners in which they have a financial interest tend to refer at higher rates than those who send their patients to unaffiliated imaging providers.

When all is said and done, ARC will be adversely impacted by ONS's acquisition of a second MRI unit, if approved by OHCA. In order to meet its generous volume projections, ONS physicians will need to refer all of their scans to practice-owned units. This will mean the loss by ARC of a significant number of commercially insured scans each year. For FY 2016, ARC is expecting more than 100 MRI referrals from ONS. OHCA should not approve a proposal that adversely impacts an existing provider, particularly if that provider cares for all patients

regardless of ability to pay and not just those select patients with commercial insurance or the financial means to pay the full cost of an MRI scan out of pocket.

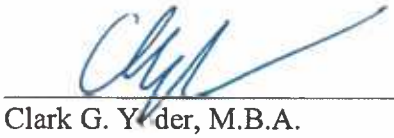
Conclusion

For the foregoing reasons, ONS's request for permission to acquire a second MRI unit should be denied. ONS will stop referring its patients to ARC and elsewhere for scans if it is approved for an additional unit. Because these patients are already well-served by existing providers, the proposed scanner is unnecessarily duplicative. In addition, by ONS's own admission it will not provide MRI services to beneficiaries through the Medicaid program and services for indigent persons will be extremely limited.

MRI volume in lower Fairfield County is growing across all payers. This is why ARC has applied for a second unit for its Stamford office. Rather than approving a limited-use MRI that excludes the most vulnerable patients in our service area, we urge OHCA to reject ONS's proposal. ARC and other full-service providers can and will continue to serve any ONS patients in need.

Thank you again for allowing me to testify. Once Dr. Kaye testifies we will be available to answer any question you have.

The foregoing is my sworn testimony.



Clark G. Yoder, M.B.A.

EXHIBIT A

Advanced Radiology Consultants
Shelton, CT

May 4, 2016

Market At-a-Glance Report

Imagination at work.

Market Reach Summary

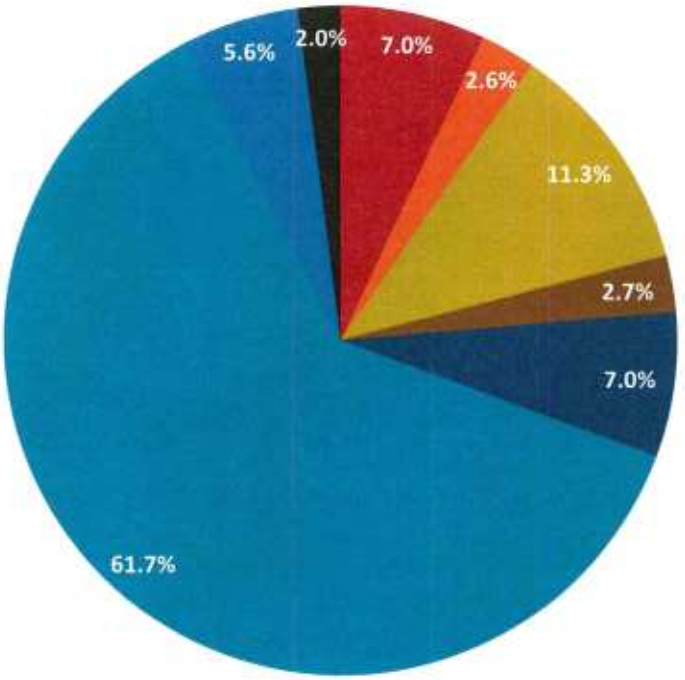
Market Reach is defined as a group of zip codes around your location for which potential patients reside.

Location:	**Advanced Radiology Consultants** Shelton, CT
Zip code radius:	6612, 6807, 6820, 6830, 6831, 6840, 6850, 6851, 6853, 6854, 6855, 6870, 6878, 6880, 6883, 6896, 6897, 6901, 6902, 6903, 6905, 6906, 6907, 10576

Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Data is available only if the volume is large enough to produce a reportable output. *In some cases, market reach data is unavailable.

Insurance coverage

2016
Payer Mix (% of Total)



Payer	2016	2021	5 year growth
Medicaid - Pre Reform	27,924	27,528	-1%
Medicaid Expansion	10,569	12,014	14%
Medicare	45,218	51,800	15%
Medicare Dual Eligible	10,775	12,117	12%
Private - Direct	28,088	27,569	-2%
Private - ESI	247,193	249,179	1%
Private - Exchange	22,415	23,963	7%
Uninsured	8,176	8,004	-2%
Total	400,359	412,173	2.95%

Projections and estimates are based on the most current Truven Health Analytics data collection methodology.

Insurance categories

Insurance Type	Description
Medicaid – Pre reform	Includes all individuals in traditional Medicaid and HMO Medicaid who are not also receiving Medicare benefits
Medicaid Expansion Population	A provision in the ACA called for expanding Medicaid eligibility in order to cover more low-income people. States have the ability to opt-in or out of this expansion.
Medicare	Includes all individuals in traditional Medicare and Medicare HMO who are not also receiving additional benefits through Medicaid
Medicare - Dual Eligible	The population currently enrolled in traditional Medicare and Medicare HMO who also receive additional benefits through Medicaid
Private – ESI (employee sponsored)	Includes all individuals in HMO, Fee for Service (FFS), or PPO plans offered as part of an employment arrangement
Private – Exchange	Includes all individuals who purchase insurance through an insurance exchange or insurance market place, not associated with employment
Private – Direct	Includes all individuals who purchase insurance directly from an insurance provider, not through an employment agreement or through an insurance exchange
Uninsured	Includes all individuals without any insurance coverage

EXHIBIT B

IN RE: New York Society for the Relief of the Ruptured and Crippled, Maintaining the Hospital for Special Surgery

DOCKET NUMBER: 12-31780-CON

AGREED SETTLEMENT

On or about August 13, 2012, New York Society for the Relief of the Ruptured and Crippled, maintaining the Hospital for Special Surgery ("HSS or the "Applicant") submitted a certificate of need ("CON") application to the Office of Health Care Access ("OHCA") seeking approval to acquire a 1.5 Tesla Magnetic Resonance Imaging ("MRI") unit to be located in Stamford, Connecticut with an associated capital expenditure of $3,245, 583.

The application was filed under Docket No. 12-31780-CON. On September 20, 2013, OHCA issued its Final Decision denying the Applicant's CON application. On or about October 15, 2013, HSS filed an administrative appeal in the Superior Court for the Judicial District of Stamford-Norwalk at Stamford bearing Docket No. FST-CV-13-6020149-S. By order of the Superior Court, this appeal was transferred to the Tax and Administrative Appeals Session of the Superior Court for the Judicial District of New Britain bearing Docket No. HHB-CV-13-6022722-S (hereinafter the administrative appeal is referred to as, "Docket No. HHB-CV-13-6022722-S").

Wherefore, HSS and OHCA sought to resolve the issues raised under Docket No. HHB-CV-13-6022722-S and entered into good-faith settlement discussions in order to avoid the continued expense of litigation;

Wherefore, HSS's original proposal sought to acquire an MRI scanner to serve its own patients who are commercially insured or who privately pay for services received; HSS now proposes to acquire an MRI scanner to serve all Connecticut residents, including Medicaid recipients and the uninsured;

ORDER

NOW, THEREFORE, OHCA and the Applicant, HHS, hereby stipulate and agree to the terms of settlement with respect to the Applicant's request to acquire a 1.5 Tesla MRI unit to be located in Stamford, Connecticut with an associated capital expenditure of $3,245, 583:

1. HHS's request to acquire a 1.5 Tesla MRI unit to be located in Stamford, Connecticut with an associated capital expenditure of $3,245, 583 is **approved.**

2. HSS shall ensure that there is equal access to the MRI service located in Stamford to all patients, including Medicaid recipients and the uninsured;

7. HSS shall apply to the Connecticut Medicaid program and make all efforts to comply with the requirements of participation;

8. HSS shall institute the same Financial Assistance Program at its Connecticut site that is in place at its main campus in New York. Currently under this program, uninsured patients with income levels below 500% of the U.S. Health and Human Services Poverty Guidelines will be eligible for a discounted patient bill. In addition, insured patients may be eligible for discounts toward their copayments, deductibles and other fees depending on income and reasonably available assets;

9. HSS shall establish clinic sessions to provide additional physician services at its Connecticut site for Medicaid recipients and the uninsured to improve the accessibility of services for this patient population;
    a. Clinic sessions shall run two days per month.
    b. Clinic sessions shall be staffed by fully credentialed Medical Doctors employed by HSS.
    c. All services available during private sessions shall be available during clinic sessions and shall be subject to the same quality standards applicable at all HSS locations.
    d. Clinic patients shall have access to all HSS services.

10. Availability of the aforementioned services to Medicaid and uninsured patients at HSS's Connecticut site shall be communicated to area health care providers, including community based health centers. HSS shall accept referrals for:
    a. Musculoskeletal MRI services at its Connecticut site from local health care providers as needed; and
    b. Other specialized musculoskeletal services available during clinic sessions from local health care providers, community based health centers or other sources as needed.

11. HSS shall allocate or block not less than one-third of its Connecticut MRI appointment slots to Connecticut residents;

12. Appointments for MRI services at the Connecticut site shall be scheduled on a "first come, first served" basis, regardless of referral source or payer. If wait times consistently exceed one week, strategies for expanding capacity (e.g. extending hours of operation) shall be considered;

13. HSS shall take all practical steps to achieve a payer mix that includes 10% Connecticut Medicaid and 2% uninsured patients for its Connecticut MRI service within the first year of operation, including but not limited to outreach efforts described in 9 and 10 above. HSS shall provide a plan detailing the foregoing steps to be taken within sixty (60) days of the execution of this settlement. HSS shall report such payer mix to OHCA at the end of its first year of operation and if this threshold is not met, HSS shall work with OHCA

to re-evaluate its outreach initiatives and develop strategies to increase utilization by Connecticut Medicaid and uninsured patients;

14. HSS shall implement educational and community outreach programs in the communities served by its Connecticut site. Implementation efforts shall include the following:
    a. Establishing a Community Service Committee, led by HSS with representation from local Connecticut communities as well as partnering organizations, i.e. Stamford Hospital, community based health centers, local school systems, consumers, etc.;
    b. Conducting a community needs health assessment in the catchment area around the Connecticut site within the first six months of operation and providing the results of the needs assessment to OHCA within thirty (30) days of completion;
    c. Identifying community partners that work with the underserved;
    d. Developing select programs to be offered to address the needs identified in the community needs health assessment, i.e., wellness classes, lectures, etc., either independently or in partnership with local providers (e.g. Stamford Hospital) based upon the results of the community needs health assessment;
    e. Distributing publications via regular mail and/or electronically to the community, i.e., Health Connection newsletter; Health Connection Fast Facts;
    f. Considering extension of existing HSS community outreach programs to the Connecticut service areas, as needed, based on the community needs health assessment. Programs may include, but are not limited to:
        i. The Leon M. Root, MD Pediatric Outreach Program (POP).
        ii. SNEAKER© (Super Nutrition Education for All Kids to Eat Right).
    g. HSS community outreach programs shall include free health screening programs, including free musculoskeletal screening and education sessions to be offered at least quarterly; and
    h. Include the Connecticut communities served by the Connecticut site within the HSS eAcademy consumer/patient programs, i.e., live streaming, webinars, etc.

15. HSS shall provide continuing professional/medical education on musculoskeletal magnetic resonance imaging to providers in the Connecticut service areas as follows:
    a. HSS shall provide educational conferences on musculoskeletal magnetic resonance imaging targeted to at least the two following groups:
        i. Program for Radiologists
        ii. Program for Technologists
    b. Conferences shall include education on musculoskeletal magnetic resonance imaging software, applications and best practices developed by HSS in collaboration with GE Healthcare.
    c. Conferences shall be provided to meet demand but occur no less frequently than annually.

d. HSS shall communicate the availability of its fellowship programs to Connecticut Radiology Residency programs and encourage application to these fellowship programs.

16. HSS shall seek to fill any additional non-medical doctor positions created as a result of the relocation and expansion of its Old Greenwich office to Stamford (approximately 25 positions) with qualified Connecticut residents;

17. Reporting to OHCA shall be required for a period of five (5) years following the opening of the Connecticut site. HSS shall immediately report to OHCA the date that the project has become fully implemented and the MRI service operational at the Connecticut location. This date shall be considered the implementation date for reporting purposes;

18. HSS shall provide documentation to OHCA evidencing acceptance within the Connecticut Medicaid Program in accordance with Condition 7. Such documentation shall be filed within thirty (30) days of approval as a Connecticut Medicaid provider;

19. HSS shall provide documentation to OHCA evidencing that HSS has provided notice to providers of its participation in the Connecticut Medicaid Program, in accordance with Condition 7 above. Such documentation shall be filed within thirty (30) days of approval as a Connecticut Medicaid provider;

20. The following shall be filed with OHCA within sixty (60) days subsequent to the one year anniversary of the implementation date for a period of five (5) years:

    a. A report of the quality data on patient outcomes regarding HSS MRI Service Integration during the past operating year, including:
        i. Report on the use of contrast for non MRI Angiography and report on comparison of the repeat studies where the base study from the outside institution used contrast ,
        ii. Report on the number of repeat studies where it was determined that the outside study was not adequate for diagnosis,
        iii. Summary of research findings from clinical practice studies (findings will also be incorporated into community based education for local radiologists where appropriate), and
        iv. Hospital wide publicly reported measures enabled by HSS integrated care which includes MRI (readmission rates, surgical site infection rates, etc.);
    b. The number of Connecticut Medicaid recipients and uninsured utilizing the clinic sessions during the past operating year, in accordance with Condition 9 above;

c. Quantification of the discounts provided through the Financial Assistance Program for the approved site during the past operating year in accordance with Condition 8 above. The information shall be provided as both a dollar amount and a volume figure (i.e., the number of scans for which a discount was provided);
d. A description of, as well as the frequency of, the free health screening programs during the past operating year and the area providers involved, in accordance with Condition 9 above;
e. A description of, as well as the frequency of, educational sessions held during the past operating year and the topics discussed, in accordance with Conditions 14 and 15 above;
f. A summarization of the collaborative efforts and the discussions with area hospitals and providers during the past operating year, in accordance with Condition 14 and 15 above;
g. A summary of communication to Connecticut Residency programs regarding HSS's Fellowship programs, in accordance with Condition 15 above;
h. The names of the radiologists from or licensed in Connecticut who participated in and completed the magnetic resonance imaging fellowship during the past operating year, in accordance with Condition 15 above.
i. A listing of the positions, both employed or under contract, at the Connecticut site for the past operating year and the State in which the individuals that hold the listed positions, reside;
j. A listing of the community needs identified and the community benefit activities undertaken during the past operating year, in accordance with Condition 14 above;
k. A copy of the Community Service Plan Report, including a summary of Community Service Committee activities and a summary of completed and planned health screening and education activities during the past operating year, in accordance with Condition 14 above;
l. Annual magnetic resonance utilization data based on number of scans shall be provided by zip code and by payer type. This data shall be filed in the following table format in Excel:

Zip Code	Medicare	CT Medicaid	Other States' Medicaid	Other Government (CHAMPUS & Tricare)	Commer-cially Insured	Uninsured	Workers Compensation	Total for Zip Code
06001	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans
06002	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans
#####	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans

#####	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans
#####	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans
Total for CT zip codes	# and %	# and %	N/A	# and %	# and %	# and %	# and %	N/A
Total for other states zip codes	# and %		# and %	# and %	# and %	# and %	# and %	N/A
Total all zip codes	# and %	# and %	# and %	# and %	# and %	# and %	# and %	N/A

m. Annual MR utilization data based on number of scans shall be provided by zip code and by diagnostic category. This data shall be filed in the following table format in Excel:

Zip Code	Diagnostic Category	Diagnostic Category	Diagnostic Category	Diagnostic Category	Diagnostic Category	Diagnostic Category	Diagnostic Category	Diagnostic Category
06001	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans
06002	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans
#####	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans
#####	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans
#####	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans	# of scans

n. Other reporting as reasonably required by OHCA.

21. OHCA and HSS agree that this settlement represents a final agreement between the OHCA and HSS with respect to Docket No. 12-31780-CON. The execution of this settlement resolves all objections, claims and disputes, which may have been raised by HSS with regard to Docket Number 12-31780-CON;

22. HSS hereby agrees to withdraw its administrative appeal filed under Docket No. HHB-CV-13-6022722-S within two (2) business days of the execution of this settlement and provide evidence thereof to OHCA.

23. OHCA may enforce this settlement under the provisions of Conn. Gen. Stat. §§ 19a-642 and 19a-653 with all fees and costs of such enforcement being the responsibility of HSS; and

24. This settlement shall be binding upon HSS and its successors and assigns.

Signed by Louis Shapiro, President & CEO
(Print name) (Title)

12/23/13
Date

Duly Authorized Agent for
New York Society for the Relief of the Ruptured and Crippled, maintaining the Hospital for Special Surgery

The above Agreed Settlement is hereby accepted and so ordered by the Department of Public Health Office of Health Care Access on December 26, 2013.

Lisa A. Davis, MBA, BSN, RN
OHCA Commissioner

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

June 14, 2013

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 12-31780-CON
New York Society for the Relief of the Ruptured and Crippled, maintaining the Hospital for Special Surgery	**Acquisition of a Magnetic Resonance Imaging Scanner to be Located in Stamford, Connecticut**

To: Stacey L. Malakoff
Executive Vice President/CFO
The Hospital for Special Surgery
535 East 70th Street
New York, NY 10021

Dear Ms. Malakoff:

This letter will serve as notice of the Final Decision of the Office of Health Care Access in the above matter, as provided by Section 19a-638, C.G.S. On June 14, 2013, the Final Decision was rendered as the finding and order of the Office of Health Care Access. A copy of the Final Decision is attached hereto for your information.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:av

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicants:	**New York Society for the Relief of the Ruptured and Crippled, maintaining the Hospital for Special Surgery** **535 East 70th Street, New York, New York 10021**
Docket Number:	**12-31780-CON**
Project Title:	**Acquisition of a Magnetic Resonance Imaging Scanner to be Located in Stamford, Connecticut**

Project Description: New York Society for the Relief of the Ruptured and Crippled, maintaining the Hospital for Special Surgery ("HSS" or "Applicant") seeks to acquire a Magnetic Resonance Imaging ("MRI") scanner to be located in Stamford, Connecticut, with an associated capital expenditure of $3,245,583.

Procedural History: The Applicant published notice of its intent to file a CON application in The Advocate (Stamford) on June 26, 27 and 28, 2012. On August 13, 2012, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application from the Applicant for the above-referenced project. On November 2, 2012, OHCA deemed the application complete.

On November 16, 2012, the Applicant was notified of the date, time, and place of the public hearing. On November 19, 2012, a notice to the public announcing the hearing was published in the *Record Journal*, *The Advocate* and *The News Times*. Thereafter, pursuant to Conn. Gen. Stat. § 19a-639a, a public hearing regarding the CON application was held on December 18, 2012.

Commissioner Jewel Mullen designated Attorney Kevin T. Hansted as the hearing officer in this matter. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the General Statutes) and Conn. Gen. Stat. § 19a-639a. The public hearing record was closed on December 24, 2012.

A Proposed Final Decision was issued on April 8, 2013. Thereafter, the Applicant filed Exceptions to the Proposed Final Decision on May 10, 2013. Included in the Exceptions was a claim that the Applicant had not been given notice that OHCA would rely on certain information in its Proposed Final Decision. In order to allow the Applicant an opportunity to submit evidence to refute the information upon which OHCA partially relied, the matter was remanded back to the Hearing Officer and the public hearing record was opened on May 21, 2013. In response, the Applicant notified OHCA on May 21, 2013 that it would not be submitting additional evidence, but rather, would rely on the information included in its Exceptions. The public hearing record was closed again on May 21, 2013.

Findings of Fact

1. HSS is a not-for-profit, acute care, academic medical center located at 535 East 70th Street, New York, NY 10021. HSS is a health care facility or institution as defined by Conn. Gen. Stat. § 19a-630. Ex. A, p. 8.

2. HSS currently provides physician services, diagnostic x-ray and fluoroscopic guidance imaging services at 143 South Beach Avenue, in Old Greenwich, Connecticut. Ex. A, p. 6.

3. HSS is a top ranked hospital in the orthopedic and rheumatology fields; its MRI centers specialize in musculoskeletal exams. Ex. A, p. 6; Ex. F, p. 340.

4. HSS is planning to expand and relocate its services from 143 South Beach Avenue, Old Greenwich, Connecticut to 1 Blachley Road, Stamford, Connecticut. Ex. A, p. 6.

5. HSS is seeking approval for the acquisition of a 1.5 Tesla Magnetic Resonance Imaging (MRI) unit at this new location. Ex. A, p. 6.

6. HSS currently operates ten MRI units at or in close proximity to its main hospital campus in Manhattan, and has received approval from the state of New York to operate a new unit at a satellite location in Uniondale, NY. Ex. A, p. 7; Ex. B, p. 347.

7. Table 1 shows historical, current and projected utilization for all MRI scanners operated by HSS.

Table 1: HSS Existing MRI Units and Volumes by Location:

	Actual Volume (Last 3 Completed CYs)			CY Vol. (d)	Projected Volume (First 3 Full Operational CYs)		
	2009	2010	2011	2012	2014	2015	2016
HSS Main Campus (a)(b):							
- Unit A	4,555	4,054	3,825	3,267	3,359	3,464	3,568
- Unit B	3,700	3,232	3,244	3,008	3,094	3,191	3,287
- Unit C	3,892	3,963	3,996	3,810	3,919	4,042	4,162
- Unit D	4,194	4,031	3,863	3,567	3,667	3,781	3,895
- Unit E	3,787	3,420	3,382	3,215	3,306	3,409	3,512
- Unit F	2,974	3,648	3,835	3,470	3,568	3,679	3,790
- Unit G (11/3/09)	754	3,754	3,654	3,489	3,587	3,699	3,811
- Unit H (c)	1,708	1,303	2,327	3,397	3,491	3,600	3,709
- Unit I (3/26/12)	-	-	-	1,934	2,591	2,672	2,753
75th St (11/28/11)	-	-	190	2,443	2,512	2,590	2,668
Uniondale, NY (1/1/13)	-	-	-	-	2,400	2,400	2,400
Stamford, CT (1/1/14)	-	-	-	-	2,175	2,540	2,540
Total	25,564	27,405	28,316	31,600	37,669	39,067	40,095

Ex. F, p. 347.

(a) HSS Main Campus MRIs operate 13.5 hours/day (Unit A – 16 hours/day) and on weekends (limited hours), whereas the units at the offsite locations operate 10 hours/day and no weekends. 75Th St, which is in close proximity to the Main Campus, operates 11.5 hours/day.

(b) Nine of the above listed units are 1.5 Tesla units and three are 3.0 Tesla units. Tesla measures the strength of the magnet. HSS operates mostly 1.5T units since these are most effective for orthopedic imaging in most cases.

(c) Unit H was converted from an Open to a 1.5T MRI in May 2011 due to obsolescence.

(d) Represents projected 2012 totals based on actual volumes through August 2012.

Note: All above years represent calendar years (CYs). Above totals are for outpatients only.

8. The Applicant states that the proposed service area would include the following towns: Stamford, Greenwich, Darien and New Canaan, Connecticut, and Scarsdale, Rye, and Mamaroneck, New York. Ex. A, p. 15.

9. Based on CY 2012 volumes, HSS projects that it will perform approximately 3,250 MRI scans for its patients residing in Connecticut and Westchester County. Of the total projected volume, 896 scans (28%) would originate from the Connecticut portion of the proposed service area. Ex. A, p. 7.

Table 2: HSS Historical/Projected MRI Volumes for the Proposed Service Area:

Town	2011	Actual through June 2012	Projected through end of 2012
Stamford	144	67	134
Greenwich	454	243	486
Darien	174	68	136
New Canaan	109	70	140
CT Portion of Proposed Service Area	**881**	**448**	**896**
Scarsdale	229	114	228
Rye	217	110	220
Mamaroneck	219	144	288
NY Portion of Proposed Service Area	**665**	**368**	**736**
Total Proposed Service Area	**1,546**	**816**	**1,632**
Other CT Residents	725	465	930
Other NY Residents	616	344	688
Total HSS MRI Volume	**2,887**	**1,625**	**3,250**

Ex. A, p. 15.

10. HSS claims that the maximum capacity of the MRI requested in this proposal will be 2,540 scans; based on a five day-per-week, 10-hour-per-day schedule. As the projected volume of 3,250 scans exceeds the claimed maximum capacity of 2,540 scans, a portion of patients would thus need to receive their MRI scan in Manhattan. Ex. A, pp. 16-17.

11. HSS is projecting the following utilization for its proposed MRI scanner:

Projected MRI Volume

	Projected Volume		
	FY 2014	FY 2015	FY 2016
MRI Total	**2,175**	**2,540**	**2,540**

Ex. A, p. 27.

12. HSS states that its MRI scans use proprietary protocols that are customized to meet the needs and specifications of individual patients and their physicians. HSS claims the protocols/customization allows each physician to maximize the usefulness of the MRI as a tool for diagnosis and to help develop effective treatment plans. The protocols used by HSS do not require specialized equipment; however, they do require specialized software for prototype pulse sequences, which is the property of General Electric (GE). Ex. A, pp. 6-7; Ex. F, p. 340.

13. HSS has a comprehensive and collaborative research agreement with GE, allowing it to use these newer sequence and MRI techniques that are not currently available to other providers in the tri-state area. Ex. F, p. 341.

14. HSS sends the majority of its patients (approximately 3,250) to its Manhattan campus to receive MRI scans. Only a small percentage of patients are referred to Connecticut providers. HSS will continue to refer patients to the HSS MRI department, regardless of whether the MRI is located in Manhattan, Stamford or another location. Ex. A, p. 7; Ex. F, pp. 349, 352.

15. HSS stated that patients are sent to New York to be imaged due to the focus on MRI quality. Transcript of December 18, 2012 Public Hearing ("Tr."), Testimony of Dr. Jo A. Hannafin, Attending Orthopedic Surgeon at the Hospital for Special Surgery.

16. HSS stated that it had only anecdotal cases to support its claim that HSS MRI protocols are better than those used by Connecticut providers. HSS' peer-reviewed literature is not based on any specific Connecticut facility. Transcript of December 18, 2012 Public Hearing ("Tr."), Testimony of Dr. Hollis Potter, Chief of the MRI department at the Hospital for Special Surgery.

17. HSS stated that it had not specifically addressed improvement in surgical outcomes as a result of using its MRI protocols. Transcript of December 18, 2012 Public Hearing ("Tr."), Testimony of Dr. Hollis Potter, Chief of the MRI department at the Hospital for Special Surgery.

18. The Applicant asserts that clear public need for this proposal is demonstrated by the following:
    - An MRI site in Stamford provides a more convenient location for Connecticut and Westchester County, NY patients than the HSS main campus in Manhattan. Ex. A, pp. 7, 13.
    - The ability to free up needed capacity and alleviate current issues with MRI backlog at HSS's Manhattan location. Ex. A, pp. 7, 13.

19. The Applicant asserts that this proposal will not impact the volumes of existing Connecticut MRI providers, due to the following:
    - MRI volume will shift from Manhattan to Stamford;
    - HSS can fill the capacity of the proposed MRI with its own patients;
    - The proposed MRI scanner will not be marketed to non-HSS physicians or patients.

    Ex. A, p. 7.

20. Although HSS does not directly market it services to non-HSS physicians, testimony received stated that HSS does currently accept referrals from non-HSS orthopedic surgeons in New York. HSS also stated that it would like to market its MRI services to an orthopedic practice affiliated with The Stamford Hospital and located within the same building (Chelsea Piers complex) where the proposed MRI would be operated. Transcript of December 18, 2012 Public Hearing ("Tr."), Testimony of Lou Shapiro, President and Chief Executive Officer for the Hospital for Special Surgery.

21. The projected patient population mix presented below is based on HSS's current MRI payer mix and assumes that the mix of patients treated in Stamford will be similar:

Table 4: HSS Projected Payer Mix:

Coverage Type	Year 1 FY 2014	Year 2 FY 2015	Year 3 FY 2016
Medicare*	18.1%	18.1%	18.1%
Medicaid*	2.1%	2.1%	2.1%
CHAMPUS & TriCare	0.0%	0.0%	0.0%
Total Government	**20.2%**	**20.2%**	**20.2%**
Commercial Insurers*	74.7%	74.7%	74.7%
Uninsured	1.4%	1.4%	1.4%
Workers Compensation	3.7%	3.7%	3.7%
Total Non-Government	**79.8%**	**79.8%**	**79.8%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**

Ex. A, p. 36.

*Includes managed care activity.

22. The total capital expenditure is $3,245,583 and will be funded from HSS operations. The capital costs include: $1,800,000 for imaging equipment and $1,445,583 for construction and renovation.

23. The Applicant projects incremental gains from operations of $1,341,000 in FY 2014, $1,659,000 in FY 2015, and $1,708,000 in FY 2016.

Table 5: Financial Projections Incremental to the Project:

Description	FY 2014	FY 2015	FY 2016
Incremental Revenue from Operations[1]	$2,176	$2,614	$2,686
Incremental Total Operating Expenses[2]	$835	$955	$978
Incremental Gain from Operations	**$1,341**	**$1,659**	**$1,708**

Ex. A, pp. 336-339.

Note: figures are in thousands.

[1] Forecasts consider volume, payer mix and payment rate trends as well as the impacts of proposed regulatory reforms, capacity constraint, and anticipated capital initiatives.

[2] Operating expenses include rent, depreciation, facility, supply and staffing costs needed to operate the MRI unit and support the forecasted volumes.

24. 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 policies and standards not yet adopted as regulations by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1))

25. This CON application was deemed complete by OHCA prior to the state wide health care facilities and services plan being published. Therefore, OHCA has not made any findings as to the relationship between this CON application and the state wide health care facilities and services plan. (Conn. Gen. Stat. § 19a-639(a)(2))

26. The Applicant has failed to establish that there is a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

27. The Applicant has satisfactorily demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

28. The Applicant has failed to satisfactorily demonstrate that the proposal would improve quality, accessibility and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat. § 19a-639(a)(5))

29. The Applicant has shown that there would be no change to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

30. The Applicant has satisfactorily identified the population to be served by its proposal, but has failed to satisfactorily demonstrate that this population has a need as proposed. (Conn. Gen. Stat. § 19a-639(a)(7))

31. The utilization of existing health care facilities and services in the service area does not support this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

32. The Applicant has failed to satisfactorily demonstrate that its proposal would not result in an unnecessary duplication of existing MRI services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

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 General Statutes § 19a-639(a). The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Goldstar Medical Services, Inc., et al. v. Department of Social Services, 288 Conn. 790 (2008).*

The New York Society for the Relief of the Ruptured and Crippled, maintaining the Hospital for Special Surgery ("Applicant" or "HSS"), a not-for-profit hospital located in New York City, proposes to acquire a 1.5 Tesla MRI scanner to be located in Stamford, Connecticut. *FF1&5.*

The proposal is based upon the assertion that a new MRI unit in Stamford would provide a more convenient location for HSS patients residing in Connecticut and Westchester County to receive HSS' MRI services. The relevant portion of HSS' patient volume would shift from Manhattan to a new location in Stamford. HSS has stated that the approval of this proposal would help alleviate capacity constraints and backlog at the hospital's main campus in Manhattan. *FF18-19.*

HSS claims that its use of proprietary and customized MRI protocols result in higher quality images and improved diagnostic accuracy. *FF12-13&15.* Thus, the application is not based on whether the service area needs additional capacity, but rather upon the claimed unique benefits of HSS' MRI protocols.

Although HSS has provided credible testimony as to its experience and expertise generating musculoskeletal MRI scans, it has failed to provide conclusive evidence (i.e., comparative scientific studies or empirical evidence) to validate their claim that HSS' MRI protocols provide significantly better imaging results or lead to better surgical outcomes than MRI protocols used by existing Connecticut providers. *FF3; FF16-17.* Given this lack of evidence to substantiate the Applicant's claim of a unique benefit, approval of this proposal would result in the duplication of services in the region.

HSS represented that it would not directly market its services to non-HSS physicians even though HSS' current practice is to accept referrals from non-HSS physicians, if presented. In addition, HSS stated that it would like to provide MRI services to a local orthopedic practice located within the same building as the proposed MRI. *FF20.* Both of these factors support the conclusion that approval of this proposal would lead to decreased patient volumes and revenues for existing MRI providers in the service area and result in an unnecessary duplication of MRI services in the region.

OHCA's determination on the acquisition of an MRI is based, in part, on the demonstrated need for the acquisition, not whether an MRI may provide a more convenient location for the patient or help to address capacity issues outside of Connecticut. *FF18.* Although HSS provided numerous anecdotal examples and testimony about the quality of its MRI services and overall system of care, both the application and testimony lack evidence to substantiate that access or health care outcomes for Connecticut patients would be improved as a result of this proposal. After considering all of the factors listed above, OHCA concludes that the Applicant did not demonstrate clear public need for its proposal.

Order

Based upon the foregoing Findings and Discussion, the Certificate of Need application of New York Society for the Relief of the Ruptured and Crippled, maintaining the Hospital for Special Surgery to acquire a Magnetic Resonance Imaging scanner to be located in Stamford, Connecticut, with an associated capital expenditure of $3,245,583, is hereby **DENIED**.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Office of Health Care Access

6/14/2013
Date

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 21, 2015 FACSIMILE TRANSMISSION ONLY

Mr. Louis A. Shapiro
President and Chief Executive Officer
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021

Re: Compliance with Agreed-Upon Conditions set forth in Docket Number: 12-31780-CON
Hospital for Special Surgery's Acquisition of a MRI Scanner for its Planned Outpatient Center in Stamford, Connecticut
Request for Required Reporting and Project Update

Dear Mr. Shapiro:

On December 26, 2013, New York Society for the Relief of the Ruptured and Crippled, maintaining the Hospital for Special Surgery, hereinafter referred to as "HSS", entered into an Agreed Settlement with the Department of Public Health, Office of Health Care Access ("OHCA") under Docket Number ("DN"): 12-31780-CON. The settlement granted HSS the acquisition of a 1.5 telsa-strength magnetic resonance imaging ("MRI") scanner for its planned outpatient center in Stamford, Connecticut (the "Stamford Center"). A copy of the agreed settlement is enclosed as Attachment 1 of this letter for reference proposes.

OHCA has received the following filings from HSS regarding the agreed-upon conditions set forth in DN: 12-31780-CON:

- On March 3, 2014, HSS filed its plan to achieve payer mix goals in support of Condition #13;
- On April 1, 2014, HSS filed a copy of its 2013 Community Benefit Report.
- On February 11, 2015, HSS reported that the Stamford Center became operational on February 2, 2015 in response to Condition #17.
- On April 20, 2015, HSS provided documentation evidencing Stamford Center's acceptance in the Connecticut Medicaid Program in response to Condition #18.

As of this date, OHCA has not received any correspondence regarding agreed-upon Condition #19. Additionally, a recent inquiry from a Stamford-area orthopedist has given cause for OHCA to seek additional information about the Stamford Center's operation. Lastly, HSS's plan to achieve payer mix goals as required by the agreed-upon Condition #13 was found to be lacking specific information as to how the goals are to be achieved. As such, OHCA requests that the HSS provide the following:

1. With respect to Condition #19, provide OHCA with documentation evidencing that HSS has provided notice to providers of its participation in the Connecticut Medicaid Program in accordance with Condition #7. The reporting of this documentation was to have occurred within thirty (30) days of having received approval from the Connecticut Department of Social Services to HSS's application for the Stamford Center's enrollment as a Connecticut Medicaid Provider.

2. In mid-May of this year OHCA was informed by a Stamford-area orthopedist of his difficulty in referring a patient enrolled in the HUSKY Program to the Hospital for Special Surgery's Stamford Center. During the course of attempting the referral, the orthopedist was informed that the Stamford Center doesn't have clinic sessions in Stamford and that clinic sessions are only offered at HSS's New York City campus. With respect to the above circumstance and in conjunction with agreed-upon Conditions #9 and #10, please provide the following:

    a. An explanation of where in the development process the Stamford Center is in establishing its clinic sessions, which are being created to provide additional physician services for Medicaid recipients and the uninsured. Specifically address how the clinic sessions will be phased into the programs offered at the Stamford Center as well as how the individual subsections Condition #9 a. through #9 d. will be met.

    b. An explanation as to how the aforementioned clinic sessions have been or will be communicated to area health care providers.

    c. An explanation as to how the Stamford Center will handle referrals for musculoskeletal MRI services and other specialized musculoskeletal services from local health care providers, community-based health centers or other sources, as needed.

3. On March 3, 2014, HSS filed with OHCA its plan to achieve payer mix goals in support of Condition #13. OHCA finds that the four point plan is simply a recapitulation of the required actions that HSS needs to fulfill in remaining compliant with the agreed-upon conditions in the settlement's order and is lacking sufficient information as to how HSS is attempting to reach the prescribed payer mix goals. With respect to the above circumstance and in conjunction with agreed upon Condition #13, provide a revised plan which describes specific steps detailing how the payer mix goals of the Stamford Center will be achieved.

4. With respect to Condition #14, provide a description of the steps that have been taken to date in establishing the following:

    a. Educational and community outreach programs in the communities served by the Stamford Center;
    b. A Community Service Committee; and

c. Community Needs Health Assessment in the catchment area of the Stamford Center.

Kindly have a response to this letter prepared and sent to OHCA by the close of business on Friday, June 12, 2015. If there is another HSS associate that you prefer to be the recipient of future compliance correspondences from OHCA, please send me the name, title and contact information of that individual. Should you or an associate have any questions regarding the above, please feel to contact me at (860) 418-7069. I may also be reached at Jack.Huber@ct.gov.

Sincerely,

Jack A. Huber

Jack A. Huber
Health Care Analyst

Attachment

Cc: Kimberly R. Martone, Director of Operations, DPH, OHCA (Cover Letter)
Karen Roberts, Principal Health Care Analyst, DPH, OHCA (Cover Letter)

Hospital for Special Surgery
MRI Units by Zip Code and by Payor Group
12 Months Ended: February 2015-January 2016

State Group	Zip Code	Commercially Insured	CT Medicaid	Medicare	Uninsured	Worker's Compensation	Total
CT	6820	115	-	12	-	1	128
CT	6877	35	1	7	-	-	43
CT	6825	8	5	2	-	1	16
CT	6830	94	1	14	-	-	109
CT	6870	45	-	6	-	-	51
CT	6902	58	4	27	2	1	92
CT	6807	25	1	5	-	-	31
CT	6831	55	1	15	-	3	74
CT	6810	4	-	3	-	-	7
CT	6851	16	2	4	-	-	22
CT	6812	6	-	2	-	-	8
CT	6824	41	-	10	-	-	51
CT	6850	12	-	3	-	-	15
CT	6853	18	-	2	-	-	20
CT	6840	68	-	8	2	-	78
CT	6515	3	-	-	-	-	3
CT	6883	37	-	6	-	-	43
CT	6878	39	-	5	-	-	44
CT	6897	34	2	7	-	2	45
CT	6901	10	2	-	-	-	12
CT	6854	9	1	5	-	-	15
CT	6903	28	-	11	-	-	39
CT	6880	87	-	18	-	-	105
CT	6811	3	-	1	-	-	4
CT	6606	3	1	-	-	-	4
CT	6475	-	-	1	-	-	1
CT	6611	10	-	4	-	1	15
CT	6906	11	1	2	-	-	14
CT	6905	22	-	5	-	-	27
CT	6436	-	-	1	-	-	1
CT	6801	8	-	1	-	-	9
CT	6855	6	-	-	1	-	7
CT	6836	3	-	-	-	-	3
CT	6612	8	-	2	-	-	10
CT	6907	14	-	-	-	-	14
CT	6604	-	-	-	-	2	2
CT	6896	10	-	1	-	-	11
CT	6804	4	-	1	-	-	5
CT	6482	8	-	-	-	-	8
CT	6419	1	-	-	-	-	1
CT	6798	1	-	2	-	-	3
CT	6757	1	-	-	-	2	3

Hospital for Special Surgery
MRI Units by Zip Code and by Payor Group
12 Months Ended: February 2015-January 2016

State Group	Zip Code	Commercially Insured	CT Medicaid	Medicare	Uninsured	Worker's Compensation	Total
CT	6776	2	-	1	-	1	4
CT	6784	2	-	-	-	-	2
CT	6890	11	-	1	-	-	12
CT	6095	1	-	-	-	-	1
CT	6518	-	-	-	-	1	1
CT	6370	1	-	-	-	-	1
CT	6512	1	-	-	-	-	1
CT	6468	7	-	-	-	1	8
CT	6478	-	-	3	-	-	3
CT	6708	1	-	-	-	-	1
CT	6716	1	-	-	-	-	1
CT	6074	1	-	-	-	-	1
CT	6401	2	-	-	-	-	2
CT	6032	3	-	-	-	-	3
CT	6525	-	-	1	-	-	1
CT	6492	1	-	1	-	-	2
CT	6614	6	-	-	-	-	6
CT	6405	3	-	-	-	-	3
CT	6460	6	-	3	-	-	9
CT	6787	1	-	-	-	-	1
CT	6484	2	1	2	-	-	5
CT	6514	2	-	1	-	-	3
CT	6461	1	-	-	-	-	1
CT	6471	2	-	-	-	-	2
CT	6018	1	-	-	-	-	1
CT	6490	1	-	-	-	-	1
CT	6039	-	-	1	-	-	1
CT	6615	3	-	-	-	-	3
CT	6759	-	2	-	-	-	2
CT	6417	-	-	1	-	-	1
CT	6106	2	-	-	-	-	2
CT	6470	3	-	1	-	-	4
CT	6786	1	-	-	-	-	1
CT	6040	-	-	1	-	-	1
CT	6488	1	-	2	-	-	3
CT	6001	1	-	-	-	-	1
CT	6082	2	-	-	-	-	2
CT	6442	2	-	-	-	-	2
CT	6079	-	-	1	-	-	1
CT	6385	2	-	-	-	-	2
CT	6762	1	-	-	-	-	1
CT	6817	1	-	-	-	-	1

Hospital for Special Surgery
MRI Units by Zip Code and by Payor Group
12 Months Ended: February 2015-January 2016

State Group	Zip Code	Commercially Insured	CT Medicaid	Medicare	Uninsured	Worker's Compensation	Total
CT	6881	-	-	1	-	-	1
CT	6457	2	-	-	-	-	2
CT	6412	-	-	1	-	-	1
CT	6280	1	-	-	-	-	1
CT	6813	1	-	-	-	-	1
CT	6089	1	-	-	-	-	1
CT	6109	3	-	-	-	-	3
CT	6070	1	-	-	-	-	1
CT	6420	-	-	1	-	-	1
CT	6443	2	-	-	-	-	2
CT	6517	2	-	-	-	-	2
CT	6019	1	-	-	-	-	1
CT Total		**1,052**	**25**	**216**	**5**	**16**	**1,314**
CT Payor % of Total		*80.1%*	*1.9%*	*16.4%*	*0.4%*	*1.2%*	
OTHER STATES	10504	17	-	6	-	-	23
OTHER STATES	10577	5	-	-	-	-	5
OTHER STATES	10573	22	-	6	-	-	28
OTHER STATES	10801	6	-	-	-	-	6
OTHER STATES	10804	8	-	1	-	-	9
OTHER STATES	10530	5	-	2	-	3	10
OTHER STATES	10580	57	-	5	-	-	62
OTHER STATES	10461	-	-	2	-	-	2
OTHER STATES	10547	3	-	-	-	-	3
OTHER STATES	10538	26	-	6	-	-	32
OTHER STATES	10576	11	-	2	-	-	13
OTHER STATES	10021	2	-	5	-	-	7
OTHER STATES	10594	-	-	1	-	-	1
OTHER STATES	7945	1	-	-	-	-	1
OTHER STATES	10583	25	-	2	-	1	28
OTHER STATES	10920	1	-	1	-	-	2
OTHER STATES	10510	7	-	5	-	-	12
OTHER STATES	10506	18	1	1	-	-	20
OTHER STATES	10528	4	-	2	-	-	6
OTHER STATES	10591	6	-	1	-	4	11
OTHER STATES	10603	5	-	2	-	-	7
OTHER STATES	10605	9	-	7	-	-	16
OTHER STATES	11209	1	-	-	-	-	1
OTHER STATES	10549	8	-	1	-	-	9
OTHER STATES	10707	3	-	-	-	-	3
OTHER STATES	11766	-	-	-	-	1	1
OTHER STATES	10463	-	-	2	-	-	2
OTHER STATES	10589	6	-	-	-	-	6

Hospital for Special Surgery
MRI Units by Zip Code and by Payor Group
12 Months Ended: February 2015-January 2016

State Group	Zip Code	Commercially Insured	CT Medicaid	Medicare	Uninsured	Worker's Compensation	Total
OTHER STATES	10710	3	-	1	-	-	4
OTHER STATES	10924	1	-	-	-	1	2
OTHER STATES	20007	-	-	1	-	-	1
OTHER STATES	10509	6	-	2	-	-	8
OTHER STATES	10069	1	-	-	-	-	1
OTHER STATES	10465	1	-	1	-	-	2
OTHER STATES	10803	9	-	3	-	-	12
OTHER STATES	10128	4	-	-	-	-	4
OTHER STATES	10930	4	-	-	-	-	4
OTHER STATES	10543	8	-	5	-	-	13
OTHER STATES	10590	7	-	-	-	-	7
OTHER STATES	10952	4	-	-	-	-	4
OTHER STATES	10514	16	-	3	1	-	20
OTHER STATES	10541	5	-	-	-	2	7
OTHER STATES	11229	-	-	1	-	-	1
OTHER STATES	7046	-	-	1	-	-	1
OTHER STATES	10954	3	-	-	-	-	3
OTHER STATES	10526	2	-	-	-	-	2
OTHER STATES	7090	1	-	-	-	-	1
OTHER STATES	10533	3	-	-	-	-	3
OTHER STATES	10520	6	-	1	-	1	8
OTHER STATES	10536	6	-	1	-	-	7
OTHER STATES	10516	2	-	-	-	-	2
OTHER STATES	10598	6	-	-	-	1	7
OTHER STATES	7751	-	-	1	-	-	1
OTHER STATES	10001	-	-	2	-	-	2
OTHER STATES	12524	-	-	2	-	-	2
OTHER STATES	12533	2	-	1	-	-	3
OTHER STATES	10604	2	-	-	-	-	2
OTHER STATES	10570	7	-	2	-	-	9
OTHER STATES	3255	-	-	1	-	-	1
OTHER STATES	10462	2	-	-	-	-	2
OTHER STATES	11746	1	-	2	-	-	3
OTHER STATES	10595	1	-	-	-	-	1
OTHER STATES	10960	3	-	2	-	-	5
OTHER STATES	10708	10	-	-	-	-	10
OTHER STATES	11768	1	-	-	-	-	1
OTHER STATES	10606	1	-	-	-	-	1
OTHER STATES	2840	-	-	1	-	-	1
OTHER STATES	7410	1	-	-	-	-	1
OTHER STATES	10522	-	-	2	-	-	2
OTHER STATES	12590	2	-	1	-	1	4

Hospital for Special Surgery
MRI Units by Zip Code and by Payor Group
12 Months Ended: February 2015-January 2016

State Group	Zip Code	Commercially Insured	CT Medicaid	Medicare	Uninsured	Worker's Compensation	Total
OTHER STATES	10709	1	-	-	-	-	1
OTHER STATES	10014	2	-	-	-	-	2
OTHER STATES	7728	1	-	-	-	-	1
OTHER STATES	10805	2	-	1	-	-	3
OTHER STATES	7012	1	-	-	-	-	1
OTHER STATES	10552	-	-	2	-	-	2
OTHER STATES	10706	2	-	-	-	-	2
OTHER STATES	10562	4	-	-	-	-	4
OTHER STATES	7666	1	-	-	-	-	1
OTHER STATES	10567	3	-	1	-	-	4
OTHER STATES	5059	-	-	1	-	-	1
OTHER STATES	7076	1	-	-	-	-	1
OTHER STATES	10601	3	-	3	-	-	6
OTHER STATES	12594	2	-	-	-	-	2
OTHER STATES	10560	2	-	-	-	-	2
OTHER STATES	7446	2	-	-	-	-	2
OTHER STATES	10023	1	-	-	-	-	1
OTHER STATES	3110	-	-	-	1	1	2
OTHER STATES	11050	-	-	1	-	-	1
OTHER STATES	12561	2	-	-	-	-	2
OTHER STATES	22801	2	-	-	-	-	2
OTHER STATES	12603	2	-	-	-	-	2
OTHER STATES	10505	4	-	-	-	-	4
OTHER STATES	11545	1	-	1	-	-	2
OTHER STATES	11968	1	-	-	-	-	1
OTHER STATES	10956	4	-	1	-	-	5
OTHER STATES	10705	-	-	-	-	1	1
OTHER STATES	80218	-	-	-	1	-	1
OTHER STATES	10962	2	-	-	-	-	2
OTHER STATES	10965	2	-	-	-	-	2
OTHER STATES	2832	2	-	-	-	-	2
OTHER STATES	19085	1	-	-	-	-	1
OTHER STATES	10512	5	-	2	-	-	7
OTHER STATES	1036	1	-	-	-	-	1
OTHER STATES	10579	1	-	-	-	-	1
OTHER STATES	12531	1	-	-	-	-	1
OTHER STATES	10703	1	-	-	-	-	1
OTHER STATES	10022	-	-	2	-	-	2
OTHER STATES	10532	-	-	1	-	-	1
OTHER STATES	7016	1	-	-	-	-	1
OTHER STATES	12586	-	-	-	-	1	1
OTHER STATES	12550	1	-	1	-	-	2

Hospital for Special Surgery
MRI Units by Zip Code and by Payor Group
12 Months Ended: February 2015-January 2016

State Grou	Zi Code	Commercially Insured	CT Medicaid	Medicare	Uninsured	Worker's Com ensation	Total
OTHER STATES	10507	1	-	1	-	-	2
OTHER STATES	33418	-	-	1	-	-	1
OTHER STATES	11598	2	-	-	-	-	2
OTHER STATES	12520	-	-	1	-	-	1
OTHER STATES	11565	-	-	2	-	-	2
OTHER STATES	7458	1	-	-	-	-	1
OTHER STATES	10523	1	-	-	-	-	1
OTHER STATES	34476	-	-	1	-	-	1
OTHER STATES	7650	-	-	-	-	1	1
OTHER STATES	7450	1	-	-	-	-	1
OTHER STATES	7094	1	-	-	-	-	1
OTHER STATES	12553	2	-	-	-	-	2
OTHER STATES	10502	4	-	-	-	-	4
OTHER STATES	10475	-	-	-	-	1	1
OTHER STATES	33410	1	-	-	-	-	1
OTHER STATES	10471	1	-	-	-	-	1
OTHER STATES	12572	1	-	-	-	-	1
OTHER STATES	33477	1	-	-	-	-	1
OTHER STATES	12515	1	-	-	-	-	1
OTHER STATES	33036	-	-	1	-	-	1
OTHER STATES	6042	-	-	1	-	-	1
OTHER STATES	1106	-	-	-	1	-	1
OTHER STATES	11581	1	-	-	-	-	1
OTHER STATES	12508	-	-	-	-	1	1
OTHER STATES	10921	1	-	-	-	-	1
OTHER STATES	10950	1	-	2	-	-	3
OTHER STATES	1776	-	-	-	-	1	1
OTHER STATES	10017	1	-	-	-	-	1
OTHER STATES	33138	-	-	2	-	-	2
OTHER STATES	11803	1	-	-	-	-	1
OTHER STATES	10566	3	-	1	-	-	4
OTHER STATES	10994	-	-	-	-	2	2
OTHER STATES	2894	2	-	-	-	-	2
OTHER STATES	12526	-	-	-	-	1	1
OTHER STATES	10980	3	-	-	-	-	3
OTHER STATES	33037	1	-	-	-	-	1
OTHER STATES	10968	1	-	-	-	-	1
OTHER STATES	34236	-	-	1	-	-	1
OTHER STATES	3801	-	-	1	-	-	1
OTHER STATES	12601	-	-	2	-	-	2
OTHER STATES	7430	-	-	1	-	-	1
OTHER STATES	44853	2	-	-	-	-	2

Hospital for Special Surgery
MRI Units by Zip Code and by Payor Group
12 Months Ended: February 2015-January 2016

State Group	Zip Code	Commercially Insured	CT Medicaid	Medicare	Uninsured	Worker's Compensation	Total
OTHER STATES	10013	1	-	-	-	-	1
OTHER STATES	6930	1	-	-	-	-	1
OTHER STATES	10607	1	-	-	-	-	1
OTHER STATES	12582	-	-	1	-	-	1
OTHER STATES	7470	1	-	-	-	-	1
OTHER STATES	33480	-	-	1	-	-	1
OTHER STATES	7045	-	-	1	-	-	1
OTHER STATES	7457	1	-	-	-	-	1
OTHER STATES	10680	-	-	1	-	-	1
OTHER STATES	10588	-	-	1	-	-	1
OTHER STATES	2210	1	-	-	-	-	1
OTHER STATES	12563	3	-	-	-	-	3
OTHER STATES	12483	1	-	-	-	-	1
OTHER STATES	10940	1	-	-	-	-	1
OTHER STATES	12552	-	1	-	-	-	1
OTHER STATES	4563	1	-	-	-	-	1
OTHER STATES	7901	1	-	-	-	-	1
OTHER STATES	10452	-	-	-	1	-	1
OTHER STATES	48116	1	-	-	-	-	1
OTHER STATES Total		**498**	**2**	**137**	**5**	**25**	**667**
OTHER STATES Payor % of Total		*74.7%*	*0.3%*	*20.5%*	*0.7%*	*3.7%*	
Grand Total		**1,551**	**27**	**353**	**10**	**41**	**1,981**
CT+OTHER STATES Payor % of Total		*78.3%*	*1.4%*	*17.8%*	*0.5%*	*2.1%*	
MRI Scans for Recent Quarter		**450**	**14**	**98**	**6**	**7**	**575**
% of Total		*78.3%*	*2.4%*	*17.0%*	*1.0%*	*1.2%*	

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EXHIBIT C

ZIP Code	ZIP City	2016 Adjusted Population		
		Total	Medicaid - Pre Reform	Medicaid Expansion
6850	Norwalk	19,296	1,673	612
6851	Norwalk	26,884	2,279	839
6853	Norwalk	3,822	129	50
6854	Norwalk	30,017	4,617	1,717
6855	Norwalk	8,317	803	320
6901	Stamford	7,992	1,114	408
6902	Stamford	66,035	7,311	2,886
6903	Stamford	14,672	408	158
6905	Stamford	20,860	1,176	490
6906	Stamford	8,924	747	297
6907	Stamford	9,458	832	305

Insurance Coverage Estimates 1.1
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: ORTHOPAEDIC & NEUROSURGERY SPECIALISITS, P.C. ACQUISTION OF MAGENTIC RESONANCE IMAGING SCANNER	)	DOCKET NO. 16-32063-CON
	)	AUGUST 25, 2016

PREFILED TESTIMONY OF ALAN D. KAYE, M.D., FORMER CHIEF EXECUTIVE OFFICER OF ADVANCED RADIOLOGY CONSULTANTS, LLC, IN OPPOSITION TO THE CON REQUEST OF ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

Good morning Hearing Officer Hansted and members of the Office of Health Care Access ("OHCA") staff. My name is Dr. Alan Kaye and I am the former Chief Executive Officer of Advanced Radiology Consultants, LLC ("ARC"). Thank for your allowing me this opportunity to testify in opposition to Orthopaedic & Neurosurgery Specialists, P.C.'s ("ONS") request for a Certificate of Need ("CON") to acquire a second MRI unit for its Greenwich office. In addition to my work with ARC, which has spanned more than 30 years, I have been actively involved with organized medicine and advocacy efforts on behalf of radiologists on a state and national level for most of my career. As such, I have had an opportunity to witness the evolution of imaging "self-referral" and the impact that it has had on healthcare consumers, payers and private radiology practices such as ARC.

My remarks today will focus on how providing imaging services, in this case MRI, in an office such as ONS where the providers themselves both decide whether a patient needs an exam, and make referral for that exam to a unit in which they have a financial interest, results in

overutilization and increased cost. Based on the findings of numerous imaging self-referral studies, ONS's existing volume and projected "need" for MRI services within its practice may be overstated. Moreover, authorizing the acquisition of a second scanner by ONS is not the most cost-effective means of adding MRI capacity in the Stamford area and it may adversely impact quality of care.

Impact of Self-Referral on Utilization, Cost-effectiveness & Quality of Imaging Services

Put simply, self-referral is when a provider refers a patient to a facility for healthcare services and that provider has a financial interest in, or arrangement with, the facility that allows the potential for financial gain from the referral. ONS's MRI service is a classic example – a scanner owned by an orthopedic/neurosurgery group and the referral of patients for "in-office" MRI services by physicians in that group. In this case, the ONS physicians who make the referrals stand to benefit from the revenues generated by the MRI unit. They therefore have a financial incentive to maximize referrals to their existing scanner. And this incentive will only increase with the acquisition of a second scanner, at a cost of $1.5 million, on which ONS needs to perform 1,071 incremental scans in the first year of operation in order to breakeven (CON Application, pp. 25 & 30).

Compare this with private radiology practices, which only perform examinations referred by non-affiliated providers. These providers make MRI referrals for one reason only, their need for information to take care of their patients, including preventative, interventional, diagnostic, and staging studies, as well as determinations of efficacy of treatment. There is no personal incentive on the part of referring providers to send patients for procedures or scans and there is certainly no financial gain realized in doing so.

On the other hand, as our experience demonstrates and study after study unequivocally show, the volume and cost of care increases substantially when providers who refer patients for imaging tests own the machines on which the examinations are performed. Early studies, which led to initial attempts at curtailing self-referral, showed that providers engaged in self-referral ordered imaging studies at a much higher rate than their colleagues who sent patients to dedicated imaging facilities (Exhibit A). They also showed that self-referral increased the cost of care considerably (Exhibit A). Many subsequent studies showed similar results. For example, analysis of Medicare data published in 2002 showed that growth in the use of radionuclide myocardial perfusion imaging between 1996 and 1998 was 10 times higher among cardiologists (self-referred) than radiologists (Exhibit B).

There is no obvious explanation for the higher rate of use except the financial benefits of self-referral for providers making the referrals. Self-referral accounts for a majority of imaging growth. The issues regarding self-referral and its adverse impact on cost of care are so well known that many advocacy groups (i.e. American Association of Retired Persons[1]) , the GAO (Exhibit D), and President Obama's 2017 budget (Exhibit E) have all called for reform of the system to close any loopholes in the law that allow it.

Much of the evidence cited in opposition to self-referral is in the context of Medicare patients and shows the staggering financial implications of the practice. Now consider that private insurers typically reimburse physician practices 2 to 3 times what Medicare pays for MRI scans, and only 24% of ONS's MRI scans are Medicare. If one were to apply the ONS situation

[1] In a 2014 letter to U.S. Rep. Speier, the AARP stated as follows: "The in-office ancillary services exception was intended to allow physicians to perform services which can be completed in the physician's office while the patient is present and which aid in the diagnosis of the patient in order to minimize delays in patient care. Unfortunately, the exception has contributed to overutilization and rapid growth of certain services, particularly in radiation oncology, anatomic pathology, advanced imaging, and physical therapy. Closing the loophole will better serve patients and preserve Medicare's resources by saving approximately $6 billion over ten years for these services." (Exhibit C).

(commercial rates higher than Medicare) to the OMB formula for the budgetary savings from eliminating self-referral, the savings would be multiplied by an estimated 8 to 12 times (2 to 3 times the Medicare rate multiplied by 4 times the volume).

If OHCA allows ONS to acquire a second MRI unit for its Greenwich office there can be no assurances that the scanner will be used to fulfill only the legitimate healthcare needs of area patients. ONS physicians have everything to gain financially from ordering MRI scans. It would not be far-fetched to wonder whether every scan referred by ONS and performed on its MRI unit is entirely necessary. Research tells us that physicians who own imaging equipment refer patients for studies at a higher rate than those who do not self-refer. This certainly calls into question the true need for these examinations and whether they are artificially driving up the cost of care. On the other hand, if all self-referred scans are appropriate then one might ask if physicians who don't self-refer are under-ordering and if projected volume going forward should actually be higher for providers like ARC.

Note also that self-referral can have an adverse impact on the quality of imaging services. The former editor of the New England Journal of Medicine wrote that self-referral situations deprive patients of independent judgment on the part of their doctor and of peer review, factors that are inherent in any exam referred from one physician to another, and thereby undermine the integrity and trust of the medical profession and its social contract with patients (Exhibit F).

The current in-office ancillary services exception was intended to facilitate the imaging studies necessary for an office visit, like an x-ray that can be performed while you are waiting to be seen by the doctor. Allowing providers to own advanced imaging equipment like an MRI unit, and to refer patients to that unit for reasons other than the convenience associated with same-day ancillary services, was not the original intent of the law. In point of fact, while

"convenience" may come into play for some examinations, like x-rays in the case of suspected fracture, it is impractical and uncommon to perform advanced imaging, like MRI, on the same day. Those examinations are almost universally scheduled in advance; they almost always require pre-authorization from insurance companies; and commonly require preparation protocols. A 2009 article in Health Affairs, the most prestigious journal of health economics and policy, showed the following:

> Proponents of such self-referral argue that the practice offers patients convenient same-day, one-stop service and allows treatment to start sooner. Our analysis of 2006 and 2007 Medicare data showed that self-referral provided same-day imaging for 74 percent of straightforward x-rays, but for only 15 percent of more-advanced procedures such as computed tomography and magnetic resonance imaging (Exhibit G).

While legislators work to close this massive and costly loophole, we implore OHCA to look critically at whether approval of self-referred major imaging equipment is in the best interest of healthcare consumers and payers in our state.

Conclusion

Thank you again for this opportunity to speak in opposition to ONS's request for permission to acquire a second MRI unit for its Greenwich office. The fact that ONS self-refers MRI scans to a unit from which it profits calls into question the validity of its current volumes, as well as the clear public need for, and cost-effectiveness of, its proposal and the impact it will have on the quality of MRI services in lower Fairfield County. For these reasons, I urge OHCA to deny ONS's CON request.

Mr. Yoder and I are available to answer any questions that you have.

The foregoing is my sworn testimony.

Alan Kaye, M.D.

EXHIBIT A

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Frequency and Costs of Diagnostic Imaging in Office Practice — A Comparison of Self-Referring and Radiologist-Referring Physicians

Bruce J. Hillman, M.D., Catherine A. Joseph, B.A., Michael R. Mabry, B.A., Jonathan H. Sunshine, Ph.D., Stephen D. Kennedy, Ph.D., and Monica Noether, Ph.D.

N Engl J Med 1990; 323:1604-1608 | December 6, 1990 | DOI: 10.1056/NEJM199012063232306

Abstract

Abstract

To assess possible differences in physicians' practices with respect to diagnostic imaging, we compared the frequency and costs of imaging examinations as performed by primary physicians who used imaging equipment in their offices (self-referring) and as ordered by physicians who always referred patients to radiologists (radiologist-referring).

Using a large, private insurance-claims data base, we analyzed 65,517 episodes of outpatient care by 6419 physicians for acute upper respiratory symptoms, pregnancy, low back pain, or (in men) difficulty urinating. The respective imaging procedures studied were chest radiography, obstetrical ultrasonography, radiography of the lumbar spine, and excretory urography, cystography, or ultrasonography.

For all four clinical presentations, the self-referring physicians obtained imaging examinations 4.0 to 4.5 times more often than the radiologist-referring physicians ($P<0.0001$ for all four). For chest radiography, obstetrical ultrasonography, and lumbar spine radiography, the self-referring physicians charged significantly more than the radiologists for imaging examinations of similar complexity ($P<0.0001$ for all three). The combination of more frequent imaging and higher charges resulted in mean imaging charges per episode of care that were 4.4 to 7.5 times higher for the self-referring physicians ($P<0.0001$). These results were confirmed in a separate analysis that controlled for the specialty of the physician.

Physicians who do not refer their patients to radiologists for medical imaging use imaging examinations more frequently than do physicians who refer their patients to radiologists, and the charges are usually higher when the imaging is done by the self-referring physician. From our results it is not possible to determine which group of physicians uses imaging more appropriately. (N Engl J Med 1990; 323:1604–8.)

Article

THE potential for conflicts of interest and higher costs for health care arising from the ownership by physicians of the diagnostic facilities to which they refer patients has attracted considerable attention recently in the medical literature[1,2,3,4,5] and lay press[6,7] and has been the subject of government study and legislation.[8,9,10] The ownership of imaging centers by physicians has received much of the media attention. However, most self-referral for medical imaging — in which physicians perform and interpret diagnostic imaging examinations of their own patients rather than refer them to imaging specialists — takes place in the physician's office.

The few previous studies investigating the effect of self-referral on the use and costs of imaging have been limited by methodologic flaws, small study populations, and lack of controls. To overcome these limitations, we analyzed a large data base of private insurance claims and evaluated the imaging done in physicians' offices during episodes of outpatient medical care. After controlling for differences in patients' clinical presentations and physicians' specialties, we compared the frequencies

with which the patients underwent imaging examinations during episodes of medical care for acute conditions, according to whether their physicians could perform those imaging examinations themselves. We also compared the resultant charges for the imaging examinations.

We purchased access to a data base (Medstat Systems, Ann Arbor, Mich.) comprising all the health insurance claims of 403,458 employees and dependents of several large American corporations. The insurance programs provided comprehensive coverage, including outpatient imaging services, with no copayments required. The data base was selected for its uniformity and completeness. Seventy-nine percent of the study population lived in the north central United States, 6 percent in the Northeast, 11 percent in the South, and 4 percent in the West. Fifty-one percent were female, and 49 percent male. Fifty-five percent were 0 to 34 years old, 33 percent were 35 to 54 years old, and 12 percent were 55 or older. Ninety-three percent of the physicians making claims for care provided to these patients practiced in metropolitan areas.

Using this data base, we compared the frequency of imaging and the charges for imaging among self-referring physicians and among physicians who instead referred patients to radiologists (radiologist-referring physicians) for four clinical presentations, selected for their variety and the volume of associated imaging procedures. The presentations, with the associated diagnostic inquiry, were as follows: acute upper respiratory symptoms (Was chest radiography performed?), pregnancy (Was obstetrical ultrasonography performed to assess fetal size and gestational age?), low back pain (Was radiography of the lumbar spine performed?), and (in men) difficulty urinating (Was excretory urography, cystography, or ultrasonography performed?).

We surveyed the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM),[11] selecting all codes that might reasonably represent diagnoses that would be entered by physicians whose patients presented with symptoms related to any of the four clinical presentations. A detailed tabulation of the codes is available elsewhere.*

We developed and applied to the claims data base a computer algorithm, modeled on previous methods, for defining episodes of outpatient medical care occurring in physicians' offices.[12] The date of a claim for an index ICD-9-CM code in an office setting was used to define the starting date of an episode. Episodes were considered to have ended after specified periods — four weeks for upper respiratory infection, nine months for pregnancy, six weeks for low back pain, and six weeks for difficulty urinating. Claims made between the initiation and termination dates of an episode were eligible for inclusion in that episode. Depending on the clinical presentation, a lag period of two to eight weeks followed the termination of each episode, so that follow-up visits for the original episode would not be counted as new episodes of care. The length of the episodes and lag periods was initially proposed on the basis of medical experience. We ensured that these durations were appropriate by evaluating the completeness of 600 randomly selected episodes and determining that the use of alternate durations for the episodes of up to two-thirds longer affected the number of episodes by only 1 to 6 percent in the case of the clinical presentations studied.

To be included in the study, episodes of care had to begin after January 1, 1986, and end before June 1, 1988. Episodes were excluded if the only physician involved in the episode was a radiologist or if the specialty of any physician involved was unknown. Within valid episodes, we deleted any claims for which no charge or payment was made, any claims for supplemental payments, and any claims for which the age or sex of the patient or the physician's identification number was unknown. We also excluded claims that were unrelated in terms of ICD-9-CM coding to the clinical presentations under investigation and claims made by physicians whose specialty codes indicated practices unrelated to the clinical presentations under study. A list of the specialties of the physicians included in the analysis is available elsewhere.*

The physicians who filed the claims included in the episodes studied were distinguished by their physician identification numbers; these numbers were coded to protect confidentiality. With regard to each clinical presentation, the physicians were grouped, according to their involvement in episodes for which they were the only nonradiologist physician to file a claim (one-physician episodes), into the following categories: self-referring physicians, who charged at least once for an index imaging examination; radiologist-referring physicians, who never charged for an index imaging examination and who were involved in at least one one-physician episode in which a radiologist performed such an examination; and physicians whose patients had no imaging in any one-physician episodes. One-physician episodes comprised 92 percent of all valid episodes.

We considered the possibility that some physicians categorized as radiologist-referring might actually be self-referring physicians who happened not to have performed any imaging in the episodes in our sample. We performed a correction to account for this possibility (details available elsewhere*). Since this correction did not alter the results, we report only our unadjusted data here.

The categorization of the physicians who participated in the one-physician episodes was used to develop six categories of similar and dissimilar pairs of physicians for the 7 percent of valid episodes in which two different physicians, neither a radiologist, cared for the patient (two-physician episodes). The 471 valid episodes (0.7 percent) in which more than two nonradiologist physicians were involved were not included in the analysis. We performed separate classifications of the one-physician and two-physician episodes on the basis of the categorization of the physicians and whether a claim for a related imaging examination was filed during the episode, as evidenced by the encountering of an appropriate diagnostic-imaging-procedure code (CPT-4 code; the table of index codes is available elsewhere*).

*See NAPS document no. 04816 for 16 pages of supplementary material. Order from NAPS c/o Microfiche Publications, P.O. Box 3513, Grand Central Station, New York, NY 10163–3513. Remit in advance (in U.S. funds only) $7.75 for photocopies or $4 for microfiche. Outside the U.S. and Canada add postage of $4.50 ($1.50 for microfiche postage).

For the one-physician episodes, our estimates of the frequency of imaging by the self-referring physicians and the radiologist-referring physicians were based on the observed frequencies for these two categories of physicians. Applying maximum-likelihood methods to the information we derived from our data about the imaging practices of self-referring and radiologist-referring physicians, we adjusted these observed frequencies to account for the episodes attributable to the physicians who had performed no imaging. This adjustment was based on the assumption that the imaging practices of the physicians within each category were homogeneous. However, this was almost certainly not the case. As a result, the correct adjustment of the observed frequencies is uncertain. For this reason, we report here the most likely estimates of the imaging frequencies for the self-referring and the radiologist-referring physicians. In addition, to account for heterogeneity in the physicians' imaging practices, we developed estimates biased upward and downward that show that our results are not affected qualitatively by the choice of the adjustment for the episodes involving the physicians who performed no imaging over the entire range of possible adjustments. The methods we employed, the initial categorization of the physicians and classification of episodes, and the upward- and downward-biased estimations of imaging frequencies are available elsewhere.*

For the analyses of both the one-physician and the two-physician episodes, we assessed the differences between self-referring and radiologist-referring physicians in terms of the proportion of episodes that involved imaging, the charges for imaging performed, and the average imaging charges per episode. To calculate the results for the group, we weighted the results for individual physicians according to the number of episodes in which they were involved. The significance of the differences between self-referring and radiologist-referring physicians was determined by the usual t-statistic for the difference in means between the two groups. We conducted a similar analysis based on the specialties of the physicians involved in the episodes, to compare differences within specialties. The null hypothesis of no difference was rejected at a P level of <0.05.

For each clinical presentation, we compared the complexity of the imaging examinations performed by the self-referring physicians with that of the examinations performed by the radiologists by calculating the mean (±SD) relative values of their procedures (i.e., a measure of the complexity of the procedure).[13]

The data base generated 62,880 one-physician episodes for the four study groups. After exclusions (see Methods), there were 60,829 valid episodes involving 6419 physicians. One-physician episodes represented 92 percent of all valid episodes. These were distributed as follows: upper respiratory symptoms, 47,794 episodes involving 3452 physicians; normal pregnancy, 1377 episodes involving 468 physicians; back pain, 9634 episodes involving 2001 physicians; men with difficulty urinating, 2024 episodes involving 498 physicians.

Table 1 shows the frequencies with which imaging was used during the episodes, the charges for imaging, and the charges for imaging per episode for self-referring and radiologist-referring physicians. The mean imaging charges of the self-referring physicians were significantly higher (P for all comparisons, <0.0001) than those of the radiologists for all clinical presentations except difficulty urinating. Depending on the clinical presentation, the episodes involving self-referring physicians resulted in imaging 4.0 to 4.5 times as frequently, with average imaging charges per episode 4.4 to 7.5 times higher than those for the episodes involving radiologist-referring physicians ($P<0.0001$ for each clinical presentation, for both frequency of imaging and average imaging charges per episode).

TABLE 1

Categories of Physicians and Episodes, Frequencies of Imaging, and Imaging Costs in One-Physician Episodes.*

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There were 4688 valid two-physician episodes, or 7 percent of all episodes. The results for these episodes support the findings in the one-physician episodes. Depending on the clinical presentation, the episodes involving two self-referring physicians were 1.7 to 3.7 times as likely to result in imaging as episodes involving two radiologist-referring physicians ($P<0.01$ for each presentation). Complete results for all six categories of physician pairs are available elsewhere.*

For each specialty and each clinical presentation, the self-referring physicians performed imaging 2.4 to 11.1 times as often as the radiologist-referring physicians, and at a cost per episode for imaging that was 3.0 to 17.1 times higher, depending on the specialty and clinical presentation (Table 2) ($P<0.01$ for each specialty studied with regard to each clinical presentation).

TABLE 2

Frequency of Imaging and Costs per Episode in One-Physician Episodes, According to the Specialty of the Physician.*

The mean (±SD) complexity score for chest films was 3.02±0.14 for self-referring physicians, and 3.00±0.20 for radiologist-referring physicians. For obstetrical ultrasonography, the comparison was 11.24±1.14 versus 11.35±0.96; for lumbar spine films, 3.98±0.63 versus 4.14±0.52; and for the combination of urography, cystography, and ultrasonography, 8.46±0.70 versus 8.35±0.43. Thus, the differences in complexity ranged from 1 to 4 percent and do not account for the differences identified in the charges for imaging.

For the clinical presentations we studied, patients with similar sets of symptoms were at least four times as likely to have diagnostic imaging performed as part of their evaluation if they sought care from a physician who performed imaging examinations in the office rather than from one who referred patients to a radiologist. Because self-referring physicians performed imaging studies more frequently and generally charged more than radiologists for similar imaging procedures, patients seeking care from self-referring physicians incurred considerably higher charges for diagnostic imaging than patients whose physicians referred them to radiologists. These effects cannot be attributed to differences in the mix of patients, the specialties of the physicians, or the complexity of the imaging examinations performed.

Previously, Childs and Hunter[14] found that physicians other than radiologists who provided imaging services used imaging more frequently than their peers in caring for elderly patients in Northern California. In a 1978 survey of 5447 physicians, Radecki and Steele[15] determined that nonradiologist physicians with imaging facilities either in their offices or at the same site have higher rates of use than physicians without such facilities. A similar study of the effect ofthe site of imaging facilities used by family practitioners produced a similar result.[16]

The differences between our study and those performed previously include the relatively large number of patients and physicians we studied and the emphasis on specific clinical situations and episodes of medical care. Analyzing episodes of care permitted us to focus directly on the issue that seemed most pertinent — whether individual patients with specific symptoms were more likely to receive imaging examinations when their physicians operated imaging equipment. As compared with the global measures used in previous studies, this method controls better for other variables — physicians' specialization, the complexity of examinations, differences in the types of patients seen by physicians, and the number of patient—physician encounters that might occur during the course of a patient's medical care. Finally, the focus on episodes as the unit of analysis allows a more accurate assessment of the activities and costs of medical care, the chief focus of our study.[12]

We have attempted to account for what we perceive to be the major possible biases of our study. After assessing the effect of correcting our results to account for the small percentage of physicians who had probably been miscategorized, and evaluating alternative probabilistic models for assigning the episodes involving physicians whom we could not categorize definitively, we found that these considerations did not affect the results qualitatively (details of these assessments and the adjusted results are available elsewhere*). Our population of patients did not represent the American population, geographically or according to age. However, the geographic concentration tended to lessen the effects of regional differences in practice patterns, and it seems implausible that the large differences we identified in the use of imaging would be related to age. Although there is no assurance that the clinical presentations we studied represent the imaging practices of physicians in other clinical settings, the dimensions and consistency of our findings with regard to four very different clinical presentations and types of imaging examinations suggest that this practice pattern may be widespread.

We based our methods on those used by previous investigators,[12,17,18] but with adaptations to account for the large number of physicians and patients in our data base. Doubtless, the initial visits to physicians that triggered episodes of outpatient care occurred in an undefined context of patients' seeing their personal physicians, being referred by one physician to another, and seeking the specialist they believed to be appropriate. Although the manner in which the patients ended up seeing the physicians they did might potentially have affected the results, it is important to note that the results were uniformly sustained in our analysis of individual specialties. Also, with regard to our means of defining the index symptoms, determining the start of episodes, and including claims in episodes, there is nothing to suggest that our choices unequally biased the probability of imaging or the imaging charges in favor of either self-referring or radiologist-referring physicians. We believe that the differences between these two groups of physicians are so considerable that such issues have little relevance to the results.

Our findings of increased use of imaging and increased costs attributable to nonradiologist physicians who operate their own imaging equipment should be of interest to regulatory and reimbursement agencies. It is impossible to determine from our results whether the imaging practices of the self-referring physicians or those of the radiologist-referring physicians represent the more appropriate care. Nor is it possible to determine the extent to which financial incentives are responsible for the higher levels of use and charges among the self-referring physicians. These physicians may perform imaging more frequently because they have financial incentives to do so, because imaging is more convenient when performed in a physician's office, or because physicians who perform imaging more often are more likely to acquire imaging equipment. Nonetheless, the differences between the self-referring and radiologist-referring physicians in the use of imaging are so large that some concern over the role of financial incentives must be invoked. Schroeder and Showstack[19] have detailed the potent financial incentives for a physician to incorporate imaging into an office practice. More recently, Hemenway et al.[20] validated this concern by showing an increase in the use of imaging when a group of ambulatory clinics changed to a method of compensation that used the frequency with which physicians ordered imaging examinations as the basis for paying them.

The American Medical Association has stated that the referral of patients to facilities in which physicians have an ownership interest is permissible, provided that patients are apprised of this relation and have other choices, and provided that physicians always act in their patients' best interests.[21] With respect to diagnostic imaging, however, it is unlikely that patients, even if so apprised, will be able to assess the appropriateness of such referrals accurately or seek imaging elsewhere. Particularly in the office setting, patients cannot be said to have a meaningful choice when their physicians advise them to undergo imaging. The potential to self-refer patients for imaging must surely complicate physicians' decisions and perhaps jeopardize their obligation to place their patients' interests above their own.

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Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population

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Objectives and Rationale.—For 10 common clinical presentations, we assessed differences in physicians' utilization of and charges for diagnostic imaging, depending on whether they performed imaging examinations in their offices (self-referral) or referred their patients to radiologists (radiologist-referral).

Methods.—Using previously developed methodologies, we generated episodes of medical care from an insurance claims database. Within each episode, we determined whether diagnostic imaging had been performed, and if so, whether by a self-referring physician or a radiologist. For each of the 10 clinical presentations, we compared the mean imaging frequency, mean imaging charges per episode of care, and mean imaging charges for diagnostic imaging attributable to self- and radiologist-referral.

Results.—Depending on the clinical presentation, self-referral resulted in 1.7 to 7.7 times more frequent performance of imaging examinations than radiologist-referral ($P < .01$, all presentations). Within all physician specialties, self-referral uniformly led to significantly greater utilization of diagnostic imaging than radiologist-referral. Mean imaging charges per episode of medical care (calculated as the product of the frequency of utilization and mean imaging charges) were 1.6 to 6.2 times greater for self-referral than for radiologist-referral ($P < .01$, all presentations). When imaging examinations were performed—including those performed in both physicians' offices and hospital outpatient departments—mean imaging charges were significantly greater for radiologists than for self-referring physicians in seven of the clinical presentations ($P < .01$). This result is related to the high technical charges of hospital outpatient departments; in office practice, radiologists' mean charges for imaging examinations were significantly less than those of self-referring physicians for seven clinical presentations ($P < .01$).

Conclusions.—Nonradiologist physicians who operate diagnostic imaging equipment in their offices perform imaging examinations more frequently, resulting in higher imaging charges per episode of medical care. These results extend our previous research on this subject by their focus on a broader range of clinical presentations; a mostly elderly, retired population; and the inclusion of higher-technology imaging examinations.

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DURING the last decade, direct payments for physicians' services tripled, from $41.9 billion to $125.7 billion.[1] In large part, this has been due to an increase in the number of services provided to patients.[2,3] One phenomenon promoting greater intensity of care is physicians increasingly adopting more and more complex technologies into their office practices.[3] Physicians then can "self-refer" their patients to these technologies. Self-referral has been shown to be associated with higher-technology utilization than when physicians refer their patients to specialists employing these same technologies.[4-7]

See also p 2055.

Previously, we demonstrated that, for each of four common clinical presentations, self-referring physicians employed diagnostic imaging at least four times as frequently as their colleagues who referred imaging examinations to radiologists. Self-referring physicians also charged significantly more for performing and interpreting imaging studies in their offices than did radiologists.[7] This investigation employs similar methodology to expand upon our previous work assessing physicians' utilization of and charges for diagnostic imaging by studying a mostly elderly, chronically ill patient population that is of particular interest with regard to Medicare reimbursement; evaluating a broader array of imaging technologies and clinical presentations; more extensively portraying imaging charges; and assessing

patients with 10 common clinical presentations, including three of the four presentations investigated in our previous research.

METHODS

Insurance Claims Database and Clinical Presentations

Access to the insurance claims database used in this investigation was provided without charge by the United Mine Workers of America Health and Retirement Funds (Funds). Reimbursement for physicians' claims and the claims database are administered for the Funds by Alta Health Strategies, Inc (Alta). We investigated the portion of the database representing all physicians' claims for all Funds beneficiaries, regardless of age, rendered during the 2-year period January 1, 1988, through December 31, 1989. The claims history file records the billed charge for all line items for each claim.

Funds beneficiaries and their dependents receive full reimbursement, with no copayments, for outpatient diagnostic imaging examinations. The Funds administers both the Medicare and supplemental insurance components of physician reimbursements for Funds beneficiaries (84% of Funds beneficiaries are covered by Medicare Part B).

The Funds database details the health insurance coverage for their approximately 119 000 beneficiaries. Of these, 79% are 65 years or older. Thirty-four percent are male. Eighty percent live in the Appalachian coal-mining region.

Using this database, we compared the frequency of imaging and the imaging charges accrued during episodes of acute care of self-referring physicians with those of radiologist-referring physicians for 10 clinical presentations. The clinical presentations and their associated imaging examinations were chosen to obtain a broad distribution of anatomic locations, variety of imaging examinations, and sophistication of imaging technology, as well as for their frequency of appearance in the Funds' claims database and the imaging costs they represented to the Funds.

The 10 clinical presentations selected included three of the four clinical presentations investigated in our earlier research,[7] including (with the associated imaging examinations) acute upper respiratory tract symptoms (plain films, fluoroscopy), men with trouble urinating (excretory urography, cystourethrography, sonography), and low-back pain (plain films, myelography, diskography, computed tomography [CT], magnetic resonance [MR]). Additional clinical presentations investigated in this study were headache (CT, MR), transient cerebral ischemia (CT, MR, sonography including Doppler studies, angiography), upper gastrointestinal bleeding (plain films, barium studies), knee pain (plain films, arthrography, CT, MR), urinary tract infection (plain films, excretory urography, cystourethrography, sonography, CT, MR), chest pain (plain films, barium studies, radionuclide studies), and congestive heart failure (plain films, echocardiography, real-time and Doppler sonography, angiography, radionuclide studies). A complete list of the radiologic procedure (*CPT-4*) codes[8] counted in the analysis for each clinical presentation can be obtained from the National Auxiliary Publications Service (NAPS).

Development of Episodes of Medical Care

We previously have detailed the methods employed to define episodes of outpatient care.[7] Briefly, for each of the 10 clinical presentations, we defined all diagnostic (*ICD-9*) codes[9] that physicians reasonably might enter on their claims for services to these patients. The *ICD-9* codes selected for each clinical presentation (index *ICD-9* codes) can be obtained from NAPS. Each of the 10 clinical presentations was analyzed separately.

We applied to the database a version of the computerized algorithm we employed in our earlier work.[7] Briefly, an episode was initiated by a physician's claim for a service related to an index *ICD-9* code. The date of this service represented the starting date of the episode; the episode concluded after a fixed period of time, the amount of time depending on the clinical presentation. All claims from physicians with specialties relevant to the clinical presentation (see NAPS deposit), for office and hospital outpatient services, encountered between the beginning and end dates for the episode were eligible for inclusion in the episode. A lag period was observed immediately following each episode, during which neither an index *ICD-9* code nor index *CPT-4* code either counted as part of the previous episode or initiated a new episode. This restriction prevented the misclassification of a follow-up service as the initiation of a new episode. The durations of episodes and lag periods for each clinical presentation can be obtained from NAPS. The appropriateness of the durations of episodes and lag periods was established and tested by the same methods we have previously described.[7]

Episodes were eligible for inclusion in the analysis if they were triggered by an appropriate index *ICD-9* code, with a service date on or after January 1, 1988, and were completed by December 31, 1989. Because we were unable to determine which of two or more physicians decides whether to perform an imaging examination, we excluded episodes where multiple nonradiologist physicians cared for the patient or where services other than laboratory or radiology were provided in a hospital outpatient department (10% of episodes). Since we could not reliably categorize imaging services as self- or radiologist-referral when multispecialty group practices provided both radiologic and other services, we excluded episodes occurring in clinics and when a provider was involved in numbers of episodes greater than 2 SD from the mean. Following these exclusions, the episode files included 50% to 75% of the original episodes for the 10 clinical presentations.

Individual claims within valid episodes were excluded if the services were unrelated to the clinical indication or provided in nondesignated settings or if there was no charge for the claim.

Designation of Physicians as Self-referring or Radiologist-Referrinig

Each nonradiologist provider (defined by their primary specialty code and/or having less than 75% of their claims being for imaging procedures) was designated individually as "self-referring," "radiologist-referring," or "unknown," separately, for each clinical presentation in which he or she participated. A self-referring physician was one who at least once during the 2-year period submitted a claim for performing an index imaging study, even if he or she also referred a patient to a radiologist. A radiologist-referring physician never submitted a claim for an index imaging study and at least once participated in a valid episode in which the patient was referred to a radiologist for imaging. An unknown physician did not participate in a valid episode during which either he or a radiologist performed an index imaging examination.

Classification of Episodes and Estimation of the Frequency of Imaging

We classified the episodes of self- and radiologist-referring physicians on the basis of whether imaging was performed. This provided us with the observed frequencies of imaging for these two groups. These observed frequencies overestimate the actual imaging rates of self- and radiologist-referring physicians, since they do not account for physicians who were not involved in episodes where imaging occurred (the "unknown"

Table 1.—Primary Estimates of Imaging Frequency for Self-referring and Radiologist-Referring Physicians*

Clinical Presentation	Imaging Frequencies†		Ratio (95% Confidence Interval)
	Self-referring Physicians (No. of Episodes)	Radiologist-Referring Physicians (No. of Episodes)	
Chest pain	0.31 (4389)	0.16 (12 842)	1.9 (1.8-2.1)
Congestive heart failure	0.25 (13 588)	0.09 (24 840)	2.7 (2.5-2.8)
Difficulty urinating	0.11 (1111)	0.05 (5990)	2.2 (1.5-2.9)
Gastrointestinal bleeding	0.23 (1159)	0.13 (12 074)	1.7 (1.5-2.0)
Headache	0.30 (275)	0.07 (6674)	4.3 (3.3-5.4)
Knee pain	0.40 (2898)	0.05 (5191)	7.7 (6.6-8.7)
Low-back pain	0.21 (7381)	0.06 (21 179)	3.6 (3.4-3.9)
Transient cerebral ischemia	0.60 (334)	0.13 (2531)	4.7 (3.9-5.4)
Upper respiratory tract infection	0.30 (10 781)	0.13 (21 552)	2.3 (2.2-2.4)
Urinary tract infection	0.11 (1731)	0.05 (18 280)	2.4 (1.9-2.8)

*Estimates were rounded to the nearest percentage. All differences between self- and radiologist-referring physicians are statistically significant, $P<.01$.
†Imaging frequency is the number of episodes containing one or more imaging claims divided by the total number of episodes.

group). To correct for this deficiency, we employed the same method of maximum likelihood estimation as in our previous study[7] (detailed in the NAPS deposit) to estimate the imaging frequencies for all self-referring and radiologist-referring physicians, including those in the unknown group, as the proportion of episodes for each physician group in which imaging was performed. Our method of maximum likelihood estimation is based on the expectation that, within physician designations as self- or radiologist-referring, physicians' imaging practices are uniform. However, this may not strictly be the case. Thus, as in our previous study,[7] we performed upward and downward biased estimates to represent "worse case" scenarios, embodying the maximum departures from the primary estimate that could result if there were no similarities among the practices of self-referring or radiologist-referring physicians (described in the NAPS deposit).

Comparison of Physicians' Charges and Correction for the Complexity of Imaging Examinations

Our analysis of charges for imaging examinations included all global, professional, and technical charges in both the office and hospital outpatient settings.

We compared the total charges for imaging for all episodes in the database, whether or not imaging occurred. The result, termed "mean imaging charges per episode," is calculated as the product of the mean charges for diagnostic imaging claimed during episodes in which imaging occurred and the frequency of imaging.

To assess the influence of differences in the complexity of examinations on differences in mean imaging charges per episode, we assigned to each imaging service its relative value (in relative value units [RVU]), according to the relative value scale used through 1991 for payment for imaging services provided to Medicare patients.[10] Dividing the mean charge by the mean RVU provided the measurement "mean charge per RVU," which we used to compare the charges of self- and radiologist-referring physicians for comparable work. Because hospitals apply high technical charges to imaging performed in their hospital outpatient departments and because financial incentives to perform imaging examinations usually differ in office and hospital outpatient practice, we performed this analysis separately for episodes involving imaging solely in physicians' offices.

Analysis

Differences between self- and radiologist-referring physicians' estimated frequency of imaging and imaging charges were tested for statistical significance by unpaired t tests of the difference in means between the two groups. Differences were considered statistically significant at $P<.01$.

We also conducted an analysis of imaging utilization for selected individual physician specialties, investigating the imaging practices of a specialty for a clinical presentation if the number of episodes was large enough that the error of the estimate of the frequency of imaging for all physicians of that specialty was less than one fourth the magnitude of the estimate and there were at least 25 self-referring and 25 radiologist-referring physicians in the sample for each such analysis.

RESULTS

The claims database yielded 174 800 episodes for the 10 clinical presentations (Table 1).

The Frequency of Diagnostic Imaging

The primary estimates of imaging frequencies for self-referring physicians were significantly greater than the imaging frequencies of radiologist-referring physicians for all 10 clinical presentations (all presentations, $P<.01$). The ratios of the frequency of imaging varied considerably with the clinical presentation. Self-referring physicians employed imaging 7.7 times as frequently as radiologist-referring physicians for knee pain but only 1.7 times as often for gastrointestinal bleeding (Table 1).

Upward biased estimates sustained the essential result of significantly greater imaging by self-referring physicians for all clinical presentations ($P<.01$). However, in three clinical presentations, the downward biased estimate resulted in differences between self- and radiologist-referral that were not statistically significant (difficulty urinating, gastrointestinal bleeding, and transient cerebral ischemia). In two other clinical presentations, the downward biased estimates indicated imaging utilization by radiologist-referring physicians significantly greater than that of self-referring physicians (headache and urinary tract infection). A table of biased estimates is available from NAPS.

Twenty-one clinical presentation–physician specialty combinations met the screening criteria for investigation of specialty-related imaging practices. Six clinical presentations were represented in general practice, four each in internal medicine and family practice, two in general surgery, cardiology, and orthopedic surgery, and one in pulmonology. In all cases, the primary estimates indicated that self-referring physicians employed imaging significantly more frequently than radiologist-referring physicians (all specialty–clinical presentation pairs, $P<.01$) (Table 2). The ratio of the frequencies of imaging (self-referring/radiologist-referring) ranged from 1.5:1 to 4.8:1 for different clinical presentations and specialties. The finding that self-referring physicians employ imaging significantly more frequently than radiologist-referring physicians was sustained

Table 2.—Primary Estimates of Imaging Frequency by Selected Physician Specialties*

Physician Specialty and Clinical Presentation	Imaging Frequencies†		Ratio (95% Confidence Interval)
	Self-referring Physicians (No. of Episodes)	Radiologist-Referring Physicians (No. of Episodes)	
Cardiology			
Chest pain	0.38 (390)	0.19 (1327)	2.0 (1.6-2.4)
Congestive failure	0.30 (2195)	0.13 (1314)	2.4 (2.0-2.5)
Family practice			
Chest pain	0.30 (784)	0.16 (2442)	1.8 (1.5-2.1)
Congestive failure	0.20 (2472)	0.10 (5036)	2.1 (1.8-2.3)
Low-back pain	0.20 (1289)	0.05 (4475)	3.8 (3.1-4.6)
Upper respiratory tract infection	0.31 (2834)	0.13 (4216)	2.3 (2.1-2.5)
General practice			
Chest pain	0.30 (2025)	0.16 (5058)	1.9 (1.7-2.1)
Congestive failure	0.25 (4985)	0.09 (10458)	2.7 (2.5-3.0)
Gastrointestinal bleeding	0.20 (618)	0.13 (4081)	1.5 (1.2-1.8)
Knee pain	0.25 (691)	0.05 (1946)	4.8 (3.5-6.1)
Low-back pain	0.19 (2542)	0.05 (8448)	3.5 (3.0-4.0)
Upper respiratory tract infection	0.26 (4352)	0.11 (8721)	2.4 (2.2-2.7)
General surgery			
Low-back pain	0.23 (545)	0.07 (1350)	3.1 (2.3-3.9)
Upper respiratory tract infection	0.30 (726)	0.15 (1660)	1.9 (1.6-2.3)
Internal medicine			
Chest pain	0.33 (990)	0.14 (3633)	2.3 (2.0-2.6)
Congestive failure	0.25 (3715)	0.09 (7856)	2.8 (2.6-3.1)
Low-back pain	0.16 (1274)	0.05 (5693)	2.9 (2.3-3.5)
Upper respiratory tract infection	0.33 (2030)	0.16 (4581)	2.0 (1.8-2.2)
Orthopedic surgery			
Low-back pain	0.28 (1666)	0.12 (511)	2.3 (1.6-3.0)
Knee pain	0.58 (1307)	0.30 (135)	1.9 (1.3-2.5)
Pulmonology			
Upper respiratory tract infection	0.34 (360)	0.20 (184)	1.7 (1.1-2.4)

*Estimates were rounded to the nearest percentage. All differences between self- and radiologist-referring physicians are statistically significant, $P<.01$.
†Imaging frequency is the number of episodes containing one or more imaging claims divided by the total number of episodes.

in all 21 upward biased estimates and 19 of 21 downward biased estimates ($P<.01$). In two cases—general practitioners seeing patients for gastrointestinal bleeding and internists for patients with low-back pain—the differences in the downward biased estimates were not significantly different.

Imaging Charges

Mean imaging charges per episode—for all episodes, including both office and hospital outpatient department settings and regardless of whether an imaging examination occurred—are detailed in Table 3. For all 10 clinical presentations, mean imaging charges per episode were 1.6 to 6.2 times greater for self-referral than for radiologist-referral ($P<.01$, all clinical presentations).

When all episodes with imaging were considered—including office and hospital outpatient examinations—charges per RVU for self-referral were 0.8 to 1.0 of the charges per RVU referable to radiologist-referral, depending on the clinical presentation. However, the comparison of charge per RVU for examinations performed in office practice indicates that these differences are attributable to the technical charges billed by hospitals and the fact that almost all imaging examinations in hospital outpatient departments are performed by radiologists. For examinations performed in office practice, self-referral results in charges per RVU 0.9 to 1.3 times the charges per RVU of radiologists.

Table 3.—Imaging Charges per Episode of Care*

Clinical Presentation	Charges per Episode, $†		Ratio
	Self-referral	Radiologist-Referral	
Chest pain	29	19	1.6
Congestive heart failure	41	7	6.2
Difficulty urinating	19	8	2.3
Gastrointestinal bleeding	38	24	1.6
Headache	117	36	3.3
Knee pain	31	5	6.2
Low-back pain	34	13	2.5
Transient cerebral ischemia	242	65	3.7
Upper respiratory tract infection	19	9	2.2
Urinary tract infection	32	13	2.4

*Charges were rounded to the nearest dollar.
†Charges were calculated as the product of the percentage of episodes in which imaging occurred (ie, imaging frequency) and the mean imaging charge in episodes with imaging.

COMMENT

This investigation both extends and confirms our previous research into how physicians' ownership of diagnostic imaging technology in their office practices affects imaging utilization and charges. The major differences between our previous and current research include the nature of the patient and physician

populations. Also, the present investigation evaluates a broader range of clinical presentations and assesses utilization of both conventional and more advanced imaging technologies. Finally, we were able to extend our evaluation of charges for imaging examinations to include the hospital outpatient setting. Despite these differences, the essential result remains unchanged: physicians who own imaging technology employ diagnostic imaging in the evaluation of their patients significantly more often and, as a result, generate 1.6 to 6.2 times higher average imaging charges per episode of care than do physicians who refer imaging examinations to radiologists. This result is reinforced by the consistent result of significantly greater utilization associated with self-referral in our specialty-based analysis.

In this study, differences in imaging utilization between self- and radiologist-referring physicians were more varied with respect to clinical presentation than in our previous research. Almost certainly, this is attributable to characteristics of the patient population. The Funds' beneficiaries are, overwhelmingly, elderly and, because of their work histories, prone to a variety of chronic ailments. As such, they are very different from the generally healthy, younger, working individuals we evaluated in our initial research.

The large differences between self- and radiologist-referring physicians' mean imaging charges per episode are almost entirely attributable to differences in utilization. Differences in charges for imaging examinations and the complexity of examinations are largely referable to the setting in which the examinations were performed. Examinations performed by radiologists in hospital outpatient departments usually generate higher overall charges because of the high technical charges filed by hospitals. Medicare, on average, pays 58% of these charges.[11] In office practice, self-referring physicians generally charge higher fees than radiologists for comparable examinations.

In recent years, physicians' referral of their patients to medical technologies in which they have a financial interest has gained increasing attention as a significant problem promoting increasing health care costs. Investigations demonstrating that self-referral promotes greater frequency of technology utilization,[4-7] studies indicating that a financial incentive may motivate the higher frequency of self-referral,[12-15] and articles in the lay press discussing these findings have negatively affected public perceptions about the medical profession (*Wall Street Journal*. March 1, 1989; *Christian Science Monitor*. December 8, 1988). Although it is difficult to determine what proportion of the higher utilization associated with self-referral might be inappropriate, it has not been shown that more frequent application of office-based ancillary technologies provides a consonant benefit in improving patients' health.

These considerations motivated the United Mine Workers of America Health and Retirement Funds to participate in our continuing research into the costs associated with self-referral for diagnostic imaging. The Funds face a difficult financial future. While the cost of health care for the Funds' beneficiaries continues to increase, contributions to the Funds' financial base from the participating coal companies are declining. Thus, the Funds must identify means of controlling their expenditures that still sustain the high quality of care their beneficiaries receive. This research has provided information that may guide the Funds and other payers in developing new policies with respect to payment for self-referred imaging. One possible policy would be to deny payment for self-referred imaging, or to deny payment to specific specialties or individual physicians shown to utilize imaging technology at significantly higher rates than other specialties or their peers. The Funds could choose to reduce financial incentives for self-referral by reimbursing self-referred imaging at a lower level than it pays for referred examinations or bundling payment for imaging as part of the reimbursement for an office visit. Alternatively, the Funds might develop standards for image quality and physician training for different examinations, much as standards have been developed for reimbursing claims for mammography under Medicare. Nonqualified practices would become ineligible for reimbursement of their claims.

Each of these alternatives is accompanied by potential political consequences and might potentially affect patient care. The activation of policies regarding self-referral by a payer such as the Funds may provide a demonstration for government and other payers of the effects of restricting self-referral on patient access to diagnostic imaging, the quality of care patients receive, and imaging-related expenditures.

Our research was funded by the United Mine Workers of America Health and Retirement Funds, Alta Health Strategies, Inc, and The American College of Radiology

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EXHIBIT B

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Abbreviations:
CPT-4 = Current Procedural Terminology, 4th Edition
EF = ejection fraction
HCFA = Health Care Financing Administration
MPI = myocardial perfusion imaging
WM = wall motion

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Author contributions:
Guarantors of integrity of entire study, all authors; study concepts and design, all authors; literature research, D.C.L.; data acquisition, L.P., J.H.S.; data analysis/interpretation, all authors; statistical analysis, L.P.; manuscript preparation, D.C.L.; manuscript definition of intellectual content, editing, revision/review, and final version approval, all authors.

Recent Rapid Increase in Utilization of Radionuclide Myocardial Perfusion Imaging and Related Procedures: 1996–1998 Practice Patterns[1]

PURPOSE: To evaluate cardiac nuclear medicine practice patterns in different physician specialty groups to better understand a recent rapid increase in utilization of radionuclide myocardial perfusion imaging (MPI) and certain supplementary examinations.

MATERIALS AND METHODS: National Medicare Part B databases from 1996 and 1998 were used to evaluate utilization of four primary procedure codes for radionuclide MPI and two supplementary codes (add-on left ventricular wall motion or left ventricular ejection fraction). Utilization rates were calculated for cardiologists, radiologists, and other physicians. Other cardiac imaging for which radionuclide imaging might be substituted was similarly studied.

RESULTS: Overall utilization rate of radionuclide MPI per 100,000 Medicare beneficiaries increased 19.1%, from 4,046 in 1996 to 4,820 in 1998 ($P < .001$). However, for cardiologists the rate increased from 1,771 to 2,413 (36.3%), whereas for radiologists it increased from 1,958 to 2,031 (3.7%) ($P < .001$ for both changes). Overall utilization rate of add-on codes increased 264% from 1,006 to 3,657 ($P < .001$). By 1998, the ratio of these add-on examinations to primary MPI was 0.94 among cardiologists compared with 0.53 among radiologists (relative risk, 1.77; 95% CI: 1.76, 1.78). Cardiologist-performed stress echocardiography and cardiac catheterization and coronary angiography increased by 24.2% and 8.7%, respectively.

CONCLUSION: Growth in utilization of radionuclide MPI between 1996 and 1998 was almost 10 times higher among cardiologists than radiologists. Utilization of the two add-on codes increased even more dramatically. The greater use of MPI is not a substitute for other cardiac imaging.

In recent years, radionuclide myocardial perfusion imaging (MPI) has become the principal method of noninvasively imaging suspected coronary artery disease. This technique provides greater sensitivity and specificity than does exercise electrocardiographic stress testing alone (1,2). The addition of electrocardiographic gating and technetium 99m–labeled radioisotopes, such as ^{99m}Tc sestamibi and ^{99m}Tc tetrofosmin, have brought further improvements. An important advantage of ^{99m}Tc–labeled compounds, aside from providing better counting statistics for MPI, is that they also allow determination of regional and global left ventricular wall motion (WM) and left ventricular ejection fraction (EF) (2). In 1992, largely as a result of this development, two new codes were incorporated into the nuclear medicine section of the Current Procedural Terminology, 4th Edition (CPT-4) coding manual (3). Codes 78478 and 78480 for left ventricular WM and left ventricular EF, respectively, were specifically designated as "add-on" codes. That is, users of the manual were instructed that these two codes were to be used only in conjunction with one of the four primary codes (78460, 78461, 78464, or 78465) for radionuclide MPI.

Although there is little doubt about the utility of assessing myocardial perfusion and left

TABLE 1
Cardiac Radionuclide Imaging Codes in 1998

CPT-4 Code	Descriptor	Global Relative Value Units*	No. of Examinations Performed†
78460	MPI; (planar) single study, at rest or stress	3.75	11,740
78461	MPI; (planar) multiple studies, at rest and/or stress, and redistribution and/or rest injection	6.80	55,955
78464	MPI; tomographic (SPECT), single study at rest or stress	9.09	139,644
78465	MPI; tomographic (SPECT), multiple studies, at rest and/or stress and redistribution and/or rest injection	14.67	1,329,884
78478	WM (in addition to primary procedure)	2.57	673,050
78480	EF (in addition to primary procedure)	2.57	493,064
78472	CBPI, gated equilibrium; single study at rest or stress, WM plus EF	7.30	100,957
78473	CBPI, gated equilibrium; multiple studies at rest and stress, WM plus EF	10.89	16,403
78481	CBPI, first pass; single study at rest or stress, WM plus EF	6.99	43,126
78483	CBPI, first pass; multiple studies at rest and stress, WM plus EF	10.53	18,252

Note.—CBPI = cardiac blood-pool imaging, SPECT = single photon emission computed tomography.
* Refers to Medicare relative value units in 1998.
† 1998 values.

ventricular WM and EF by using radionuclide imaging techniques, concern has been raised about overutilization. The fiscal year 2000 work plan of the Office of Inspector General of the Department of Health and Human Services identified MPI as a medical service undergoing unusually rapid expansion in utilization, with a 23% increase in billing to the Health Care Financing Administration (HCFA), the administrator of the Medicare program, in just 1 year (4). Among the many thousands of physician services offered to patients, it was the only one specifically targeted by the Office of Inspector General for assessment for medical appropriateness.

The goal of this study was to evaluate cardiac nuclear medicine practice patterns among different physician specialty groups to better understand the rapid increase in utilization of these examinations.

MATERIALS AND METHODS

Our data sources were the HCFA Physician/Supplier Procedure Summary Master Files for 1996 and 1998. These files contain all Medicare Part B services performed nationwide by physicians for beneficiaries enrolled in the traditional fee-for-service Medicare program. In 1996 there were 38.1 million Medicare beneficiaries in the United States—33.2 million in traditional fee-for-service Medicare and another 4.9 million enrolled in Medicare health maintenance organizations, or HMOs. In 1998 there were 38.5 million Medicare beneficiaries—31.9 million in traditional fee-for-service and 6.6 million others in Medicare HMOs. Because services to Medicare HMO patients are generally capitated and not handled directly by Medicare fiscal intermediaries, their records are not included in these files and were therefore not included in this study.

In the files, each physician service is classified in a number of ways. The first is by type of service by using the CPT-4 codes. A second classification is by the location where the service is performed by using one of 27 HCFA location codes. A third classification is by specialty of the physician provider by using one of 107 HCFA specialty codes. For the purposes of this study, physicians were categorized as cardiologists, radiologists (including nuclear medicine physicians), or other physicians.

Table 1 lists the CPT-4 codes that were analyzed and brief descriptors from the coding manual. The first four (78460, 78461, 78464, 78465) are the primary codes used for radionuclide MPI. The next two (78478 and 78480) are the add-on codes for determination of left ventricular WM or EF when used in conjunction with a primary MPI examination. The last four codes (78472, 78473, 78481, and 78483) are "freestanding" codes for WM and EF determination when these examinations are performed separately and not in conjunction with an MPI. These four codes are used less frequently, usually in patients with some form of heart disease other than coronary disease; aside from determining the total number of these examinations performed, we did not analyze these codes further.

For each of the four primary MPI CPT-4 codes and the two add-on WM and EF codes, we first compared utilization rates during 1996 and 1998 among radiologists, cardiologists, and all other physicians. The difference in proportions for 1996 rates versus 1998 rates was calculated by using the *z* test. Since the rates are complete counts of the entire Medicare population rather than a sample, it might be argued that no inferential statistics are required. However, the particular counts obtained in 1996 and 1998 can be considered theoretically as samples of a superpopulation of samples influenced by various random factors and traditional sampling statistics, such as the *z* test, and can be calculated. Of course, population parameters change systematically from year to year in ways that may be associated with increased utilization—such as the aging of the Medicare population. While it would have been desirable to adjust for age differences, the data set utilized does not contain demographic information, and no adjustment was possible. Because the points are close in time, changes in such parameters are not great, and it is reasonable to treat these years as samples of a superpopulation. Since this confounder could not be eliminated, we caution that our inferential statistics should be considered descriptive rather than true tests of significance. We also calculated the percentages of the examinations performed by each of the three physician groups. We further analyzed the physician utilization rates according to location of the examinations. For this, we used the location codes for *(a)* hospital inpatient settings, *(b)* hospital outpatient settings, *(c)* private offices, and *(d)* a final group encompassing all other locations. Utilization rates were calculated as the number of examinations per 100,000 Medicare fee-for-service beneficiaries that year. We then calculated the ratios of the add-on WM and EF studies to the primary MPI studies according to physician specialty and location to determine if these variables influenced the utilization of WM and EF studies. The ratios were measures of the risk that a patient undergoing MPI would have a WM and/or EF

TABLE 2
Changes in Utilization Rates of Cardiac Radionuclide Imaging between 1996 and 1998 among Cardiologists, Radiologists, and Other Physicians in All Places of Service

Examination Type and Physician Category	1996*	1998*	Change* (%)
MPI†			
Cardiologists	1,771	2,413	36.3
Radiologists	1,958	2,031	3.7
Other physicians	317	376	18.6
Total	4,046	4,820	19.1
Add-on WM or EF‡			
Cardiologists	603	2,275	277
Radiologists	330	1,080	227
Other physicians	73	302	314
Total	1,006	3,657	264

Note.—For all differences between 1996 and 1998 rates, $P < .001$ (z test).
* Utilization per 100,000 Medicare beneficiaries.
† Four codes.
‡ Two codes.

TABLE 3
Cardiac Radionuclide Imaging Performed by Radiologists, Cardiologists, and Other Physicians during 1996 and 1998 in All Places of Service

Examination Type and Physician Category	1996*	1998*
MPI†		
Cardiologists	1,771 (43.8)	2,413 (50.1)
Radiologists	1,958 (48.4)	2,031 (42.1)
Other physicians	317 (7.8)	376 (7.8)
Total	4,046 (100.0)	4,820 (100.0)
Add-on WM or EF‡		
Cardiologists	603 (59.9)	2,275 (62.2)
Radiologists	330 (32.8)	1,080 (29.5)
Other physicians	73 (7.3)	302 (8.3)
Total	1,006 (100.0)	3,657 (100.0)

Note.—Data in parentheses are percentages.
* Utilization per 100,000 Medicare beneficiaries (specialty percentage).
† Four codes.
‡ Two codes.

study added. Relative risks (one ratio divided by another) and CIs were calculated separately for 1996 and 1998 utilization of add-on WM and/or EF studies in all places of service for cardiologists and other physicians versus radiologists.

Because increases in utilization of diagnostic studies like cardiac radionuclide imaging might be offset by decreases in utilization of other imaging tests that provide comparable or supplementary information, we also assessed stress echocardiography and cardiac catheterization. Cardiologists perform the majority of these procedures. We therefore compared 1996 and 1998 utilization rates among cardiologists for stress echocardiography (code 93350) and the seven codes encompassing adult cardiac catheterization and coronary angiographic procedures (codes 93510, 93511, 93526, 93539, 93540, 93543, and 93545).

HCFA uses eight "specialty" codes in which it is not actually possible to determine the medical specialty of the physician who provides the service—multispecialty clinic or group practice, ambulatory surgical center, portable x-ray supplier, clinical laboratory, independent physiological laboratory, skilled nursing facility, intermediate care nursing facility, and other nursing facility. We excluded claims filed under these specialty codes; they accounted for only 4% of all Medicare fee-for-service claims in 1998.

RESULTS

Data are presented in the Tables. Table 2 demonstrates 1996 and 1998 utilization rates per 100,000 Medicare beneficiaries among cardiologists, radiologists, and other physicians. Total utilization per 100,000 of the four MPI codes increased 19.1% from 4,046 in 1996 to 4,820 in 1998. However, the utilization rate increased 36.3% among cardiologists compared with only 3.7% among radiologists. Utilization of these codes by other physicians was considerably lower but increased 18.6% during the 2-year interval. The total utilization rate of the two add-on WM and EF codes increased 264% from 1,006 in 1996 to 3,657 in 1998. The growth in utilization of the latter two codes during the 2 years was high for all three physician groups—277% among cardiologists, 227% among radiologists, and 314% among other physicians. Differences in utilization rates between 1996 and 1998 reported in Table 2 all show probabilities of less than .001 by using the z-test. As we noted in the Materials and Methods section, these probabilities are to be interpreted descriptively rather than as customary significance tests.

Table 3 is derived from Table 2 and shows the percentages of MPI and add-on WM and/or EF examinations performed by radiologists, cardiologists, and other physicians during 1996 and 1998. During 1996, radiologists performed 48.4% of MPI examinations, while cardiologists performed 43.8%. By 1998, the cardiologists' share had increased to 50.1% while radiologists' share had decreased to 42.1%. However, during the 2-year interval, the utilization rate among radiologists increased (from 1,958 to 2,031). The shift to the greater utilization proportion by cardiologists thus appears to be due to a much more rapid increase in their utilization (from 1,771 to 2,413), rather than to a shift in procedure volume from radiologists to cardiologists.

Table 4 further demonstrates overall physician utilization by categorizing it according to the place where the service was performed. The three principal places of service where imaging is performed are hospital inpatient settings, hospital outpatient settings, and private offices. All other locations were grouped together as a fourth category, but the table shows that utilization in this category was much less than in the three principal locations. The numeric columns in Table 4 show utilization rates per 100,000 beneficiaries for both 1996 and 1998, as well as the percentage change between them. For hospital inpatients, the utilization rate of MPI increased 21.8% between 1996 and 1998 among cardiologists (from 252 to 307) compared with 6.0% among radiologists (from 581 to 616). In hospital outpatient settings, where the utilization of MPI was considerably higher, the rate increased 18.2% between 1996 and 1998 among cardiologists (from 396 to 468) compared with 2.2% among radiologists (from 1,109 to 1,133). In private offices, cardiologist utilization increased 45.8% (from 1,115 to 1,626) during the period, whereas radiologist utilization increased 8.1% (from 223 to 241). The utilization of the add-on WM and/or EF codes between 1996 and 1998

TABLE 4
Changes in Rates of Utilization of Cardiac Radionuclide Imaging between 1996 and 1998 by Physician Category and Place of Service

Examination Type and Physician Category	Hospital Inpatient	Hospital Outpatient	Office	Other Locations	Total per Physician Category
MPI					
Cardiologists	252/307 (+21.8)	396/468 (+18.2)	1,115/1,626 (+45.8)	9/12 (+33.3)	1,771/2,413 (+36.3)
Radiologists	581/616 (+6.0)	1,109/1,133 (+2.2)	223/241 (+8.1)	45/41 (−8.9)	1,958/2,031 (+3.7)
Other physicians	67/64 (−4.5)	113/115 (+1.8)	134/193 (+44.0)	3/3 (0)	317/376 (+18.6)
Total	900/987 (+9.7)	1,618/1,716 (+6.1)	1,472/2,060 (+39.9)	57/56 (−1.8)	4,046/4,820 (+19.1)
Add-on WM or EF					
Cardiologists	45/182 (+304)	87/302 (+247)	466/1,781 (+282)	5/9 (+80)	603/2,275 (+277)
Radiologists	79/301 (+281)	152/550 (+262)	95/206 (+117)	4/24 (+500)	330/1,080 (+227)
Other physicians	11/38 (+245)	14/54 (+286)	48/207 (+331)	1/2 (+100)	73/302 (+314)
Total	135/521 (+286)	253/906 (+258)	609/2,194 (+260)	10/35 (+250)	1,006/3,657 (+264)

Note.—For all numbers in table, utilization per 100,000 Medicare beneficiaries for 1996/1998; data in parentheses are percentage change.

TABLE 5
Changes in Ratios of Add-on WM and/or EF Studies to Primary MPI Studies between 1996 and 1998

Physician Category	Hospital Inpatient	Hospital Outpatient	Office	Other Locations	Total
Cardiologists	0.18/0.59	0.22/0.65	0.42/1.10	0.56/0.75	0.34/0.94*
Other physicians	0.16/0.59	0.12/0.47	0.36/1.07	0.33/0.67	0.23/0.80†
Radiologists	0.14/0.49	0.14/0.49	0.43/0.85	0.09/0.59	0.17/0.53
Total	0.15/0.53	0.16/0.53	0.41/1.07	0.18/0.63	0.25/0.76

Note.—For all numbers in table, utilization ratios for 1996/1998.
* Relative risk is 2.02 (95% CI: 2.00, 2.04)/1.77 (95% CI: 1.76, 1.78) for cardiologists vs radiologists for all places of service.
† Relative risk is 1.38 (95% CI: 1.35, 1.40)/1.51 (95% CI: 1.49, 1.52) for other physicians vs radiologists for all places of service.

increased proportionately among cardiologists and radiologists in the hospital inpatient and outpatient settings. However, in private offices, utilization of these codes increased 282% among cardiologists compared with 117% among radiologists.

Table 5 shows the 1996 and 1998 ratios of add-on WM and EF studies to primary MPI studies. This ratio indicates the proportion of MPI examinations to which a WM or EF examination is appended. Since the physician performing the examination can elect to add both WM and EF studies to a basic MPI study, the ratio can range from 0 to 2.0. Ratios are shown for cardiologists, radiologists, and other physicians in each of the four place of service categories. The ratios in this table are derived from Table 4. For example, Table 4 shows that in 1996, the total utilization rate of WM or EF studies was 1,006 per 100,000 Medicare beneficiaries, while the total utilization rate of MPI that year was 4,046. The ratio is 1,006/4,046, or 0.25. Because the WM or EF codes can be used only in conjunction with MPI, this indicates that approximately 25% of all MPI studies were accompanied by a WM or EF determination in 1996. In 1998, this ratio was 3,657/4,820, or 0.76, indicating that by then more than three-fourths of all MPI studies were accompanied by a WM or EF determination. In 1996, the ratio among cardiologists was 0.34 versus 0.17 among radiologists. By 1998, the ratio among cardiologists was 0.94 compared with 0.53 among radiologists. Analysis by location shows that the highest ratios were generally found in private offices. By 1998, the ratios among cardiologists and other physicians in private offices exceeded 1.0. Table 5 shows that for both 1996 and 1998, the relative risk of a patient undergoing WM and/or EF studies is higher for cardiologists and other physicians compared with radiologists.

We noted a different utilization pattern for the four freestanding WM and EF codes (78472, 78473, 78481, and 78483) than for the add-on codes. Claims under the freestanding codes were much less frequent than claims for the WM and EF studies. In 1996 there were 194,585 claims for the four freestanding codes and 333,820 for the two add-on codes; in 1998 there were 178,738 claims for the former and 1,166,114 for the latter. Thus, WM or EF determinations were much more commonly performed along with MPI as part of the evaluation of suspected coronary disease.

The utilization rate for stress echocardiography among cardiologists increased 24.2%, from 727 per 100,000 Medicare beneficiaries in 1996 to 903 in 1998. For the seven cardiac catheterization and/or coronary angiographic codes, the utilization rate among cardiologists in 1996 was 7,318 per 100,000 beneficiaries. By 1998, this rate had increased 8.7% to 7,958. Cardiologists performed 85.3% of all stress echocardiograms and 91.7% of all cardiac catheterization/coronary angiographic procedures in 1998.

DISCUSSION

Our data provide interesting insight into the concerns expressed about MPI in the Medicare program. Between 1996 and 1998 there was a substantial increase (19.1%) in the overall utilization rate of MPI. However, there was a striking difference between the practice patterns of radiologists and cardiologists. The utilization rate increased 3.7% among radiologists during the 2-year interval compared with 36.3% among cardiologists. As shown in Table 4, the most dramatic MPI increase among cardiologists occurred in private offices, with a 45.8%

increase in 2 years. In hospital settings, the utilization increase among cardiologists was more modest (21.8% for inpatients and 18.2% for outpatients). It is thus apparent that a major contributing factor in the increase in Medicare billing for radionuclide myocardial perfusion codes was the rapid increase in utilization of MPI by cardiologists.

Overall utilization of the add-on WM and EF codes increased far more rapidly (264%) than MPI between 1996 and 1998. This is perhaps not surprising, since these studies rely on the use of radioisotopes, nuclear camera improvements, and billing codes that have been developed relatively recently. As shown in the listing of relative value units in Table 1, these studies are considerably less costly than the primary MPI studies. Increases in rates of the WM and/or EF studies during the 2-year period were 277% among cardiologists, 227% among radiologists, and 314% among other physicians. The ratios shown in Table 5 represent a more direct measure of the tendency to utilize these supplementary procedures. This table shows that the ratios for cardiologists were considerably higher than for radiologists in both 1996 and 1998, in all locations. By 1998, the overall ratio for cardiologists was 0.94 compared with 0.53 for radiologists. The relative risk that patients undergoing an MPI examination performed by a cardiologist would also undergo an add-on WM and/or EF exam was 1.77 compared with the risk if the patient was referred for an MPI examination to a radiologist.

The rapid increase in use of cardiac radionuclide imaging might be justified if it was being substituted for other examinations for coronary artery disease. However, at the same time the increases in utilization of cardiac radionuclide imaging were occurring, cardiologists' use of stress echocardiography increased by 24.2%, and their use of cardiac catheterization and coronary angiography increased by 8.7%. Thus there was no evidence that the growth in utilization of radionuclide examinations resulted in lower utilization of these other related diagnostic studies.

MPI and the associated add-on WM and EF studies performed by cardiologists are often self-referred. The opportunity for physicians to self refer has been shown to be a potent stimulus to increased utilization of imaging studies. Hillman et al (5,6) demonstrated that self-referring physicians who operated their own imaging equipment used 2–8 times as many imaging studies as did physicians who referred their patients to radiologists. Findings of a large-scale General Accounting Office study (7) of the Medicare population in Florida showed substantially the same results. These findings have been confirmed by other study findings as well (8–11). It is not clear whether the increased utilization of imaging among self-referring physicians is due to a belief that their patients are sicker than the norm, to an enthusiasm for technology, to a desire to maximize income, or to some other motivation, but the net effect is increased cost to the health care system.

Some limitations of our study should be noted. First, although it is possible that the MPI utilization increase among cardiologists may be due to self referral within a single practice or group, our database does not allow precise determination of the degree of self referral. Second, we cannot determine whether the rapid growth resulted from higher utilization among a small group of cardiologists, or whether a larger number of cardiologists acquired nuclear cameras and began performing the examinations. Third, the data do not allow us to assess the appropriateness of the imaging examinations. However, there is no reason to assume that the populations of patients studied by radiologists, cardiologists, or other physicians are inherently different or that the latter two populations have greater need for cardiac nuclear imaging examinations. It would be difficult to ascertain whether the increased utilization detected in this study was medically necessary or not. Fourth, this study was conducted among the Medicare population only and may not exactly reflect events occurring in other health insurance databases. Fifth, there are small year-to-year changes in the underlying Medicare population demographics, which may contribute to small changes in utilization and which we are unable to adjust for. Consequently, as noted earlier, probability levels reported should be interpreted as descriptive rather than as traditional significance tests. Finally, the 107 HCFA physician specialty codes are self designated by physician providers and this may lead to minor inaccuracies. For example, in a given hospital, a cardiologist may work in the nuclear medicine section of the department of radiology, and his billings to HCFA might be classified as being from a "radiologist."

In summary, this study has provided insight into the concerns expressed in the Office of Inspector General work plan for 2000 (4). There was sharp growth between 1996 and 1998 in the utilization rate of MPI; this growth was almost entirely due to increased utilization by cardiologists, particularly in the office setting. There was an even more striking increase in the use of add-on WM and/or EF codes; however, this can be at least partially explained by the fact that these were still relatively new codes, which had been available only for 4 years in 1996. Although the increase in utilization of the add-on WM and/or EF codes was high among all physicians, by 1998 the probability that a patient would undergo one of these examinations was substantially higher if the primary MPI examination was performed by a cardiologist than if it was referred to a radiologist. The recent higher utilization seen in cardiac radionuclide imaging is not being offset by declines in use of other related imaging studies.

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EXHIBIT C

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December 11, 2014

The Honorable Jackie Speier
House of Representatives
211 Cannon Office Building
Washington, DC 20515

Dear Representative Speier:

On behalf of AARP's nearly 38 million members and the millions more with Medicare, thank you for your continued work to close provider reimbursement loopholes. AARP agrees that restrictions on physician self-referral and provider-kickback schemes must be strengthened. Closing the in-office ancillary services exception for certain services will save taxpayers and Medicare beneficiaries money and reduce unnecessary care.

As you know, the in-office ancillary services exception was intended to allow physicians to perform services which can be completed in the physician's office while the patient is present and which aid in the diagnosis of the patient in order to minimize delays in patient care. Unfortunately, the exception has contributed to overutilization and rapid growth of certain services, particularly in radiation oncology, anatomic pathology, advanced imaging, and physical therapy. Closing the loophole will better serve patients and preserve Medicare's resources by saving approximately $6 billion over ten years for these services.

We look forward to working with you and your colleagues in both parties to improve Medicare and reduce health care spending. If you have any questions, please contact me or have your staff contact Ariel Gonzalez of our Government Affairs team, at agonzalez@aarp.org or 202-434-3770.

Sincerely,

Joyce A. Rogers

Joyce A. Rogers
Senior Vice President
Government Affairs

EXHIBIT D

September 2012

GAO
Accountability * Integrity * Reliability

Highlights

Highlights of GAO-12-966, a report to congressional requesters

MEDICARE

Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions

Why GAO Did This Study

Medicare Part B expenditures—which include payment for advanced imaging services—are expected to continue growing at an unsustainable rate. Questions have been raised about self-referral's role in this growth. Self-referral occurs when a provider refers patients to entities in which the provider or the provider's family members have a financial interest. GAO was asked to examine the prevalence of advanced imaging self-referral and its effect on Medicare spending. This report examines (1) trends in the number of and expenditures for self-referred and non-self-referred advanced imaging services, (2) how provision of these services differs among providers on the basis of whether they self-refer, and (3) implications of self-referral for Medicare spending. GAO analyzed Medicare Part B claims data from 2004 through 2010 and interviewed officials from the Centers for Medicare & Medicaid Services (CMS) and other stakeholders. Because Medicare claims lack an indicator identifying self-referred services, GAO developed a claims-based methodology to identify self-referred services and expenditures and to characterize providers as self-referring or not.

What GAO Recommends

GAO recommends that CMS improve its ability to identify self-referral of advanced imaging services and address increases in these services. The Department of Health and Human Services, which oversees CMS, stated it would consider one recommendation, but did not concur with the others. GAO maintains CMS should monitor these self-referred services and ensure they are appropriate.

View GAO-12-966. For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

From 2004 through 2010, the number of self-referred and non-self-referred advanced imaging services—magnetic resonance imaging (MRI) and computed tomography (CT) services—both increased, with the larger increase among self-referred services. For example, the number of self-referred MRI services increased over this period by more than 80 percent, compared with an increase of 12 percent for non-self-referred MRI services. Likewise, the growth rate of expenditures for self-referred MRI and CT services was also higher than for non-self-referred MRI and CT services.

GAO's analysis showed that providers' referrals of MRI and CT services substantially increased the year after they began to self-refer—that is, they purchased or leased imaging equipment, or joined a group practice that already self-referred. Providers that began self-referring in 2009—referred to as switchers—increased MRI and CT referrals on average by about 67 percent in 2010 compared to 2008. In the case of MRIs, the average number of referrals switchers made increased from 25.1 in 2008 to 42.0 in 2010. In contrast, the average number of referrals made by providers who remained self-referrers or non-self-referrers declined during this period. This comparison suggests that the increase in the average number of referrals for switchers was not due to a general increase in the use of imaging services among all providers. GAO's examination of all providers that referred an MRI or CT service in 2010 showed that self-referring providers referred about two times as many of these services as providers who did not self-refer. Differences persisted after accounting for practice size, specialty, geography, or patient characteristics. These two analyses suggest that financial incentives for self-referring providers were likely a major factor driving the increase in referrals.

Change in Average Number of MRI Services Referred, 2008 and 2010

	Average 2008 referred MRI services	Average 2010 referred MRI services	Percentage change
Switchers	25.1	42.0	67.3
Non-self-referrers	20.6	19.2	-6.8
Self-referrers	47.0	45.4	-3.4

Source: GAO analysis of Medicare data.

Note: Pattern observed for MRI services was similar for CT services. GAO defines switchers as those providers that did not self-refer in 2007 or 2008, but did self-refer in 2009 and 2010.

GAO estimates that in 2010, providers who self-referred likely made 400,000 more referrals for advanced imaging services than they would have if they were not self-referring. These additional referrals cost Medicare about $109 million. To the extent that these additional referrals were unnecessary, they pose unacceptable risks for beneficiaries, particularly in the case of CT services, which involve the use of ionizing radiation that has been linked to an increased risk of developing cancer.

EXHIBIT E

White House Releases FY 2017 Budget Proposal

On February 9, President Obama released his proposed federal budget for the 2017 fiscal year (FY). The FY 2017 budget will be the last of his presidency. The budget is comprised of $4.1 trillion in spending on receipts of $3.6 trillion, resulting in a $503 billion deficit for the year. Although several provisions in the Obama budget may be included throughout the year as separate policies to congressional legislation, due to the Republican majority in Congress, the vast majority of the president's proposals contained in his budget will not be considered or debated.

The President's budget is chock-full of various Medicare-related changes that present both opportunities and threats to radiologists. The American College of Radiology (ACR) is encouraged that the Administration, once again, included provisions to close the in-office ancillary services (IOAS) exception to the Ethics in Patient Referrals Act, commonly referred to as the Stark law, after its author, former Congressman Fortney "Pete" Stark. The budget stipulates that, starting in 2018, advanced imaging, radiation therapy, anatomic pathology and physical therapy services would be removed from the IOAS exception. The Obama Administration would only permit these four services to be self-referred within clinically integrated practices that are required to demonstrate cost containment. In total, closure of the IOAS exception is expected to produce slightly more than $4.9 billion in savings over 10 years.

However, the ACR continues to be frustrated by the Obama Administration's annual effort to establish a Medicare prior authorization program. Although the Administration did not specifically cite a prior authorization policy strictly for advanced imaging services as it has in past budgets, the president did call for a broader, prior authorization policy that affects all Medicare fee-for-service procedures. The ACR is puzzled as to why the Administration would pursue such a policy for imaging services in light of the passage of a mandatory imaging appropriate use criteria (AUC) consultation policy specifically designed to reduce imaging overutilization. Furthermore, the ACR remains deeply skeptical that a prior authorization policy would generate any savings for Medicare because of the considerable administrative costs associated with implementing the policy. Above all, the ACR continues to hold strong reservations about prior authorization programs limiting patient access to lifesaving imaging services.

In addition to some of the more specific policies the ACR monitors within the President's budget, The White House's medical research funding included a $33.1 billion budget for the National Institutes of Health (NIH) in fiscal year 2017. Some of the Administration's research priorities include:

Cancer Moonshot

The budget provides $680 million to the NIH to expand clinical trials for health disparity populations, pursue new vaccine technology and fund exceptional opportunities in cancer research. These investments will drive scientific advances that aim to understand the causes of cancer, discover new prevention strategies, improve early detection and diagnosis and cultivate effective treatments.

Advances the Precision Medicine Initiative

The budget provides the Department of Health and Human Services with $309 million to continue scaling up the Precision Medicine Initiative. Recent breakthroughs in genomics, computing and molecular medicine have created extraordinary opportunities to advance health care into a new era when many more treatments are based on the genetic characteristics of each patient. Research based on this cohort will lay the foundation for findings for many diseases that can lead to new prevention strategies, novel therapeutics and medical devices.

BRAIN Initiative

The budget provides $195 million within NIH, $45 million more than FY2016, for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. Increased funds in FY 2017 will continue to support basic neuroscience research, human neuroscience, neuroimaging and training initiatives. The funding is also expected to be used on potential projects to collaborate with industry to test novel devices in the human brain, new ways to address big data from the brain, and to develop devices for mapping and tuning brain circuitry.

The ACR will continue to monitor the budget process as it progresses through the legislative process and evaluate any policies that emerge from it that may impact imaging services and/or the practice of radiology.

EXHIBIT F

not detected by current assays may yet be found in both serum and cryoprecipitates.

The possibility that HCV infection is responsible for many or perhaps most cases of Type II and Type III cryoglobulinemia has therapeutic implications. In the past, treatment with plasmapheresis or plasma exchange plus corticosteroids or cytotoxic drugs was reserved for patients with severe manifestations, such as vascular insufficiency, renal failure, and progressive involvement of the peripheral nerves. Combined treatment was often remarkably effective under these circumstances, but it was less effective in patients with smoldering renal or neurologic involvement or painful episodes of cutaneous vasculitis. The favorable results of treatment of mixed cryoglobulinemia with interferon alfa are encouraging[9]; this drug should be subjected to multicenter controlled therapeutic trials to determine its efficacy in mixed cryoglobulinemia due to HCV infection.

Several viruses have also been implicated in the pathogenesis of Sjögren's syndrome,[10] but there is no rigorous proof of an etiologic role for any of them. The finding of HCV RNA in the serum of three of four patients raises this issue anew. Possibly, HCV will prove to be the etiologic agent of Sjögren's syndrome, or perhaps HCV is merely another virus capable of infecting salivary and lacrimal glands to produce a clinical and histologic picture resembling idiopathic Sjögren's syndrome.

Meticulous adherence to the proper methods of collecting and processing samples is essential to the detection of cryoprecipitable substances in serum. At least 20 ml of blood (large amounts enhance the likelihood of detecting small amounts of cryoprecipitate) should be taken from a fasting patient (lipids may interfere with the test by precipitating in the cold). The blood (not treated with an anticoagulant) is placed in tubes in warm water and transported promptly to the laboratory. Once there, it is allowed to clot at 37°C for 1 hour and then separated in a warm centrifuge; the clear serum supernatant is removed and stored at 4°C for 72 hours. The serum is examined daily for cryoprecipitate. If any is detected, the amount of cryoprecipitate (the cryocrit) is determined, and the carefully washed cryoprecipitate is dissolved by warming. Its constituents are then identified by immunodiffusion. Delay in the transport or refrigeration of the sample before processing will lead to the loss of cryoprecipitable substances in the clot, which is discarded when serum is obtained. Hence, in most instances, blood to be examined for cryoprecipitable substances should not be drawn when the laboratory is closed or about to close.

Finally, in view of the demonstration of HCV RNA in the cryoprecipitate from many patients with Type II and Type III cryoglobulinemia, the term "cryoglobulin" no longer accurately describes the cold-precipitable substances recoverable from serum. The phenomenon is once again in search of a name.

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"SELF-REFERRAL" — WHAT'S AT STAKE?

"SELF-REFERRAL" is the term used to describe a physician's referral of patients to an outside facility in which he or she has a financial interest but no professional responsibility. This practice has become particularly prevalent in certain parts of the country, where for-profit imaging centers, diagnostic laboratories, home health care services, radiotherapy centers, physiotherapy units, and other free-standing facilities have been soliciting investments by physicians who can refer patients to them. Self-referral is a prime example of the current and growing encroachment of commercialism on medical practice. The contentious and emotional debate that has been waged over this issue reflects the increasing tension between professional and business values in medicine.[1]

In December 1991, the American Medical Association (AMA) seemed finally to have ended years of ambivalence and uncertainty about self-referral when its House of Delegates approved without dissent a report from the Council on Ethical and Judicial Affairs.[2] Taking a strong stand on the side of professional values, the council advised physicians to avoid self-referral, except when there is a demonstrated need in the community for the facility and alternative financing is not available. The council acknowledged the mounting evidence of excessive costs and rates of use in jointly owned for-profit facilities but emphasized that it was primarily concerned about the integrity of the profession. The following passage from the report expresses its essential message:

> At the heart of the Council's view of this issue is its conviction that, however others may see the profession, physicians are not simply business people with high standards. Physicians are engaged in the special calling of healing, and, in that calling, they are the fiduciaries of their patients. They have different and higher duties than

even the most ethical business person. . . . There are some activities involving their patients that physicians should avoid whether or not there is evidence of abuse.[2]

This admirable statement supports a position I have repeatedly advocated for more than a decade[3-6] — one that was also strongly recommended by the Institute of Medicine in its 1986 report on for-profit enterprise in health care.[7]

Coming on the heels of recent similar statements on self-referral by such other major medical organizations as the American College of Physicians, the American College of Surgeons, and the American College of Radiology, the council's report and its endorsement by the AMA's House of Delegates seemed to have settled the debate once and for all. Unfortunately, that did not prove to be the case. Six months later, in June of this year, the House of Delegates reversed its position. By a close margin, the delegates approved a new resolution introduced by the New Jersey delegation that declared self-referral to be ethical as long as the patient is fully informed about the physician's financial interest in the facility. Although the vote could not change the council's report, which remains part of the AMA's code of ethics, this sudden about-face reveals the confusion and the conflicting interests that still prevent many physicians from recognizing their professional obligations.

The justification offered for the new resolution was unconvincing. Proponents argued that the policy recommended by the council would limit the access of many patients to necessary health services. They also claimed that the great majority of self-referring physicians, who do not abuse their patients' trust, were being penalized because of concern over the few who did. One delegate from New Jersey was quoted in the press as saying, "Sanctions should be applied [to "overutilizers"] when appropriate. . . . But must we always punish the innocent along with the guilty?"[8]

These arguments are transparently spurious. As already noted, the council's report allows for self-referral if the facility is clearly needed by the community and could not be built without physician-investors. As for distinguishing between physicians who abuse self-referral and those who do not, there would be no way to do that without prohibitively expensive and intrusive surveillance of the private practices of all physicians who practice self-referral. Besides, the argument that self-referring physicians should be trusted unless they can be proved to have abused that trust misses an essential point about fiduciary responsibility: people in important positions of trust should not put themselves in situations that inevitably raise questions about their motives and priorities, regardless of whether they actually behave in accordance with that trust.

Physicians are trusted to act as medical purchasing agents for their patients. A doctor who thinks there should be no concern about self-referral as long as it is disclosed and the referrals are monitored is analogous to a purchasing agent for a large corporation who discloses to the chief executive officer (CEO) that he has a vested interest in certain vendors with whom he does business, and who thinks that this disclosure, plus careful surveillance of his purchases by management, should assuage the CEO's concerns. Obviously, it would not do so. In fact, the CEO would probably fire the purchasing agent on the spot. Why should physicians want to apply a lower standard of fiduciary responsibility to themselves than is generally accepted in business?

Two articles in this issue of the *Journal* add to the growing body of evidence that self-referral leads to the overuse of services and excessive cost.[9,10] In a study of free-standing radiation-therapy facilities in Florida, where at least 40 percent of all practicing physicians are involved in some kind of self-referral,[11] Mitchell and Sunshine[9] report that none of the joint-venture facilities were located in inner-city neighborhoods or rural areas, thus refuting the suggestion that joint ventures often bring needed services to otherwise underserved communities. These authors also found that self-referral in radiation therapy, as already reported for other services, was associated with increased use and costs.[9] The second study, by Swedlow et al.,[10] reports on self-referral to three different kinds of outside services in California's workers' compensation system. They found that self-referral increased the rate of use and the cost per case of physiotherapy and increased the cost per case of psychiatric evaluation. Even more interesting, they report that the inappropriate use of magnetic resonance imaging was more frequent among the patients cared for by self-referring physicians, although there was no difference in the cost per case. None of this new evidence is particularly surprising, but taken together with the results of earlier studies cited in the council report, it convincingly demonstrates that self-referral adds to the cost of medical care.

No wonder that government has begun to take restrictive action. In September 1991 the U.S. Department of Health and Human Services issued so-called safe-harbor regulations, which allow physicians to refer Medicare and Medicaid patients to facilities in which they have a financial interest only under limited conditions.[12] These regulations are new interpretations of a Medicare and Medicaid anti-kickback statute that has been on the books since 1972, but they may soon become moot as a result of new, more comprehensive laws at the federal and state levels. A law passed by Congress in 1989 that took effect this year bans the referral of Medicare and Medicaid patients to clinical laboratories owned by their physicians. There is discussion about extending the ban to other kinds of facilities, a move favored by the Bush administration as a means of restraining Medicare expenses. The Internal Revenue Service, reversing its previous stance, has announced that not-for-profit hospitals may lose their tax-exempt status if they enter into certain types of financial arrangements with physicians, including those that involve self-referral. The Federal Trade Commission, which had formerly en-

dorsed self-referral as enhancing competitiveness, now thinks the practice may be anticompetitive because it tends to limit the referring physician's choice to the facility in which he or she has invested, and because it keeps prices up. There has also been much activity at the state level. Florida and New Jersey recently banned most self-referrals, and several other states, including California and New York, are considering similar legislation. Thus, it seems evident that still more legislative restrictions are in the offing.

Those who say that ethics cannot and should not be legislated[13] are right, but for government the issue is clearly economic, not ethical. Voluntary ethical guidelines, although essential for the morale of the profession and for its public image and self-image, cannot establish firm national policy. That requires legislation. Some medical organizations oppose legislation because they fear the indiscriminate banning of referrals to all facilities with which the referring physician has any financial connection — even when the arrangement is in the interest of patients and necessary for good medical practice. This concern is legitimate, but the problem can easily be solved if professional groups work constructively with government to develop laws and regulations that are appropriate. Attempts simply to obstruct corrective legislation are, in my opinion, ill advised. They merely strengthen the public's impression that physicians are more interested in pursuing their own economic interests than in preserving their good name or helping to keep costs down. In any case, as recent history has shown, most efforts to prevent legislative action are likely to fail, leaving a residue of public cynicism and ill will toward organized medicine.

The AMA is worried about the erosion of professionalism in a system of medical care that is becoming increasingly commercialized, and its concern is justified. The reputation of medicine as a trusted profession is at stake, as is the profession's own view of its basic values. The AMA has wisely chosen to make the promulgation and enforcement of ethical standards a major strategic goal. It has sought help from state and local organizations in this task and has asked the Federal Trade Commission to allow physicians more flexibility in self-regulation. These initiatives deserve support, but there is still much more to be done in the profession's struggle against commercialization. In addition to self-referral, the AMA should look closely at the sale of drugs by office-based physicians,[14] deals between physicians and the manufacturers of devices and prostheses, and a wide variety of other kinds of joint ventures between physicians and the facilities in which they treat their patients.[5]

It would be a major victory for professional values if the AMA could once again endorse a simple precept that stood as one of the beacons of its pre-1980s ethical code: "In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients."[15] In today's chaotic medical market, doctors need a few clear guidelines. This is one of the best.

It is hard to predict what our health care system will look like in the year 2000, or what the conditions of medical practice will be. What seems clear, however, is that physicians will have little opportunity to help shape the future if they do not retain their public credibility. That is the real importance of the self-referral debate. If physicians choose to act from self-interest, or even if they merely put themselves in positions that suggest self-interest, they risk damaging their most precious possessions — the trust and respect of their patients and the esteem of the general public.

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EXHIBIT G

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TECHWATCH

The Practice Of Imaging Self-Referral Doesn't Produce Much One-Stop Service

ABSTRACT Imaging as a result of self-referral—when a physician refers patients for imaging tests at a facility owned or leased by the same physician—is widespread. The practice has come under much scrutiny because it is associated with higher volumes of imaging services. Proponents of such self-referral argue that the practice offers patients convenient same-day, one-stop service and allows treatment to start sooner. Our analysis of 2006 and 2007 Medicare data showed that self-referral provided same-day imaging for 74 percent of straightforward x-rays, but for only 15 percent of more-advanced procedures such as computed tomography and magnetic resonance imaging. Policy makers attempting to make the use of imaging more responsible should consider narrowing Medicare's special provision allowing referrals to a physician's own practice so that the provision covers x-rays only.

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Referring a patient for imaging tests to a facility that the physician owns or leases—known as self-referral—is a controversial practice. Proponents say that it has multiple important advantages, most of them arising because it provides what might be called one-stop service.[1–3] In other words, in a single trip to a physician's office, the patient can obtain the following: an initial evaluation of his or her health problem; imaging that the treating physician feels is appropriate; and the initiation of well-informed, definitive treatment.

One-stop service purportedly has several advantages. It is more convenient for the patient, who makes just one trip to a provider instead of several. Because patients who are asked to make separate visits to different providers sometimes do not follow through, one-stop service also means that more patients are likely to get appropriate treatment. And episodes of illness are shorter because definitive treatment can start right away and can build on an information base that includes imaging.

Physicians who are not radiologists can bill and receive payment for self-referred imaging by buying or leasing equipment such as a computed tomography (CT) scanner and either interpreting the images themselves or contracting with others for interpretation.

Opponents of self-referral say that the practice leads to much greater use of imaging, which means that costs are needlessly high and patients are exposed to more radiation than is necessary.[4,5]

Empirical research has concentrated on the issue of use and does indeed show that self-referral is associated with much higher use of imaging, compared to referrals to radiologists.[6–9] This finding has drawn attention because imaging had repeatedly been found to be by far the most rapidly growing component of physician services.[10–12]

As noted, research on self-referred imaging has focused on use. There has been no empirical study of the purported advantages of the practice. To address that knowledge gap, we studied the prevalence of one-stop imaging.

Study Data And Methods

When self-referral is, in fact, a one-stop process, patients have an office visit and receive an imaging service on the same day. It is easy to ascertain from health care claims whether or not this actually happens. Accordingly, we analyzed claims to ascertain how often self-referred imaging is accompanied by a same-day office visit.

DATA The data primarily came from Medicare's 5 percent Research Identifiable Files for 2007 (the latest year available at the time of the study) and 2006. These are files of insurance claims for all services rendered by physicians and other noninstitutional providers to a random 5 percent of beneficiaries enrolled in fee-for-service Medicare. Among other things, the files contain the date of service, the physician's unique provider identification number and specialty, diagnosis and procedure codes, payment amounts, and information on the patient's characteristics.

ANALYSIS For imaging services[13] that took place in an office, we identified as self-referred the procedures where claims had the same unique provider identification number in both the referring physician and the performing physician fields. If either identification number was missing, we omitted the claim from the analysis.[14]

We grouped imaging services into types based on Berenson-Eggers Type of Service codes.[13] This classification groups each of the several thousand billing codes in the Current Procedural Terminology and Healthcare Common Procedure Coding System[15,16] into one of just over a hundred types of procedures, including twenty-three categories and subcategories of imaging.

For each type of imaging, we computed the percentage of self-referred imaging services that were accompanied by a same-day office visit to the same physician (Exhibit 1). We included only global claims, which charge for the entire imaging service, and technical-component-only claims, which charge for the use of the equipment, space, technicians, and supplies—in other words, for everything except the physician's role in supervising and interpreting the scan. We did not include claims that charge only for the physician's service (professional-component-only claims) because there is an accompanying technical-component-only claim and we did not want to double-count claims.

We examined differences in the rate of same-day imaging based on the specialty of the treating physician. That specialty is recorded on the claim.

In 2007 Medicare was shifting to a different physician identifier system, the national provider identifier. Therefore, to ensure that the 2007 data were not anomalous, we replicated our analyses using Medicare's 2006 Research Identifiable Files. We conducted all data analyses with the statistical analysis software SAS, version 9.1.

EXHIBIT 1

Types Of Self-Referred Imaging And Same-Day Office Visits, 2007

Type of imaging	BETOS codes	Number of self-referred images	Percent of all self-referred images	Number with same-day office visit	Percent with same-day office visit
Most straightforward x-rays	I1A, I1B	621,300	28.2	459,015	73.9
Chest x-rays	I1A	148,076	6.7	117,113	79.1
Musculoskeletal x-rays	I1B	473,224	21.5	341,902	72.2
Other x-rays	I1C, I1D, I1F	37,649	1.7	14,681	39.0
High-tech imaging	I1E, I2	1,079,739	49.0	163,744	15.2
Nuclear medicine	I1E	1,034,426	47.0	153,556	14.8
CT	I2A, I2B	29,241	1.3	7,797	26.7
MRI	I2C, I2D	16,072	0.7	2,391	14.9
Ultrasound	I3	434,159	19.7	149,689	34.5
Abdomen/pelvic	I3B	39,047	1.8	21,836	55.9
Echocardiography	I3C	246,911	11.2	83,878	34.0
Other	I3A-F	148,201	6.7	43,975	29.7
Procedural imaging	I4	29,765	1.4	7,222	24.3
All except most straightforward x-rays	All except I1A, I1B	1,581,312	71.8	335,336	21.2

SOURCE Authors' analysis of Medicare's 2007 Research Identifiable Files. **NOTES** Figures represent only global and technical component–only claims, as explained in the text. BETOS codes are Berenson-Eggers Type of Service codes, used by the Centers for Medicare and Medicaid Services to classify procedures. CT is computed tomography. MRI is magnetic resonance imaging.

Study Results

Provider identifier codes were present on 96.0 percent of 2007 claims and 99.5 percent of 2006 claims.

2007 RESULTS After we omitted claims that lacked provider identifier codes, there remained 2.2 million self-referred imaging services received by the 2.6 million Medicare fee-for-service beneficiaries in the 2007 Research Identifiable Files data set.

Of these images, 28.2 percent were relatively straightforward x-rays—specifically, chest x-rays and musculoskeletal x-rays (Exhibits 1 and 2). Of these, 73.9 percent were accompanied by an office visit on the same day.

In contrast, only 15.2 percent of high-tech images—nuclear medicine, CT scanning, and magnetic resonance imaging (MRI)—had a same-day office visit. Nuclear medicine accounted for 47.0 percent of all self-referred imaging services.

For ultrasound, sometimes thought of as "medium-tech," 34.5 percent of self-referred services were accompanied by an office visit on the same day. Abdominal and pelvic ultrasound had a same-day rate of 55.9 percent but accounted for just 1.8 percent of all self-referred imaging services.

Overall, 21.2 percent of patients receiving self-referred imaging services other than chest or musculoskeletal x-rays had an office visit on the same day.

Individual specialties vary greatly in the types of self-referred imaging that they predominantly perform. However, for each type of imaging, the percentage of patients with a same-day office visit was quite similar across specialties. It was also similar to the percentages given above for all providers (Exhibit 3).

For example, self-referred imaging of orthopedists, not surprisingly, consisted predominantly (95.0 percent) of musculoskeletal x-rays, although those x-rays were only 21.5 percent of all physicians' self-referred imaging. But the percentage of orthopedists' patients with a musculoskeletal x-ray and an office visit on the same day was 72.4 percent—virtually identical to the 72.2 percent for patients of all doctors.

2006 RESULTS For 2006 we analyzed 2.1 million self-referred imaging services (Appendix Exhibit A1).[17] For every moderately specific category of imaging, the percentage of self-referred images that had a same-day office visit was very similar in 2006 and 2007. For example, for high-tech self-referred imaging, the same-day office visit rate was 15.6 percent in 2006 and 15.2 percent in 2007.

However, the proportion of total self-referred imaging other than chest and musculoskeletal x-rays that was accompanied by a same-day office visit declined somewhat from 2006 to 2007, from 22.9 percent (Appendix Exhibit A1)[17] to 21.2 percent (Exhibit 1). The decline was due primarily to the growing role of nuclear medicine, whose low same-day office visit rate, approximately 15 percent, did not vary. Nuclear medicine increased from 42.0 percent of all self-referred in-office imaging services in 2006 to 47.0 percent in 2007.

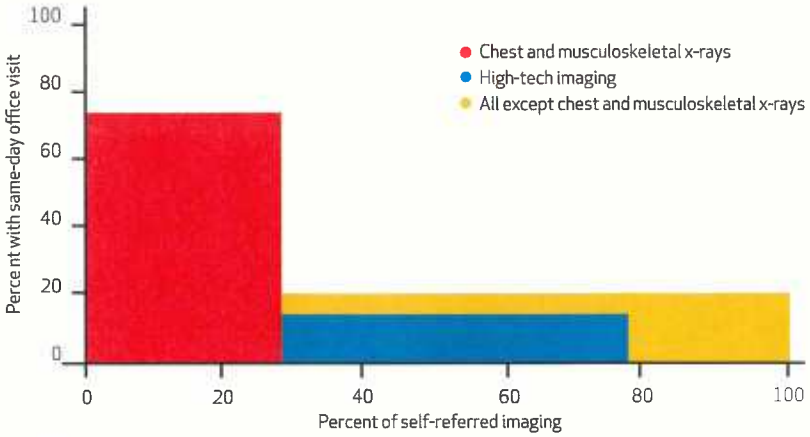
In 2006, as in 2007, the types of specialists who were chiefly responsible for self-referrals differed greatly in the type of self-referred imaging they primarily performed. However, their same-day office visit rate for any given type of imaging was similar to the all-physician average for the same service (Appendix Exhibit A2).[17] For example, in 2006, echocardiography constituted 30.7 percent of cardiologists' self-referred imaging, compared to only 12.1 percent of the self-referred imaging of all physicians. But the same-day office visit rate for echocardiography was 34.8 percent for cardiologists—very similar to the 34.1 percent rate for all physicians (Appendix Exhibit A1).[17]

STUDY LIMITATIONS For two reasons, our findings on same-day imaging may seriously overestimate the extent to which self-referral is truly a one-stop process, at least for high-tech imaging. First, Jean Mitchell[18] has shown that much self-referred high-tech imaging that supposedly takes place in the treating physician's office actually occurs at another location under what the Centers for Medicare and Medicaid Services (CMS) terms "abusive" leasing and other arrangements that the Medicare and Medicaid programs are just beginning to curb.[19–21]

Second, our methodology generally recorded a

EXHIBIT 2

Percentage Of Self-Referred Imaging With Same-Day Office Visit



SOURCE Authors' analysis of Medicare's 2007 Research Identifiable Files.

EXHIBIT 3

Main Types Of Self-Referred Imaging Services By The Most Common Self-Referring Specialties And All Physicians, 2007

		Primary care		Cardiology		Orthopedics		All physicians	
Type of imaging	BETOS codes	% of imaging self-referred	% with same-day office visit	% of imaging self-referred	% with same-day office visit	% of imaging self-referred	% with same-day office visit	% of imaging self-referred	% with same-day office visit
Most straightforward x-rays	IIA, IIB	37.7	75.4	—[a]	—[a]	95.1	72.4	27.8	73.3
Chest x-rays	I1A	18.0	79.6	—[a]	—[a]	—[a]	—[a]	6.7	77.5
Musculoskeletal x-rays	I1B	19.8	71.7	—[a]	—[a]	95.0	72.4	21.5	72.2
Nuclear medicine	I1E	35.6	17.5	67.0	10.8	—[a]	—[a]	47.2	14.7
Echocardiography	I3C	13.8	31.4	26.9	35.4	—[a]	—[a]	11.0	34.0

SOURCE Authors' analysis of Medicare's 2007 Research Identifiable Files. **NOTE** BETOS codes are Berenson-Eggers Type of Service codes, used by the Centers for Medicare and Medicaid Services to classify procedures. [a]Constitutes only a minimal percentage of the specialty's self-referred imaging.

same-day office visit when self-referral was, in fact, a two-stop process. For example, a patient might visit a treating physician and be scheduled for high-tech imaging several days later. If the patient has an office visit to start treatment on the same day that the imaging took place, we counted that as a same-day visit.[22]

Our study included only Medicare beneficiaries. However, as noted below, the limited published data for a younger population are similar to our findings. Moreover, the advantages of one-stop service are probably greater for the elderly, who more often than younger patients have mobility and transportation difficulties.

Our study did not address any advantages claimed for self-referral other than one-stop service.

Discussion

Our analyses of 2007 data and 2006 data produced very similar results. Specifically, same-day imaging was the exception, other than for the most straightforward types of x-rays. Overall, less than one-fourth of imaging other than these types of x-rays was accompanied by a same-day office visit. The fraction for high-tech imaging was even lower—approximately 15 percent.

A likely explanation is that the equipment required for high-tech imaging is expensive, typically costing $0.5–$2.0 million per machine, and it is inefficient for such equipment to be idle and available to patients on an essentially walk-in basis. Rather, the norm is to schedule appointments ahead of time, to maximize use of the equipment. It is ironic that a major justification for self-referrers' acquiring this expensive equipment is to provide same-day convenience to their patients—but, presumably to keep their costs down, the physicians inconvenience the vast majority of their imaging patients by scheduling scans for a later date.

Our results were similar to the very limited data previously published.[8] These data cover a few combinations of health problems and types of imaging in a population mainly under age sixty-five with health insurance through their employer. The data show very high same-day office visit rates (at least 85 percent) for chest and musculoskeletal x-rays and low rates (averaging 14 percent) for high-tech imaging.

Policy Implications

Medicare generally bans financially self-interested referral but allows it for designated "ancillary services," including imaging, if the service takes place in a physician's office.[23]

Previous research indicates that self-referral for imaging is associated with high use of imaging. This means that costs and radiation exposure are high. We have shown that self-referral is seldom a one-stop process (with the exception of relatively straightforward x-rays), although its purported benefits are heavily dependent on its being a one-stop process. Thus, relatively straightforward x-rays are the only form of imaging for which one main benefit of self-referral—one-stop service—seems likely to offset its apparent drawbacks.

Two policy implications emerge. First, Medicare should consider limiting its "in-office ancillary services exemption" for imaging to x-rays.[24] However, Medicare should first acquire two additional types of empirical evidence.

For one, evidence is needed as to whether the

Same-day imaging was the exception, other than for the most straightforward types of x-rays.

demonstrated relationship between self-referral and high use of imaging is actually causal. Possibly, some physicians who are not radiologists may acquire imaging equipment because their personal pattern of practice makes intensive use of imaging, and their use of imaging might not be affected by their acquisition of equipment.

Also, we need more information on the potential benefits of self-referral beside one-stop service. For example, does self-referral lead to better coordination and integration of care? Does it shorten episodes of illness? And does it offset the cost of higher use of imaging by providing information that can save money in the long run? We and other researchers are investigating these questions.

The second policy-related implication of our study is that in-office exemptions for ancillary services other than imaging—such as physical therapy, clinical laboratory tests, and durable medical equipment—should be analyzed as well. Are the exemptions associated with high use of these services, and do their purported benefits actually occur? Studies of self-referral for services other than imaging generally find increased use as well as other undesirable effects.[4,25–30] These undesirable effects include higher markups and "cream skimming"—that is, disproportionately serving patients with relatively mild illnesses or generous insurance, thereby increasing the burden on physicians who care for sicker and less remunerative patients. ■

A version of this paper was presented as a poster at the American Public Health Association Annual Meeting, November 7–11, 2009, in Philadelphia, Pennsylvania.

NOTES

1 American Urological Association. Talking points: physician self-referral [Internet]. Linthicum (MD): The Association; 2005 [cited 2008 Jul 15]. Available from: http://www.auanet.org/content/legislative-and-regulatory/imaging/selfreftalkingpoints.pdf

2 Williams KA. Testimony at the hearing on managing the use of imaging services, before the Subcommittee on Health of the House Committee on Ways and Means [Internet]. Washington (DC): US Government Printing Office; 2005 [cited 2010 Oct 15]. Available from: http://waysandmeans.house.gov/Hearings/Testimony.aspx?TID=905

3 Pontzer K. Statement at the hearing on managing the use of imaging services before the Subcommittee on Health of the House Committee on Ways and Means [Internet]. Washington (DC): US Government Printing Office; 2005 [cited 2010 Oct 15]. Available from: http://waysandmeans.house.gov/Hearings/Testimony.aspx?TID=6101

4 Casalino LP. Physician self-referral and physician-owned specialty facilities [Internet]. Princeton (NJ): Robert Wood Johnson Foundation; 2008 Jun [cited 2010 Oct 15]. (Research Synthesis Report No. 15). Available from: http://www.rwjf.org/files/research/062408.policysynthesis.physreferral.rpt.pdf

5 Levin DC, Rao VM. Turf wars in radiology: updated evidence on the relationship between self-referral and the overutilization of imaging. J Am Coll Radiol. 2008;5(7):806–10.

6 Hillman BJ, Joseph CA, Mabry MR, Sunshine JH, Kennedy SD, Noether M. Frequency and costs of diagnostic imaging in office practice—a comparison of self-referring and radiologist-referring physicians. N Engl J Med. 1990;323(23):1604–8.

7 Hillman BJ, Olson GT, Griffith PE, Sunshine JH, Joseph CA, Kennedy SD, et al. Physicians' utilization and charges for outpatient diagnostic imaging in a Medicare population. JAMA. 1992;268(15):2050–4.

8 Gazelle GS, Halpern EF, Ryan HS, Tramontano AC. Utilization of diagnostic medical imaging: comparison of radiologist referral versus same-specialty referral. Radiology. 2007;245(2):517–22.

9 Medicare Payment Advisory Commission. Report to the Congress: improving incentives in the Medicare program [Internet]. Washington (DC): MedPAC; 2009 Jun [cited 2010 Oct 15]. Available from: http://www.medpac.gov/documents/Jun09_EntireReport.pdf

10 Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2003 Mar [cited 2008 Jun 15]. Available from: http://www.medpac.gov/documents/Mar03_Entire_report.pdf

11 Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2006 Mar [cited 2008 Jun 15]. Available from: http://www.medpac.gov/documents/Mar06_EntireReport.pdf

12 Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2008 Mar [cited 2008 Jun 15]. Available from: http://www.medpac.gov/documents/Mar08_EntireReport.pdf

13 To define which services are imaging, we used the standard Berenson-Eggers Type of Service classification. Centers for Medicare and Medicaid Services. Berenson-Eggers Type of Service (BETOS) codes [Internet].

Baltimore (MD): CMS; [cited 2009 Dec 2]. Available from: http://www.cms.gov/MedicareFeeforSvcPartsAB/Downloads/BETOSDescCodes.pdf

14 Medicare's data system treats independent diagnostic testing facilities as a physician; the specialty of the actual physician in charge is unknown. We excluded from the analysis imaging performed in these facilities. Because Medicare rules generally preclude reimbursing radiologists for self-referring, we also excluded from the analysis their self-referred imaging. Such imaging, approximately 2 percent of the total, had a particularly low rate of same-day service.

15 American Medical Association. About CPT [Internet]. Chicago (IL): AMA; [cited 2010 Oct 15]. Available from: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.shtml

16 Centers for Medicare and Medicaid Services. Healthcare Common Procedure Coding System (HCPCS)—general information [Internet]. Baltimore (MD): CMS; [cited 2010 Oct 15]. Available from: http://www.cms.gov/MedHCPCSGenInfo/01_Overview.asp

17 To access the Appendix, click on the Appendix link in the box to the right of the article online.

18 Mitchell JM. The prevalence of physician self-referral arrangements after Stark II: evidence from advanced diagnostic imaging. Health Aff (Millwood). 2007;26(3):w415–24. DOI: 10.1377/hlthaff.26.3.w415.

19 The best-known of the abuses is the so-called per click lease, in which a referring physician or practice contracts with an off-site imaging center to perform imaging at a fixed fee per imaging examination. According to the contract, the referrer leases the imaging equipment and personnel involved in each examination. The equipment and its off-site location is thereby deemed—for however many minutes the examination takes—to be part of the referrer's office and thus to fall within the in-office exemption.

20 US Department of Health and Human Services. Centers for Medicare and Medicaid Services, 42 CFR Parts 411, 412, 413, 422, and 489. Fed Regist [serial on the Internet]. 2008 Aug 19;73(161):48713–21, 48742–3 [cited 2010 Oct 27]. Available from: http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf

21 US Department of Health and Human Services. Centers for Medicare and Medicaid Services, 42 CFR Parts 405, 409, et al.. Fed Regist [serial on the Internet]. 2008 Nov 19;73(224):69799–817, 69935–6 [cited 2010 Oct 27]. Available from: http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf

22 When imaging and an office visit take place on the same day, to distinguish this situation from actual one-stop service would require knowing whether the imaging had been scheduled when a previous visit took place. Claims do not include information about when the scheduling of an imaging took place. They provide only the dates of the imaging and office visits.

23 The "in-office ancillary services exemption" is found at 42 USC 1395 nn.

24 X-rays that are not chest or musculoskeletal x-rays are less than 2 percent of all self-referred in-office imaging (Exhibit 1). Thus, the desirability of excluding them from the exemption would probably be offset by the simplicity of an exemption for all x-rays.

25 Scott E, Mitchell JM. Ownership of clinical laboratories by referring physicians: effects on utilization, charges, and profitability. Med Care. 1994;32(2):164–74.

26 Swedlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California workers' compensation system as a result of self-referral by physicians. N Engl J Med. 1992;327(21):1502–6.

27 Mitchell JM, Sunshine JH. Consequences of physicians' ownership of health care facilities—joint ventures in radiation therapy. N Engl J Med. 1992;327(21):1497–501.

28 Mitchell JM, Scott E. Physician ownership of physical therapy services: effects on charges, utilization, profits, and service characteristics. JAMA. 1992;268(15):2055–9.

29 Strope SA, Daignault S, Hollingsworth JM, Ye Z, Wei JT, Hollenbeck BK. Physician ownership of ambulatory surgery centers and practice patterns for urological surgery: evidence from the state of Florida. Med Care. 2009;47(4):403–10.

30 Mitchell JM. Utilization changes following market entry by physician-owned specialty hospitals. Med Care Res Rev. 2007;64(4):395–415.

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FACSIMILE TRANSMITTAL SHEET

TO: Office of Health Care Access Attn: Kimberly Martone	FACSIMILE NO.: 860-418-7053
CC:	FACSIMILE NO.:
FROM: Karen P. Wackerman Stephen M. Cowherd	DATE: 8/25/16
RE: Docket No. 16-32063-CON	TOTAL NO. OF PAGES INCLUDING COVER: 14

NOTES/COMMENTS:

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August 25, 2016

VIA EMAIL AND FEDERAL EXPRESS

Hon. Janet Brancifort, M.P.H.
Deputy Commissioner
Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Re: Certificate of Need Application for the Acquisition of a Second Magnetic Resonance Imaging Scanner; Docket No. 16-32063-CON

Dear Deputy Commissioner Brancifort:

This firm represents The Stamford Hospital ("TSH"). In connection with the above-referenced CON application, I attach the following documents (original and four (4) copies):

- Notice of Appearance of Jeffers Cowherd P.C.
- TSH's Petition to be Designated as Intervenor
- The Pre-filed Testimony of Ms. Ruth Cardiello

These documents are being delivered in connection with the August 30, 2016 public hearing that will be held on the above-referenced CON application. Ms. Cardiello will attend the hearing to adopt her pre-file testimony under oath and for cross-examination.

Please do not hesitate to call me if you have any questions.

Very truly yours,

Karen P. Wackerman

cc: Michele Volpe, Esq. – via email and U.S. mail
Kimberly Martone – via email
Alla Veyberman – via email
Steven Lazarus – via email

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

THE STAMFORD HOSPITAL	)	DOCKET NO. 16-32063
	)	
IN RE CERTIFICATE OF NEED APPLICATION OF	)	
ORTHOPAEDIC & NEUROSURGERY SPECIALISTS	)	
P.C. TO ACQUIRE A MAGNETIC RESONANCE	)	AUGUST 25, 2016
IMAGING SCANNER	)	

NOTICE OF APPEARANCE

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Jeffers Cowherd P.C. (the "Firm") in the above-captioned proceeding on behalf of The Stamford Hospital. The Firm, through undersigned counsel, will appear and represent The Stamford Hospital at the public hearing on this matter scheduled for August 30, 2016.

Respectfully submitted by:

THE STAMFORD HOSPITAL

By: Karen P. Wackerman

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Karen P. Wackerman (Juris No. 408615)
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Its Attorneys

CERTIFICATION

I hereby certify that a copy of the foregoing was mailed via First Class U.S. Mail, postage prepaid, and via electronic mail, this 25th day of August, 2016 to:

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By: Karen P. Wack
Karen P. Wackerman

BEFORE THE OFFICE OF HEALTH CARE ACCESS DIVISION OF THE DEPARTMENT OF PUBLIC HEALTH	:	Docket No. 16-32063-CON
IN RE APPLICATION OF ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C. TO ACQUIRE A SECOND MAGNETIC RESONANCE IMAGING SCANNER	:	August 25, 2016

PETITION OF THE STAMFORD HOSPITAL FOR INTERVENOR STATUS WITH FULL PROCEDURAL RIGHTS

Pursuant to the Connecticut Uniform Administrative Procedures Act ("UAPA"), Connecticut General Statutes ("Conn. Gen. Stat.") §§ 4-166 and 4-177a(a) and (b), and §§ 19a-9-26(a) and 19a-9-27 of the Regulations of Connecticut State Agencies, The Stamford Hospital ("TSH" or the "Petitioner"), located at One Hospital Plaza, Stamford, Connecticut 06904, hereby requests the opportunity to participate in the August 30, 2016 public hearing in the above captioned proceeding as an intervenor with full procedural rights.

Preliminary Statement

Orthopaedic & Neurosurgery Specialists, P.C. ("ONS") has submitted the above-referenced Certificate of Need ("CON") Application to request a second magnetic resonance imaging scanner ("MRI") for its practice. In its response to an inquiry by the Office of Health Care Access ("OHCA") in its completeness letter dated February 19, 2016, ONS has stated that this second MRI will be located in its Greenwich office. App. p. 86. Petitioner is taking no position on ONS's application with respect to siting the proposed MRI in Greenwich, which is where its current MRI scanner is also located. However, TSH would strongly oppose any attempt by ONS to use this proceeding as a means for it to eventually "relocate" either its new or existing MRI to TSH's primary service area of Stamford, Darien and Rowayton, which is already served

by ten MRIs and possibly an eleventh if the CON Application of Advanced Radiology Consultants under OHCA Docket No. 16-32093-CON is approved.

Accordingly, Petitioner respectfully requests that ONS be prohibited from relocating either the new or its existing MRI, or any replacement thereof, to Stamford, Darien or Rowayton at any time in the future as a condition of any CON approval given ONS on its pending Application.

A. TSH's Interests Are Affected and its Participation in the Hearing will Assist OHCA

1. The interest of TSH in participating in this proceeding is that, as the only non-profit acute care hospital in the City of Stamford, it is responsible for providing a wide variety of health care services, including MRI, to the general public. In keeping with its charitable mission, this includes providing services to the indigent and uninsured as well as Medicaid beneficiaries that currently account for almost 28% of its payor mix based on gross revenues. In fact, TSH accounts for one of the highest amounts of uncompensated care of any hospital in the State, valued at over $62,000,000 in fiscal year 2015 (including charity care and bad debt). Further, access to care is one of three high priority concerns in TSH's upcoming Community Needs Assessment, stressing the healthcare needs of families with low household income and the need to foster access to health services. Charitable hospitals located throughout the State are held to this standard of providing access to such services. In contrast, ONS provides no significant MRI or other services to these highly vulnerable patients.

2. The Petitioner believes that its participation in the hearing will assist OHCA in its decision-making process regarding this Application because TSH is uniquely positioned to understand the health needs and resources of its primary service area of Stamford, Darien and Rowayton where there is no need for ONS to add additional MRI capacity to the market. Indeed,

if ONS were to relocate either its proposed new MRI or its existing unit to any of these three municipalities, it would significantly raise the risk of creating excess capacity and drawing commercially insured patients away from TSH and other established providers who also service the uninsured and underserved. Such a result would add unnecessary cost to the health care delivery system and weaken rather than strengthen its financial health.

3. As shown in the attached chart, 10 MRIs are already located in and around the Stamford/Darien/Rowayton service area with nine of these being operated by non-profit hospitals: TSH, Greenwich Hospital, the Hospital for Special Surgery and Norwalk Hospital. The tenth unit is operated by Advanced Radiology, which is presently seeking to add a second MRI to its offices located at Washington Boulevard in Stamford. All accept outside referrals and are accessible to the general public. And, through their combined hours of operation, these existing units provide service area residents with the ability to obtain MRI scans seven days a week and on nights and weekends.

4. The fact of the matter is that within Stamford, Darien and Rowayton collectively there is ample access to both hospital-based and freestanding MRI services. As a "closed model" MRI provider (that is, one that does not accept referrals from outside its own private practice), ONS should not be provided with the opportunity to operate two MRIs and encroach upon providers outside of its traditional Greenwich market, especially when it is able to selectively choose the high margin, commercially insured patients that make up the predominant part of the patient population it serves.

5. TSH's status as an existing provider of MRI services and its familiarity with the needs of patients and the MRI resources presently available in Lower Fairfield County make it particularly qualified to offer evidence and information on the above topics that would not

otherwise be available to OHCA and will assist the agency in conducting the public hearing in a manner that can result in the best allocation of health care resources. Petitioner's participation in the public hearing will not disrupt the orderly conduct of the proceedings, is in the interest of justice and will aide OHCA in its deliberations on this Application which, if approved without conditions, has the potential to create overcapacity and a proliferation of MRI services within TSH's primary service area.

B. Summary of Testimony to be Presented at the Public Hearing

6. Petitioner seeks to present the attached pre-filed testimony of Ruth Cardiello, Vice President, Enterprise Risk Management of TSH, who will testify that, based on the current number of MRI providers already servicing Stamford, Darien and Rowayton, the relocation of an MRI by ONS to any of these three municipalities could lead to overutilization of MRI services and drive up healthcare costs in the community. The Stamford/Darien/Rowayton service area already has an abundant supply of established, high quality MRI providers. In addition, Advanced Radiology is applying for a certificate of need to add another MRI at its Stamford office. If the CON requested by Advanced Radiology is approved, the service area will have 11 MRIs available to meet the needs of residents.

7. In correspondence related to ONS's CON Application already filed by Advanced Radiology, it has raised concerns regarding the lack of services ONS provides to medically underserved populations. As one of the largest providers of charity and other uncompensated care in Connecticut, TSH echoes those remarks and is especially concerned that approval of a second MRI for ONS will provide the Greenwich-based physician practice with a platform to move either of its MRIs into TSH's primary service area without CON approval. This ability to relocate will add unnecessary capacity to the service area and raise the risk that ONS will

continue to dilute the pool of commercially insured as well as Medicare patients that established providers like TSH are able to serve.

8. This is especially true since ONS is a "closed model" MRI provider that has been able to insulate itself from serving the large number of Medicaid and indigent patients, while hospitals such as TSH as well as other "open model" MRI providers, who take referrals from outside their own organizations, accept such patients. ONS states in the Pre-File Testimony of Dr. Mark Camel that it saw 23 patients in 2015 with Medicaid as their primary insurance. *Camel Testimony at page 15.* However, Dr. Camel also testifies that ONS's total patient population in 2016 is projected to be 56,664. *Camel Testimony at page 3.* 23 patients of a total of more than 50,000 is not even a measurable fraction of Medicaid patients served. Moreover, it is not clear that any of those 23 Medicaid patients had an MRI at ONS.

9. In the case of TSH and other non-profit hospital providers, MRI and other advanced imaging services also help support a full array of health care services such as 24/7 emergency care that are available to all members of the community regardless of the ability to pay. In fiscal year 2015, TSH ranked as one of the largest providers of charity and uncompensated care in the State of Connecticut based on percentage of its overall expenses. The ability to continue providing these services would be put at further risk by the incursion of an ONS MRI into the Stamford, Darien and Rowayton market as the local health care delivery system simply does not need another MRI provider who does not increase access to healthcare for the underserved populations in the region in any meaningful way.

Conclusion

10. In sum, Petitioner will demonstrate through the above summarized evidence, as well as other evidence that may be discovered or presented in rebuttal or cross examination, that

if ONS's application for a CON is approved, the approval must include a condition that neither of its MRI scanners be moved to Stamford, Darien or Rowayton, as granting the Applicant an unfettered right to relocate either of its unit would cause an unnecessary duplication of health care services that would raise the risk of overcapacity, overutilization and increased health care costs while simultaneously hindering the ability of TSH and other established providers to meet the needs of the indigent and uninsured.

11. For all the above reasons, TSH respectfully requests that it be designated as an intervenor in the public hearing on the above Application with full procedural rights.

THE STAMFORD HOSPITAL

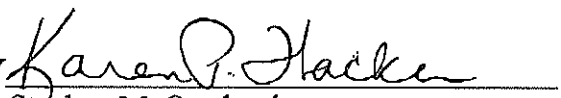
BY 

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Chart of MRI Providers in the Stamford/Darien/Rowayton Area

MRI Provider	Location	No. of MRI Scanners at Location	Hours of Operation
Advanced Radiology Consultants, LLC	1315 Washington Blvd, Stamford, CT 06902	1 (Currently applying for CON to acquire a second)	8:00 a.m. – 10:00 p.m. Monday – Saturday
Greenwich Hospital Diagnostic Center	2015 W. Main Street, Stamford, CT 06902	1	7:30 a.m. – 4:30 p.m. Monday – Friday
HSS Stamford Outpatient Center	1 Blachley Road, Stamford, CT 06902	1	8:00 a.m. – 5:00 p.m. Monday – Friday
Stamford Hospital	One Hospital Plaza, Stamford, CT 06904	1	8:00 a.m. – 8:00 p.m. Monday - Saturday
Stamford Hospital's Darien Imaging Center	6 Thorndale Circle, Suite 104, Darien, CT 06820	1	8:00 a.m. – 4:00 p.m. Monday, Wednesday, Friday 8:00 a.m. – 8:00 p.m. Tuesday, Thursday 8:00 a.m. – 12:00 p.m. Saturday
The Tully Health Center/Elliot and Roslyn Jaffe Diagnostic Imaging Center	32 Strawberry Hill Court, Stamford, CT 06902	1	8:00 a.m. – 8:00 p.m. Monday – Friday 8:00 a.m. – 4:00 p.m. Saturday - Sunday
Norwalk Hospital	24 Stevens Street, Norwalk, CT 06856	1	24 hours/day Saturday & Sunday
Norwalk Hospital d/b/a Norwalk Radiology & Mammography Center	148 East Avenue, Norwalk, CT 06851	3*	7:15am-4:30pm Monday – Thursday 7:15am-4:30pm Friday 7:30am-11:45am Saturday

* As indicated on the most recent published Statewide Healthcare Facilities & Services Inventory released by OHCA in 2014.

BEFORE THE OFFICE OF HEALTH	:	
CARE ACCESS DIVISION OF THE	:	
DEPARTMENT OF PUBLIC HEALTH	:	Docket No. 16-32063-CON
	:	
IN RE APPLICATION OF ORTHOPAEDIC &	:	
NEUROSURGERY SPECIALISTS, P.C. TO	:	August 30, 2016
ACQUIRE A SECOND MAGNETIC	:	
RESONANCE IMAGING SCANNER	:	

Pre-File Testimony of Ruth Cardiello

Thank you for this opportunity to address the Office of Health Care Access on the above-referenced CON Application of Orthopaedic & Neurosurgery Specialists, P.C. to acquire a second magnetic resonance imaging ("MRI") scanner. My name is Ruth Cardiello and I am the Vice President, Enterprise Risk Management for The Stamford Hospital.

Based on the current number of MRI providers already servicing Stamford, Darien and Rowayton, the relocation of an MRI by ONS to any of these three municipalities could lead to overutilization of MRI services and drive up healthcare costs in the community. The Stamford/Darien/Rowayton service area, which is our hospital's primary service area, already has an abundant supply of established, high quality MRI providers. In addition, Advanced Radiology is applying for a certificate of need to add another MRI at its Stamford office. If the CON requested by Advanced Radiology is approved, this service will have 11 MRIs available to the public.

TSH is concerned about the lack of services ONS provides to medically underserved populations. As one of the largest providers of charity and other uncompensated

care in Connecticut, TSH is especially concerned that approval of a second MRI for ONS will provide the Greenwich-based physician practice with a platform to move either of its MRIs into TSH's primary service area without CON approval. If ONS follows through on its ability to relocate, it will add unnecessary capacity to the service area and raise the risk that ONS will continue to dilute the pool of commercially insured as well as Medicare patients that established providers like TSH are able to serve.

This is especially true since ONS is a "closed model" MRI provider that has been able to insulate itself from serving the large number of Medicaid and indigent patients, while hospitals such as TSH as well as the other established MRI providers in the Stamford, Darien and Rowayton service area take referrals from outside their own organizations and accept such patients. In the case of TSH and other non-profit hospital providers, MRI and other advanced imaging services also help support a full array of health care services such as 24/7 emergency care that are available to all members of the community regardless of the ability to pay. In fiscal year 2015, TSH ranked as one of the largest providers of charity and uncompensated care in the State of Connecticut based on percentage of its overall expenses. The ability to continue providing these services would be put at further risk by the incursion of an ONS MRI into the Stamford, Darien and Rowayton market as the local health care delivery system simply does not need another MRI provider who does not increase access to healthcare for the underserved populations in the region in any meaningful way.

For all these reasons, Stamford Hospital respectfully urges OHCA, if it decides to approve the application of ONS, to impose as a condition the requirement that ONS may not relocate either of its MRI's to TSH's service area of Stamford, Darien and Rowayton. Thank you and I am happy to address any questions you may have.

CERTIFICATE OF SERVICE

This is to certify that a true and accurate copy of the foregoing Petition of The Stamford Hospital for Intervenor Status with Full Procedural Rights and supporting pre-file testimony was sent by U.S. mail, postage prepaid, to Michele Volpe, attorney for Orthopaedic & Neurosurgery Specialists, P.C. on August 25, 2016.

Karen P. Wackerman

DEPARTMENT OF PUBLIC HEALTH	:	
DIVISION OF OFFICE OF	:	
HEALTH CARE ACCESS	:	**DOCKET NO. 16-32063-CON**
	:	
IN RE: ORTHOPAEDIC & NEUROSURGERY	:	
SPECIALISTS, P.C.	:	
ACQUISITION OF MAGNETIC	:	
RESONANCE IMAGING SCANNER	:	**AUGUST 26, 2016**

OBJECTION TO PETITION OF THE STAMFORD HOSPITAL FOR INTERVENOR STATUS WITH FULL PROCEDURAL RIGHTS AT AUGUST 30, 2016 HEARING

Othopaedic & Neurosurgery Specialists, P.C., the applicant in the above-captioned matter ("ONS" or the "Applicant"), hereby objects to The Stamford Hospital's ("TSH's" or "Petitioner's") Petition for Intervenor Status with Full Procedural Rights, dated August 25, 2016 (the "Petition"). TSH is requesting relief on an issue that is not before the Department of Public Health division of Office of Health Care Access ("OHCA") thus TSH has not established that its interests will be affected by these proceedings in any way that would justify its request to participate. Conn. Agencies Reg. §19a-9-27(b)(2). Nor has TSH established that its participation in this proceeding will add evidence or arguments on relevant issues that would not otherwise be available to OHCA (Conn Agencies Reg. § 19a-9-27(b)(4). TSH's participation is not in the interest of justice and will certainly impair the orderly conduct of the proceedings (Conn. Gen. Stat. §4-177a(b)). For these reasons, the Petition should be denied.

A. TSH Is Requesting Relief On an Issue That Is Not Before OHCA Thus TSH Has Not Established That Its Interests Will Be Affected by These Proceedings in Any Way That Would Justify Its Request to Participate

TSH is requesting relief on a matter that is not appropriate and is not an issue before OHCA. TSH has sought intervenor status requesting OHCA to prevent ONS from placing the proposed MRI scanner in Stamford. However, ONS has already represented that the proposed

MRI will be located in Greenwich. Petitioner is taking no position on whether OHCA should approve or deny the acquisition of an MRI by ONS. The approval of the MRI in Greenwich is the only issue in the Certificate of Need application (the "Application") before OHCA. ONS's Application clearly states the proposed MRI will be located in Greenwich and does not contemplate relocation.[1] TSH's request is not appropriate because ONS is not seeking to place the MRI in Stamford.

Additionally, TSH's argument that it can provide unique assistance to OHCA relating to the proceeding is not germane to its sole concern that an approved MRI remain in Greenwich. By TSH's own admission, it does not state its interests are affected by ONS receiving approval to obtain an MRI in Greenwich, which is the only issue before OHCA. TSH's request is not appropriate without approval of the Application, which has not yet been granted.

ONS has no intention of moving the proposed scanner to Stamford. However, if ONS were to relocate the proposed MRI, TSH will have an opportunity to oppose at such time. Relocation is not at issue in the Application nor is it an issue that has been requested by ONS. Therefore, TSH's request is not ripe or appropriate. As such, the Petition should be denied.

B. TSH Has Not Established That Its Participation in This Proceeding Will Add Evidence or Arguments On Relevant Issues That Would Not Otherwise Be Available to OHCA

TSH presents no basis that it will add evidence or arguments on relevant issues that are not otherwise available to OHCA. ONS patients do not come to ONS from TSH nor does ONS send patients to TSH for MRI services. TSH's evidence is related to relocation, specifically its pre-filed testimony is only relating to "the relocation of an MRI by ONS to any of

[1] Application at 86.

these three municipalities [Stamford, Darien, Rowayton]."[2] As stated above, this testimony is not appropriate and does not relate to the Application or the issues before OHCA. As such, the Petition should be denied.

Conclusion

For these reasons, and in order to ensure a fair and orderly hearing, ONS respectfully requests that TSH's Petition be denied and that its testimony be stricken from the record. If the Petition is approved, ONS requests that TSH be denied full procedural rights, including the right to conduct cross-examination, as its concerns only relate to relocation, an issue that is not before OHCA.

Respectfully Submitted,

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

BY: _____

Michele M. Volpe, Juris No. 412124
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Tel. No. 20 3 777-5800
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mmv@bvmlaw.com
Its Attorney

[2] Petition at 4.

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 26th day of August 2016 to the following:

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Michele M. Volpe
Bershtein, Volpe & McKeon P.C.

Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Monday, August 29, 2016 9:13 AM
To: Hansted, Kevin; Lazarus, Steven; Riggott, Kaila; Fernandes, David; Greer, Leslie; User, OHCA
Cc: Jennifer Groves Fusco; kwackerman@jeffers-law.com; 'pmonahan@pppclaw.com'; Michele Volpe; Jennifer O'Donnell
Subject: Docket No. 16-32063 - ONS Objection to Petition of ARC for Intervenor Status
Attachments: Docket No. 16-32063 - ONS Objection to Petition of ARC for Intervenor Status (8.29.16).pdf

Please see attached with respect to the above-captioned docket.

Kathleen Gedney-Tommaso
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DEPARTMENT OF PUBLIC HEALTH	:	
DIVISION OF OFFICE OF	:	
HEALTH CARE ACCESS	:	**DOCKET NO. 16-32063-CON**
	:	
IN RE: ORTHOPAEDIC & NEUROSURGERY	:	
SPECIALISTS, P.C.	:	
ACQUISITION OF MAGNETIC	:	
RESONANCE IMAGING SCANNER	:	**AUGUST 29, 2016**

OBJECTION TO PETITION OF ADVANCED RADIOLOGY CONSULTANTS LLC TO BE DESIGNATED AS AN INTERVENOR WITH FULL RIGHTS INCLUDING THE RIGHT OF CROSS-EXAMINATION AT AUGUST 30, 2016 HEARING

Othopaedic & Neurosurgery Specialists, P.C., the applicant in the above-captioned matter ("ONS" or the "Applicant"), hereby objects to Advanced Radiology Consultants, LLC ("ARC" or "Petitioner's") Petition to be Designated as an Intervenor with Full Rights Including the Right of Cross-Examination, dated August 25, 2016 (the "Petition"). There will be no duplication of services if the proposed MRI is approved and ARC performs a de minims number of MRIs on ONS patients. Therefore, Petitioner has not established that its interests will be affected by these proceedings in any way that would justify its request to participate. Conn. Agencies Reg. §19a-9-27(b)(2). The Petitioner has not referenced all of the facts nor has it established that its participation in this proceeding will add evidence or arguments on relevant issues that are not otherwise available to OHCA. Conn Agencies Reg. § 19a-9-27(b)(4). ARC's participation is not in the interest of justice and will certainly impair the orderly conduct of the proceedings. Conn. Gen. Stat. §4-177a(b). Thus, the Petition should be denied.

A. ARC's Interests Are Not Affected by ONS's Proposal and Therefore ARC Has Not Established That Its Interests Will Be Affected by These Proceedings in Any Way That Would Justify Its Request to Participate

ARC has inaccurately stated that approval of ONS's Application will result in unnecessary duplication of existing health care service and that ARC's interests will be affected. ARC's interests will not be affected.

First, ARC's assertion that its interests will be affected because approval of proposed scanner will result in unnecessary duplication of services is unfounded. ONS has proved its specific need for MRI services in the Application. There is an undisputed need for additional MRI services in the ONS service area as there is insufficient capacity for MRI in such service area. Based on application of the standards and criteria in the Statewide Health Plan, there is insufficient capacity and thus there is no duplication of services if the proposed MRI is approved. The proposed MRI will alleviate unmet need and will have no effect on the Petitioner.

In addition, it is contradictory for the Petitioner to state that an additional MRI in the service area will result in unnecessary duplication of existing health care services while applying for an additional MRI itself. As such, the assertion that approval of ONS's Application will result in unnecessary duplication of existing health care services is unfounded and should not be considered as affecting the Petitioner.

Further, ARC will not be impacted by the proposed MRI. ONS does not refer patients to ARC due to ARC's inferior scan quality and ONS's inability to utilize the scans during surgery. ARC does not receive any overflow volume from ONS. As important, individuals who become patients of ONS may have had MRIs before arriving at ONS or may need to be sent to another MRI provider based on the specific needs of the patient. Even if approved, the proposed MRI

ONS will not recapture all of the MRI scans or even a significant amount of the MRI scans being performed by other MRI providers. ONS will always be ordering more MRI's than it can accommodate as outlined in Attachment D of the pre filed testimony of Dr. Camel.

In sum, ONS should dismiss ARC's arguments that ONS's proposed scanner will impact ARC and deny its Petition.

B. ARC Relies on Improper Evidence and Has Not Established that its Participating in the Proceeding Will Add Evidence or Arguments on Relevant Issues that Would Not Otherwise Be Available to OHCA

The Petitioner relies on improper evidence and has not established that its participating in the proceeding will add evidence or arguments on relevant issues that are not otherwise available to OHCA as ONS has meticulously and clearly outlined need for the proposed scanner in the Application and the pre-filed testimony. Specifically, ARC relies on unfounded statements about Medicaid and ONS and preferential treatment of commercial patients, inaccurately states that ONS has not meet the criteria in the Statewide Health Plan, and relies on improper evidence relating to the impact of self-referred scans.

First, ARC puts forth baseless arguments that there is an underserved MRI need for Medicaid patients and about ONS's preferential treatment of commercial patients. ONS services the Medicaid population in a substantial and financially significant manner. There is a coordinated care approach in greater Greenwich area through the ONS orthopedists and neurosurgeons and Greenwich Hospital. Because ONS physicians typically see Medicaid patients first in the Greenwich Hospital clinic or emergency room, such patients typically receive their MRI at Greenwich Hospital. As such, ONS is not referring Medicaid out of its practice or to other providers but rather is coordinating their care with Greenwich Hospital to ensure access

and service in the most appropriate manner. ONS also treats Medicaid patients at its office. In 2015, ONS wrote of care provided to Medicaid patients at its offices in the amount of $87,868.81. ONS also provides hundreds of thousands of dollars in free care and surgery to the Medicaid population.

ONS also provides free services to patients in the Service Area. ONS provides a surgeon and Physician Assistant to the Greenwich Hospital Orthopedic Clinic one (1) day a week from 1-4 PM, three (3) weeks of each month. On average, ONS providers see twelve (12) patients in a day. These patients include Medicaid and uninsured. Services to these patients are all provided pro bono including any surgeries that result from the visits. The surgery value alone of the free care to Medicaid patients in 2015 was in excess of $200,000. Additionally, ONS works one on one with patients who may be unable to pay part or all of the bills. Based on the specific patient's circumstances, the patient may be offered a payment plan or a payment discount/adjustment. ONS has dedicated insurance specialists to assist patients with questions regarding out of network care, copays, deductibles and other insurance and financial need questions. ONS services many government patients and has a 24% Medicare patient population. *Application* at 33.

There is no evidence provided by the Petitioner that the Medicaid population in the service area is underserved. On the contrary, specific efforts to increase Medicaid patient population by an MRI provider located in Stamford have been unsuccessful. Specifically, The Hospital for Special Surgery's ("HSS") efforts to attract Medicaid recipients to its Stamford MRI have only resulted in 1.9% percent of its total patient population. With respect to is Stamford MRI, HSS has enrolled in Medicaid, sent letters to providers informing area providers of its Medicaid participation status, offered clinic hours, hosted community education events, and done

many other steps to increase its Medicaid population. In spite of these efforts, HSS's Medicaid patient population remains under 2%. ACR, who has been servicing the population for nearly two decades has only been able to have Medicaid account for 3.9% of its Stamford practice. This indicates that the Medicaid need for MRI is low in Fairfield county and statements presented by ARC on this issue will not be relevant or helpful to OHCA.

Second, ONS meets all of the statutory requirements for an MRI as well as satisfies all of the criteria in the Statewide Health Plan, including specific requirements for MRI. ONS has meticulously detailed all OHCA and Statewide Health Plan criteria in its Application and pre-filed testimony. ARC falsely states that ONS's Application does not meet the Statewide Health Plan criteria for Medicaid patients. ONS has indisputably met this criterion as it does not deny MRI services to uninsured, underinsured and Medicaid patients. Advanced Radiology presents no evidence of any specific circumstance or patient being denied MRI services based on payor status. In fact, ONS provides significant care to the Medicaid population. ARC's statements on this issue will not add evidence or arguments on relevant issues that have not already been detailed in ONS's application and pre-filed testimony.

Additionally, ARC intends to present and rely on evidence regarding in-office imaging referrals that is extremely outdated. The Applicant relies on studies that that are approximately 25, 30 and 20 years old. More important, such studies are not specific to MRI or orthopedic or neurosurgical practice. Federal and state regulations relating to in-office imaging have evolved substantially in the past 20-30 years and thus these articles no longer present persuasive arguments and will not add evidence or arguments on relevant issues for OHCA. Further, the cited studies do not take into account the appropriateness of use of imaging. Therefore, the Applicant's reliance on these studies is misplaced because the studies are outdated, improper and

do not address the appropriateness of the use of imaging. As important, ONS has always referred the same percentage of patients for MRI, even before it received its existing MRI. Additionally, payors monitor and authorize scans as well as have credentialing and privileging standards for MRI services which prevent necessary utilization. ARC's statements on this issue will not add evidence or arguments on relevant issues that have not already been detailed in ONS's application and pre-filed testimony.

Further, ONS provides cost effective MRI services as its reimbursement and costs are lower than facilities who perform MRI. In addition, ONS times slots are longer and the scans are more detailed that other providers in the service area. ONS spends more time scanning a patient than ARC. Although this is costlier for ONS as it limits scan capacity, it provides ONS with better quality images to treat its patients. ONS's coordination of care in having an MRI performed on a patient at its practice is crucial when ONS physicians are operating on that patient and relying on the results of an MRI scan. ARC's statements on the negative impact of self-referred MRI scans are not applicable to ONS and will not add evidence or arguments on relevant issues for OHCA to consider.

Conclusion

For these reasons, and in order to ensure a fair and orderly hearing, ONS respectfully requests that ARC's Petition be denied and that its testimony be stricken from the record. If the Petition is approved, ONS requests that ARC be denied the right to conduct cross-examination.

Respectfully Submitted,

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

BY: _____

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Its Attorney

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 29th day of August 2016 to the following:

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Michele M. Volpe
Bershtein, Volpe & McKeon P.C.

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:

A Certificate of Need Application by
Orthopaedic & Neurosurgery Specialists, P.C.
Notice to Petitioner re: Request for Status

Docket Number: 16-32063-CON

**RULING ON A PETITION FILED BY
ADVANCED RADIOLOGY MRI CENTERS LIMITED PARTNERSHIP
TO BE DESIGNATED AS AN INTERVENOR**

By petition dated August 25, 2016, Advanced Radiology MRI Centers Limited Partnership ("Petitioner") 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") application of Orthopaedic & Neurosurgery Specialists, P.C. ("Applicant") filed under Docket Number: 16-32063-CON.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with full rights of cross-examination at the hearing scheduled for August 30, 2016 at 410 Capitol Avenue, Hartford, Connecticut. As an Intervenor with full rights of cross-examination, the Petitioner may participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 16-32063-CON and shall be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with full rights of cross-examination, the Petitioner may be cross-examined by the Applicant and the Petitioner has the right to cross-examine the Applicant.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

August 29, 2016
Date

Kevin T. Hansted
Kevin T. Hansted
Hearing Officer

Connecticut Department of Public Health

Phone: (860) 418-7001• Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
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

IN THE MATTER OF:

A Certificate of Need Application by
Orthopaedic & Neurosurgery Specialists, P.C.
Notice to Petitioner re: Request for Status

Docket Number: 16-32063-CON

**RULING ON A PETITION FILED BY
THE STAMFORD HOSPITAL
TO BE DESIGNATED AS AN INTERVENOR**

By petition dated August 25, 2016, The Stamford Hospital ("Petitioner") 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") application of Orthopaedic & Neurosurgery Specialists, P.C. ("Applicant") filed under Docket Number: 16-32063-CON.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with limited rights at the hearing scheduled for August 30, 2016 at 410 Capitol Avenue, Hartford, Connecticut. As an Intervenor with limited rights, the Petitioner may participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 16-32063-CON and shall be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with limited rights, the Petitioner may be cross-examined by the Applicant but the Petitioner may not cross-examine the Applicant.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

August 29, 2016
Date

Kevin T. Hansted
Kevin T. Hansted
Hearing Officer

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

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Olejarz, Barbara

From: Lazarus, Steven
Sent: Monday, August 29, 2016 2:12 PM
To: Karen Wackerman (kwackerman@Jeffers-Law.com); Michele Volpe (mmv@bvmlaw.com); Kathleen Gedney (kgg@bvmlaw.com); Patrick J. Monahan II (pmonahan@pppclaw.com); Jennifer Groves Fusco (jfusco@uks.com)
Cc: Veyberman, Alla; Fernandes, David; Riggott, Kaila; Olejarz, Barbara; Greer, Leslie; Hansted, Kevin
Subject: Docket Numbers: 16-32063-CON and 16-32093-CON
Attachments: 16-32063- Ruling re Intervenor Status Advanced Rad.docx; 16-32063- Ruling re Intervenor Status Stamford.docx; 16-32093- Ruling re Intervenor Status ONS.docx; 16-32093- Ruling re Intervenor Status WestMed.docx

Good Afternoon,

Please see the attached rulings in the above referenced public hearing to be held tomorrow morning. If you have any questions, please feel free to Alla Veyberman (@860-418-7007) or me directly.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
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Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Monday, August 29, 2016 2:25 PM
To: Hansted, Kevin; Lazarus, Steven; Riggott, Kaila; Fernandes, David; Greer, Leslie; User, OHCA
Cc: Jennifer Groves Fusco; kwackerman@jeffers-law.com; 'pmonahan@pppclaw.com'; Michele Volpe; Jennifer O'Donnell
Subject: Docket No. 16-32063 - ONS Rebuttal to ARC Testimony
Attachments: ONS Rebuttal of ARC Testimony (8.29.16).pdf

Please see attached with respect to the above-captioned docket.

Kathleen Gedney-Tommaso
Attorney at Law
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New Haven, CT 06511
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DEPARTMENT OF PUBLIC HEALTH	:	
DIVISION OF OFFICE OF	:	
HEALTH CARE ACCESS	:	**DOCKET NO. 16-32063-CON**
	:	
IN RE: ORTHOPAEDIC & NEUROSURGERY	:	
SPECIALISTS, P.C.	:	
ACQUISITION OF MAGNETIC	:	
RESONANCE IMAGING SCANNER	:	**AUGUST 29, 2016**

REBUTTAL OF ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C. IN RESPONSE TO TESTIMONY OF ADVANCED RADIOLOGY CONSULTANTS LLC

Othopaedic & Neurosurgery Specialists, P.C., the applicant in the above-captioned matter ("ONS" or the "Applicant"), hereby submits the following rebuttal testimony of Clark G. Yoder and Alan D. Kaye on behalf of Advanced Radiology Consultants, LLC ("ARC" or "Petitioner") dated August 25, 2016 (the "ARC Testimony") filed in ONS's Certificate of Need application.[1]

ARC has made the following inaccurate, irrelevant and/or intentionally misleading statements through the testimony of Mr. Yoder and Dr. Kaye, which ONS rebuts as follows:

- ARC has falsely represented that ONS does not treat Medicaid patients.[2] The CON statutes require that OHCA consider how a CON proposal impacts access to and the quality of care for Medicaid recipients and indigent persons. C.G.S. §19a-639(5) requires an applicant to demonstrate how its proposal "will improve the quality, accessibility and cost effectiveness of healthcare delivery in the region, including ... provision of ... and access to services for Medicaid recipients and indigent persons ..." Similarly, C.G.S. §19a-639(6) requires OHCA to consider the applicant's "past and proposed provision of health care services to relevant patient populations and payer mix, including …access to services by Medicaid recipients and indigent persons." ONS provides services to the Medicaid population. ONS has never

[1] Docket No. 16-32063-CON "*Orthopaedic & Neurosurgery Specialists, P.C. Acquisition Of Magnetic Resonance Imaging Scanner*" (January 21, 2016) (hereinafter the "ONS Application").
[2] ARC Testimony at 14.

denied an MRI to any patient based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients. ONS sees patients with Medicaid as their primary or secondary insurance. ONS writes off care provided to these patients and such write off in 2015 is hundreds of thousands of dollars. ONS provides Medicaid neurosurgery care at its office. Additionally, ONS works one on one with patients who may be unable to pay part or all of the bills. Based on the specific patient's circumstances, the patient may be offered a payment plan or a payment discount/adjustment. ONS has dedicated insurance specialists to assist patients with questions regarding out of network care, copays, deductibles and other insurance and financial need questions. In addition to the Medicaid patients, in 2015 ONS saw 46 patients who had no health insurance.

- ARC makes false and misleading representations about ONS's treatment of Medicaid patients stating that "to the extent that [Medicaid patients] required MRI services, ONS chose to refer them elsewhere."[3] As stated above, ONS provides services to the Medicaid population. ONS has never denied an MRI to any patient based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients. ARC's statement is based on conjecture and assumption and should be stricken.
- ARC falsely and inaccurately states that the ONS's proposal does not improve the quality, accessibility or cost-effectiveness of care for Medicaid recipients and indigent persons.[4] ONS's proposal improves the quality, accessibility or cost-effectiveness of care for Medicaid recipients and indigent persons. ONS provides a surgeon and physician assistant to the Greenwich Hospital Orthopedic Clinic one (1) day a week from 1-4 PM, three (3) weeks of each month. On average, ONS providers see twelve (12) patients in a day. These patients

[3] ARC Testimony at 16.
[4] ARC Testimony at 17.

include Medicaid and uninsured. Based on Medicaid patient population patterns when assessing healthcare in the region, ONS physicians see Medicaid patients first in the Greenwich Hospital clinic or emergency room, therefore Medicaid patients typically receive their MRI at Greenwich Hospital. As such, ONS is not referring Medicaid out of its practice or to other providers but rather is coordinating their care with Greenwich Hospital to ensure access and service in the most appropriate manner. Services to these patients are all provided pro bono including any surgeries that result from the visits. The surgery value alone of the free care to Medicaid patients in 2015 was in excess of $200,000. ONS is committed to serving the orthopedic needs of all residents of the Service Area.

- The ARC Testimony falsely and inaccurately states: "ONS does not care for Medicaid recipients or indigent persons in any appreciable numbers."[5] As stated above, ONS provides services to the Medicaid population in a value of hundreds of thousands of dollars. ONS has never denied an MRI to any patient based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients. ONS has treated Medicaid and uninsured patients and provides services to the Greenwich Hospital Orthopedic Clinic.
- ARC does not reliably prove that the number of Medicaid beneficiaries is increasing and that its Medicaid volume will increase.[6] There is no unmet need for the Medicaid population as this population is well-served. ARC presents conflicting information in its own application regarding Medicaid. In its own CON application ARC presents an estimate in its GE survey that shows a growth of 14% in Medicaid Expansion and 15% in Medicare.[7] However, these drastic projected increases in Medicaid and Medicare populations are not factored into

[5] ARC Testimony at 17.
[6] ARC Testimony at 18.
[7] Docket No. 16-32096, "*Advanced Radiology MRI Centers Limited Partnership Acquisition of 3.0 Tesla MRI Unit For Stamford Office*" at 63 (June 14, 2016) (hereinafter the "ARC Application").

ARC's projected payor mix presented in its own application.[8] Specifically, ARC has not calculated any additional anticipated Medicaid population into its projected payor mix. In ARC's financial projections, there are no additional allocations for uninsured patients.[9] ARC continues to represent it will have a Medicaid patient population of 3.89% in 2016 and until 2019.[10] Therefore, ARC does not present reliable information on the Medicaid population as it does not rely on such information in its own application.

- ARC falsely and inaccurately states that "ONS's volume projections shows that the practice intends to take back a significant percentage of the MRI scans that its physicians refer to ARC and other providers."[11] ONS is not taking back volume. On the contrary, ONS can never perform all MRIs that need to be done on its patients for all the reasons set forth in Attachment D of Dr. Mark Camel's pre-filed testimony. Specifically, the number of scans required in ONS's service area will always be more than the number of MRIs performed at ONS because some patients will require an MRI on a 3.0T or can only tolerate an open MRI and certain NY residents may choose to have an MRI scan closer to their home in New York, the same is true for other ONS Connecticut patients who work in New York. Certain ONS patients may not receive scans on ONS's scanner even if the Proposed Scanner is approved, such patients will continue to require scans at other providers for reasons including but not limited to scanner capability. Specifically, certain head injury patients, patients with varying kinds of embedded hardware, patients who require diffuse tensor imaging, and patients who cannot handle a longer duration scan may require scans performed on a 3.0T scanner. In addition, certain patients may receive scans on other MRIs based on commercial insurance

[8] ARC Application at 134.
[9] *Id.*
[10] ARC Application at 41.
[11] ARC Testimony at 20.

participating provider status, for example, workers' compensation does not allow patients to be scanned at ONS. As stated above, some New York patients will receive scans at New York providers for reasons of geographic preference. Finally, some patients seek an MRI at another location because they are able to obtain an MRI scan closer to their home. ONS does not refer patients to ARC due to ARC's inferior scan quality and ONS's inability to utilize the scans during surgery. As important, individuals who become patients of ONS may have had MRIs before arriving at ONS or may need to be sent to another MRI provider based on the specific needs of the patient. Even if approved, the proposed MRI ONS will not recapture all of the MRI scans or even a significant amount of the MRI scans being performed by other MRI providers. ONS will always be ordering more MRIs than it can accommodate.

- ARC falsely and inaccurately states that ONS cannot account for a projected 22% increase in scan volume.[12] ARC inaccurately attempts to break down scan volume by provider. As stated in its completeness responses, ONS does not track patient volume by provider.[13] Patient volume and MRI utilization are tracked by the office as a whole. In 2012, the average number of scans per physician was 267. With respect to years 2017-2019, a rate of 267 scans per physician is assumed.[14] ONS projections for 2017 are based on the fact that ONS will accommodate backlogs for its own patients and will get greater throughput on both machines. ARC's statement is based on speculation, are contrary to ONS information and should be stricken from the record.

[12] ARC Testimony at 23.
[13] ONS Application at 94 (completeness responses dated 5.11.16).
[14] ONS Application at 94 (completeness response filed 5.11.16).

- ARC falsely and inaccurately states that "[p]roviders like ARC are already accommodating ONS's overflow scans, and we will continue to do so despite our own capacity constraints."[15] ARC is not handling ONS's overflow. As stated above, ONS does not refer scans to ARC. ONS's acquisition of a second unit is not an unnecessary duplication of MRI services. There is insufficient capacity pursuant to the standards as outlined in the Statewide Health Plan as well as the utilization and capacity of all MRI providers in the region as well.
- ARC falsely and inaccurately states that "the ability to coordinate care is no better when an orthopedic practice owns its own MRI unit." In fact, when ONS patients do not have to travel to other facilities to receive MRI scans, ONS is able to accomplish better patient compliance with receiving an MRI as well as with treatment plan protocol by having onsite MRI. ARC only "suspects" that turnaround time is similar to its own scanners but lacks any such factual analysis.[16] ARC's statement is baseless and does not reflect ONS's information regarding the same and should be stricken.
- ARC falsely and inaccurately states that there is less risk of overutilization and increased costs for patients and payors because it does not self-refer patients.[17] ARC's statements on the negative impact of self-referred MRI scans are not applicable to ONS. ARC's evidence supporting its statement is extremely outdated. ARC relies on studies that that are approximately 25, 30 and 20 years old and, as important, such studies are not specific to MRI or orthopedic or neurosurgical practice. Federal and state regulations relating to in-office imaging have evolved substantially in the past 20-30 years and thus these articles no longer present persuasive arguments. Further, the cited studies do not take into account the

[15] ARC Testimony at 23.
[16] ARC Testimony at 24.
[17] ARC Testimony at 24.

appropriateness of use of imaging: "it is not possible to determine which group of physicians [self-referring and radiologist-referring] uses imaging more appropriately."[18] Therefore, ARC's statements are false and misleading.

Conclusion

Consistent with the foregoing, ARC's statements in its pre-filed testimony are inaccurate, irrelevant and/or intentionally misleading and should be stricken. Thank you for allowing us the opportunity to submit this rebuttal.

Respectfully Submitted,

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

BY: _____

Michele M. Volpe, Juris No. 412124
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New Haven, Connecticut 06511
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mmv@bvmlaw.com
Its Attorney

[18] Applicant's Pre-Filed Testimony at 178 quoting Hillman, M.D., Bruce, et al, N Eng J. Med 1990: 323:1604-1608 (December 6, 1990).

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 29th day of August 2016 to the following:

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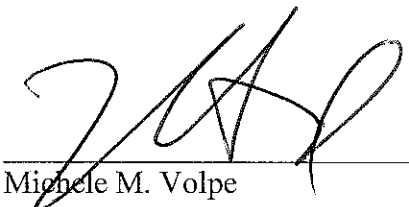

Michele M. Volpe
Bershtein, Volpe & McKeon P.C.

Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Monday, August 29, 2016 5:47 PM
To: Hansted, Kevin; Lazarus, Steven; Riggott, Kaila; Fernandes, David; Greer, Leslie; User, OHCA; Veyberman, Alla
Cc: Jennifer Groves Fusco; kwackerman@jeffers-law.com; 'pmonahan@pppclaw.com'; Michele Volpe; Jennifer O'Donnell
Subject: Docket No. 16-32063 - ONS Rebuttal to TSH
Attachments: ONS Rebuttal to TSH (8.29.16).pdf

Please see attached with respect to the above-captioned docket.

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
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DEPARTMENT OF PUBLIC HEALTH	:	
DIVISION OF OFFICE OF	:	
HEALTH CARE ACCESS	:	**DOCKET NO. 16-32063-CON**
	:	
IN RE: ORTHOPAEDIC & NEUROSURGERY	:	
SPECIALISTS, P.C.	:	
ACQUISITION OF MAGNETIC	:	
RESONANCE IMAGING SCANNER	:	**AUGUST 29, 2016**

REBUTTAL OF ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C. IN RESPONSE TO THE STAMFORD HOSPITAL'S REPLY TO OBJECTION OF ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C. TO PETITION OF THE STAMFORD HOSPITAL FOR INTERVENOR STATUS WITH FULL PROCEDURAL RIGHTS

Othopaedic & Neurosurgery Specialists, P.C., the applicant in the above-captioned matter ("ONS" or the "Applicant"), hereby submits the following rebuttal in response to The Stamford Hospital's ("TSH's" or "Petitioner's") Reply to Objection of Orthopaedic & Neurosurgery Specialists, P.C. to Petition of The Stamford Hospital for Intervenor Status With Full Procedural Rights (the "Reply to Objection") filed in ONS's Certificate of Need application.[1]

TSH has made the following inaccurate, irrelevant and/or intentionally misleading statements through the Reply to Objection, which ONS rebuts and asks that these statements be stricken from the record. These statements are as follows:

- TSH falsely and inaccurately states that ONS has a "deliberate failure to provide any meaningful services to [Medicaid and indigent] populations both presently and in the past."[2] TSH also inaccurately and falsely states that it will provide testimony regarding "a provider that does not participate in Medicaid or provide meaningful services to other underserved populations…"[3] These statements are false as ONS provides services to the Medicaid and

[1] Docket No. 16-32063-CON "*Orthopaedic & Neurosurgery Specialists, P.C. Acquisition Of Magnetic Resonance Imaging Scanner*" (January 21, 2016) (hereinafter the "ONS Application").
[2] Reply to Objection at 2.
[3] Reply to Objection at 3.

indigent populations. ONS has never denied an MRI to any patient based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients. ONS sees patients with Medicaid as their primary or secondary insurance. ONS writes off care provided to these patients and such write off in 2015 is hundreds of thousands of dollars. ONS provides Medicaid neurosurgery care at its office. Additionally, ONS works one on one with patients who may be unable to pay part or all of the bills. Based on the specific patient's circumstances, the patient may be offered a payment plan or a payment discount/adjustment. ONS has dedicated insurance specialists to assist patients with questions regarding out of network care, copays, deductibles and other insurance and financial need questions. In addition to the Medicaid patients, in 2015 ONS saw 46 patients who had no health insurance. Additionally, ONS provides a surgeon and physician assistant to the Greenwich Hospital Orthopedic Clinic one (1) day a week from 1-4 PM, three (3) weeks of each month. On average, ONS providers see twelve (12) patients in a day. These patients include Medicaid and uninsured. Services to these patients are all provided pro bono including any surgeries that result from the visits. The surgery value alone of the free care to Medicaid patients in 2015 was in excess of $200,000. ONS is committed to serving the orthopedic needs of all residents of the service area. The Petitioner's statement is wholly inaccurate and should be stricken from the record.

- TSH falsely and inaccurately states that "the Applicant was silent as to which "office" of ONS it planned for the location of the proposed MRI throughout the entirety of its initial 84-page CON submission. The intention to place the proposed MRI in Greenwich was only revealed after OHCA asked ONS to confirm the Greenwich location in its first set of

completeness questions."[4] In fact, ONS clearly lists its proposed project location as the Greenwich office on page 10 of the application. Further, ONS has never refused to indicate where it will locate the proposed MRI. The Petitioner's statement is wholly inaccurate and should be stricken from the record.

- TSH falsely and inaccurately states that ONS has "overflow patients." ONS does not have overflow patients. On the contrary, ONS can never perform all MRIs that need to be done on its patients for all the reasons set forth in Attachment D of Dr. Mark Camel's pre-filed testimony. Specifically, the number of scans required in ONS's service area will always be more than the number of MRIs performed at ONS because some patients will require an MRI on a 3.0T or can only tolerate an open MRI and certain New York residents may choose to have an MRI scan closer to their home in New York, the same is true for other ONS Connecticut patients who work in New York. Certain ONS patients may not receive scans on ONS's scanner even if the Proposed Scanner is approved, such patients will continue to require scans at other providers for reasons including but not limited to scanner capability. Specifically, certain head injury patients, patients with varying kinds of embedded hardware, patients who require diffuse tensor imaging, and patients who cannot handle a longer duration scan may require scans performed on a 3.0T scanner. In addition, certain patients may receive scans on other MRIs based on commercial insurance participating provider status. As important, individuals who become patients of ONS may have had MRIs before arriving at ONS or may need to be sent to another MRI provider based on the specific needs of the patient. Even if approved, the proposed MRI will not recapture all of the MRI scans or even a significant amount of the MRI scans being performed by other MRI providers. ONS

[4] Reply to Objection at 2 (footnote 3).

will always be ordering more MRIs than it can accommodate. Thus, the Petitioner's statement is wholly inaccurate and should be stricken from the record.

Conclusion

Consistent with the foregoing, TSH's statements in the Reply to Objection are inaccurate, irrelevant and/or intentionally misleading and should be stricken from the record. Thank you for allowing us the opportunity to submit this rebuttal.

Respectfully Submitted,

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

BY: _____

Michele M. Volpe, Juris No. 412124
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Tel. No. 20 3 777-5800
Fax No. 203 777-5806
mmv@bvmlaw.com
Its Attorney

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 29th day of August 2016 to the following:

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Michele M. Volpe
Bershtein, Volpe & McKeon P.C.

Olejarz, Barbara

From: Hansted, Kevin
Sent: Tuesday, September 06, 2016 3:01 PM
To: Olejarz, Barbara
Cc: Riggott, Kaila
Subject: FW: Docket No. 16-32063-CON
Attachments: ONS Rebuttal to TSH (8.29 (00063306xAE9B0).pdf

Barbara,

Please add to the record.

Kevin T. Hansted
Staff Attorney
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7044
kevin.hansted@ct.gov

From: Stephen Cowherd [mailto:SCowherd@jeffers-law.com]
Sent: Tuesday, September 06, 2016 2:59 PM
To: Hansted, Kevin <Kevin.Hansted@ct.gov>
Cc: 'Michele Volpe' <michelemvolpe@aol.com>; Jennifer Groves Fusco <jfusco@uks.com>
Subject: Docket No. 16-32063-CON

Hearing Officer Hansted:

At the beginning of the August 30, 2016 Public Hearing in the above docket, OHCA issued a scheduling order by which ONS was to convert the attached ONS Rebuttal (submitted after close of business on August 29, 2016 and after OHCA had ruled on Stamford Hospital's Petition for Intervenor Status) into a Motion that would be filed with OHCA by Friday, September 2 and objected to by Stamford Hospital by September 9, 2016.

In discussions with ONS counsel, it is my understanding that ONS has not and will not be submitting such a Motion. Accordingly, Stamford Hospital stands on its original objection to the attached ONS Rebuttal for the reasons stated on the record at the Public Hearing.

Respectfully submitted,

Stephen M. Cowherd | Jeffers Cowherd P.C.
55 Walls Drive | Fairfield | CT | 06824| ☎: 203.259.7900 | 🖷: 203.259.1070 | ✉: scowherd@jeffers-law.com

JEFFERS
COWHERD
ATTORNEYS AT LAW

DEPARTMENT OF PUBLIC HEALTH	:	
DIVISION OF OFFICE OF	:	
HEALTH CARE ACCESS	:	**DOCKET NO. 16-32063-CON**
	:	
IN RE: ORTHOPAEDIC & NEUROSURGERY	:	
SPECIALISTS, P.C.	:	
ACQUISITION OF MAGNETIC	:	
RESONANCE IMAGING SCANNER	:	**AUGUST 29, 2016**

REBUTTAL OF ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C. IN RESPONSE TO THE STAMFORD HOSPITAL'S REPLY TO OBJECTION OF ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C. TO PETITION OF THE STAMFORD HOSPITAL FOR INTERVENOR STATUS WITH FULL PROCEDURAL RIGHTS

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[2] Reply to Objection at 2.
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Conclusion

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Respectfully Submitted,

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

BY: _____

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Fax No. 203 777-5806
mmv@bvmlaw.com
Its Attorney

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 29th day of August 2016 to the following:

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Attorney
Updike, Kelly & Spellacy, P.C.
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Karen P. Wackerman
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Michele M. Volpe
Bershtein, Volpe & McKeon P.C.

Olejarz, Barbara

From: Olejarz, Barbara
Sent: Monday, August 29, 2016 3:01 PM
To: Karen Wackerman (kwackerman@Jeffers-Law.com); Michele Volpe (mmv@bvmlaw.com); Kathleen Gedney (kgg@bvmlaw.com); Patrick J. Monahan II (pmonahan@pppclaw.com); Jennifer Groves Fusco (jfusco@uks.com)
Cc: Veyberman, Alla; Fernandes, David; Riggott, Kaila; Greer, Leslie; Hansted, Kevin
Subject: Hearing scheduled for August 30, 2016
Attachments: Directions to the Office of Health Care Access revised.doc; 32063 table.doc; 32093 table.doc; 16-32063 16-32093 Combined Agenda KH.docx

Tracking:

Recipient	Delivery
Karen Wackerman (kwackerman@Jeffers-Law.com)	
Michele Volpe (mmv@bvmlaw.com)	
Kathleen Gedney (kgg@bvmlaw.com)	
Patrick J. Monahan II (pmonahan@pppclaw.com)	
Jennifer Groves Fusco (jfusco@uks.com)	
Veyberman, Alla	Delivered: 8/29/2016 3:01 PM
Fernandes, David	Delivered: 8/29/2016 3:01 PM
Riggott, Kaila	Delivered: 8/29/2016 3:01 PM
Greer, Leslie	Delivered: 8/29/2016 3:01 PM
Hansted, Kevin	Delivered: 8/29/2016 3:01 PM

8/29/16

Attached are the Table of Records and Tentative Agenda for tomorrow's hearing. Also attached are directions to the Office, if there is not a visitor parking space in the back lot when you arrive the guard will direct you to where you can park.

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

Directions to the Office of Health Care Access

From I-91 North or South and from East of the River:

In Hartford take I-84 westbound. Exit at Asylum Street, exit 48.

At the signal at the bottom of the ramp, make a gradual right, staying to the left of the fork in the road.

At the first light, take an immediate left onto Broad Street.

Travel on Broad Street to the light at the first four-way intersection; take a right onto Capitol Avenue. OHCA (tan brick building at 410 Capitol Avenue) is two blocks down on the right.

* Pass 410 and enter in the driveway between 410 and 450 Capitol Avenue. Turn right into the parking lot behind the building and proceed to the Security building in the lot. You will be directed to available parking.

From the West:

Take I-84 East to Capitol Avenue, Exit 48B. Bear right on the exit ramp. At the end of the ramp, turn right onto Capitol Avenue. OHCA is 3 blocks down on the right (tan brick building at 410 Capitol Avenue).

Proceed from * above

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Orthopaedic & Neurosurgery Specialists, P. C.**

DOCKET NUMBER: **16-32063-CON**

PUBLIC HEARING: **August 30, 2016 at 10:00 am**

PLACE: **Department of Public Health, Office of Health Care Access**
470 Capitol Avenue, Conference Room A/B
Hartford, CT 06134

EXHIBIT	DESCRIPTION
A	Letter from Orthopaedic & Neurosurgery Specialists, P.C. (Applicant) dated January 20, 2016 enclosing the Certificate of Need (CON) application for the acquisition of a 1.5 tesla MRI scanner at is private physician practice under Docket Number 16-32063, received by OHCA on January 21, 2016. (84 Pages)
B	OHCA's letter to the Applicants dated February 19, 2016, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 16-32063.(2 Pages)
C	Applicants responses to OHCA's letter of February 19, 2016, dated March 30, 2016 in the matter of the CON application under Docket Number 16-32063, received by OHCA on March 30, 2016. (11 Pages)
D	OHCA's letter to the Applicants dated April 29, 2016, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 16-32063.(2 Pages)
E	Applicants responses to OHCA's letter of April 29, 2016, dated May 11, 2016 in the matter of the CON application under Docket Number 16-32063, received by OHCA on May 11, 2016. (3 Pages)
F	OHCA's letter to the Applicants dated June 13, 2016 deeming the application complete in the matter of the CON application filed under Docket Number 16-32063. (1 page)
G	Letters from the public in the matter of the CON application filed under Docket Number 16-32063. (1 page)
H	Letter from Advanced Radiology dated June 21, 2016 in the matter of the CON application filed under Docket Number 16-32063. Received by OHCA on June 23, 2016. (7 pages)

I	Letter from the Applicants to OHCA dated July 7, 2016 responded to Advanced Radiology's letter dated June 21, 2016 in the matter of the CON application filed under Docket Number 16-32063. Received by OHCA on July 7, 2016. (3 pages)
J	Designation of Hearing Officer in the in the matter of the CON application under Docket Number 16-32063, dated July 25, 2016. (1 page)
K	OHCA's request for legal notification in *The Advocate* of OHCA's Notice to the Applicants of the public hearing scheduled for August 30, 2016, and an order consolidating this hearing with Docket Number 16-32093 for hearing purposes in the matter of the CON application under Docket Number 16-32063, dated August 5, 2016. (5 pages)
L	Applicants letter to OHCA dated August 8, 2016 requesting to receive copies of all correspondence from Docket Number 16-32093-CON in the matter of the CON application under Docket Number 16-32063, received by OHCA on August 8, 2016. (2 pages)
M	OHCA's letter to the Applicants dated August 10, 2016 requesting prefile testimony and enclosing issues in the matter of the CON application under Docket Number 16-32063. (3 pages)
N	Letter from Advanced Radiology MRI Centers Docket Number (16-32093-CON) objecting to request to receive copies of all correspondence by the Applicant in the matter of the CON application under Docket Number 16-32063-CON, received by OHCA on August 10, 2016.(8 pages)
O	Letter from the Applicants to OHCA dated August 23, 2016 enclosing prefile testimony, responses to issues and noticing the appearance of attorney Michele Volpe in the matter of the CON application under Docket Number 16-32063, received by OHCA on August 23, 2016. (41 pages)
P	Letter from Advanced Radiology MRI Centers Limited Partnership ("Petitioner") to OHCA dated August 25, 2016 requesting intervenor status and enclosing notice of attorney appearance and prefile testimony in the in the matter of the CON application under Docket Number 16-32063, received by OHCA on August 25, 2016. (106 pages)
Q	Letter from Stamford Hospital ("Petitioner") to OHCA dated August 25, 2016 requesting intervenor status and enclosing notice of attorney appearance and prefile testimony in the in the matter of the CON application under Docket Number 16-32063, received by OHCA on August 25, 2016. (10 pages)
R	Letter from the Applicant to OHCA dated August 26, 2016 enclosing their objection to Stamford Hospital's request for intervenor status in the in the matter of the CON application under Docket Number 16-32063, received by OHCA on August 26, 2016. (4 pages)
S	Letter from the Applicant to OHCA dated August 29, 2016 enclosing objection to petition of Advance Radiology Consultants LLC request for intervenor status in the in the matter of the CON application under Docket Number 16-32063, received by OHCA on August 29, 2016. (8 pages)

T	OHCA's Ruling on a Petition filed by Advanced Radiology MRI Centers Limited Partnership to be designated as an Intervenor in the matter of the CON application under Docket Number 16-32063, dated August 29, 2016. (1 page)
U	OHCA's Ruling on a Petition filed by The Stamford Hospital to be designated as an Intervenor in the matter of the CON application under Docket Number 16-32063, dated August 29, 2016. (1 page)

Administrative Notice:

- Administrative notice is take of Docket Number: 16-32093-CON, Advanced Radiology MRI Centers Limited Partnership

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

Docket Number: 16-32063-CON
Orthopaedic & Neurosurgery Specialists, P. C.
Acquisition of Magnetic Resonance Imaging Scanner

And

Docket Number: 16-32093-CON
Advanced Radiology MRI Centers
Acquisition of a 3.0 Tesla MRI Unit

August 30, 2016 at 10:00 am

I. Convening of the Public Hearing

II. Docket Number: 16-32063-CON

- **A. Applicant's Direct Testimony**
- **B. Intervenors' Direct Testimony**
- **C. Applicant cross-examination of Intervenors**
- **D. Advanced Radiology MRI Centers' cross-examination of Applicant**

III. Docket Number: 16-32093-CON

- **A. Applicant's Direct Testimony**
- **B. Intervenors' Direct Testimony**
- **C. Applicant cross-examination of Intervenors**
- **D. Orthopaedic & Neurosurgery Specialists, PC's cross-examination of Applicant**

IV. OHCA Questions

V. Closing Remarks

VI. 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

TENTATIVE AGENDA

Docket Number: 16-32063-CON
Orthopaedic & Neurosurgery Specialists, P. C.
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V. Closing Remarks

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Connecticut Department of Public Health

Office of Health Care Access

~~**APPLICANT**~~ Intervenors

(Only persons speaking on behalf of Applicants must sign in)

PUBLIC HEARING-SIGN UP SHEET

August 30, 2016

10:00 am

Docket Number: 15-32063-CON +32093

Orthopaedic & Neurosurgery Specialists, P. C.

Acquisition of Magnetic Resonance Imaging Scanner

PRINT NAME	Phone	Email	Title
Ruth Cardillo			V.P. Enterprise Risk Mgt
Alan Kaye	203 691-6125		Member
Clark Yobbe			CEO - Adrad
IAN KAROL			ARC - Advanced Rad Consultants
Gerard Muro			Physician - Advanced Radiology

Intervenors

Docket 06:32093 ARC

PRINT NAME	Phone	Email	Title
Mary Heffernan	203 858 5840	maryheffernan@optonline.net	Principal, Tunnery Lane Partners
Pat Monahan	203-588-6016	pmonahan@goodlaw.com	Attorney PPP&C for West Med
Richard Morel	914-831-6864	rmorel@westmedgasp.com	Westmed Medical Group
PAT GERNER	860 794-1907	KLG1@ad.com	PRINCIPAL, LAW OFFICE OF PATRICIA A. GERNER, LLC
Jon Weiss MD	914 682 6431	jweiss@westchestermed.com	Westmed
Dennis Condon	203 696-3611	dennis.condon@adrad.com	COO Advanced Radiology
Carol Fria	203 696 3609	carol.fria@adrad.com	Dir of Finance Advanced Radiology
JOHN SCO	203 780 8316	JHSCO@UKC.com	ARC
Dr. Mark Camel ONS			

Applicant Sign up-*Only persons speaking behalf of the Applicant may put their names on this sheet*

Office of Health Care Access

APPLICANT

(Only persons speaking on behalf of Applicants must sign in)

PUBLIC HEARING-SIGN UP SHEET

August 30, 2016
10:00 am

Docket Number: 16-32093-CON + 32063
Advance Radiology MRI Centers
Acquisition of a 3.0 Tesla MRI Unit

PRINT NAME	Phone	Email	Title
Michele Volpe			BVM, for ONS
Mark Camel, MD.			ONS
Kathleen Tommaso			BVM, for ONS
CLARK YODER			CEO - Advanced Radiology
IAN KAROL			Advanced Radiology

PRINT NAME	Phone	Email	Title
Gerard Muro			Physician Advanced Radiology
Dennis Conda	2036963611	dennis.conda@adrad.com	Adv. Rad
Alan Kaye	203 696-6125		
Carol Fria	2036963609	Carol.fria@adrad.com	Advanced Radiology Dir of Finance
Jennifer Tusco	2037866831 ce	JTUSCO@UKS.com	ARC
Dr. Scott Sullivan			Greenwich Radiology

Applicant Sign up-*Only persons speaking behalf of the Applicant may put their names on this sheet*

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.
ACQUISITION OF MAGNETIC RESONANCE IMAGING SCANNER

DOCKET NO. 16-32063-CON

AND

ADVANCED RADIOLOGY MRI CENTERS
ACQUISITION OF A 3.0 TESLA MRI UNIT

DOCKET NO. 16-32093-CON

AUGUST 30, 2016

10:00 A.M.

DEPARTMENT OF PUBLIC HEALTH
410 CAPITOL AVENUE
HARTFORD, CONNECTICUT

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

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Orthopaedic & Neurosurgery Specialists, P.C., acquisition of Magnetic Resonance Imaging scanner and Advanced Radiology MRI Centers, acquisition of a 3.0 Tesla MRI unit, held at the Department of Public Health, 410 Capitol Avenue, Hartford, Connecticut, on August 30, 2016 at 10:00 a.m. . . .

HEARING OFFICER KEVIN HANSTED: Good morning, everyone. This public hearing before the Office of Health Care Access is being held on August 30, 2016 to consider applications by Orthopaedic & Neurosurgery Specialists, P.C. for the acquisition of an MRI, which has been identified as Docket No. 16-32063-CON, and an application by Advanced Radiology MRI Centers, Limited Partnership, for the acquisition of an MRI, which has been identified as Docket No. 16-32093-CON.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a(f)2, and will be conducted as a contested case, in accordance

with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Kevin Hansted, and I have been designated as the Hearing Officer for these matters.

The staff members assigned to assist today are Kaila Riggott, Steven Lazarus and Alla Veyberman. The hearing is being recorded by Post Reporting Services.

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

Orthopaedic & Neurosurgery Specialists, P.C. and Advanced Radiology MRI Centers, Limited Partnership, have been designated as parties under their respective docket numbers.

Advanced Radiology MRI Centers, Limited Partnership has been granted Intervenor status with full rights in Docket No. 16-32063-CON, and Orthopaedic & Neurosurgery Specialists, P.C. has been granted Intervenor status with full rights in Docket No. 16-32093-CON.

The Stamford Hospital has been granted Intervenor status with limited rights in Docket No. 16-32063-CON, and Westchester Medical Group, P.C. has been

granted Intervenor status with limited rights in Docket No. 16-32093-CON.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record in these matters.

All documents have been identified in the Table of the Record for reference purposes. Mr. Lazarus?

MR. STEVEN LAZARUS: Good morning. Steven Lazarus. First, I will read the exhibits that we're going to be entering in Docket No. 16-32063. That's for the Orthopaedic & Neurosurgery Specialists, P.C. We're entering into the exhibit, into the record, Exhibit A through U, and, also, we're going to be noticing a filing that was received this morning that was for the rebuttal of Orthopaedic & Neurosurgery Specialists, P.C. in response to the Stamford Hospital reply to the objection of ONS.

HEARING OFFICER HANSTED: Thank you. Counsel, are there any objections or any corrections that need to be made? I understand, Attorney Volpe, there may be one?

MS. MICHELE VOLPE: Yes. Michele Volpe, legal counsel for Orthopaedic & Neurosurgery Specialists.

We have one correction. Exhibit G, a

letter from the public in the matter of the CON application, that should not be in this record. That is for Connecticut Orthopaedic Specialists, and it is Town of Essex letter from the Selectman's office, from the First Selectman. That belongs in a different docket for COS.

HEARING OFFICER HANSTED: So that should be in 16-32093-CON?

MS. VOLPE: If that's Connecticut Orthopaedic Specialists docket, yes.

HEARING OFFICER HANSTED: That is.

MS. VOLPE: Yes.

HEARING OFFICER HANSTED: Yes, okay.

MS. VOLPE: Yes.

MS. JENNIFER GROVES FUSCO: No. Actually, 32093 is our docket in this case. I think Michele has a letter that belongs in the application that was just filed by Connecticut Orthopaedic Specialists.

MS. VOLPE: The Specialists, COS, yes.

HEARING OFFICER HANSTED: Okay, not the one before us right now?

MS. GROVES FUSCO: Neither one.

MS. VOLPE: Correct.

HEARING OFFICER HANSTED: Okay. Thank

you. We'll have that removed.

MS. VOLPE: Okay.

MR. LAZARUS: And then we have Table of the Record for Docket No. 16-32093.

MR. STEPHEN COWHERD: Excuse me, Steven.

MR. LAZARUS: Yes?

COURT REPORTER: I'm sorry.

HEARING OFFICER HANSTED: Steve, can you come up to a microphone, please?

MR. COWHERD: Sure. This is an objection to the record on the ONS application. Stephen Cowherd on behalf of Stamford Hospital.

Hearing Officer Hansted, members of OHCA staff, I'm interposing an objection to the rebuttal that ONS submitted to the response of Stamford Hospital's reply to their objection for Intervenor status.

That was not testimony. That was a reply to an ONS objection. The Office of Health Care Access made its ruling on Intervenor status at 2:12 p.m. That's when I received it.

The rebuttal was submitted at 5:46 p.m., so the whole issue was moot. This is not rebuttal to testimony that Stamford Hospital supplied. It is rebuttal to our reply to their objection.

The Office of Health Care Access already ruled on that matter at 2:00 p.m. for ONS to submit at 5:46 p.m. A rebuttal to that objection is wholly improper. It's not testimony, so we'd ask first that it be stricken from the record, and, secondly, since you can't unring the bell that it's been submitted to the agency, in Stamford Hospital's closing remarks, we'd like to address those issues.

HEARING OFFICER HANSTED: If it's a rebuttal to an objection, based upon the Intervenor status, then it's moot, since the Intervenor order has already been sent out, so, with that respect, I won't strike it, but it's moot. We'll give it any weight it's due, which, at this point, is due none.

With respect to responding to it at the end of this hearing, I'm not going to allow that, because, as I just stated, it's a moot filing anyway at this point.

MR. COWHERD: I'd still like to reserve our ability on closing remarks to address the application.

HEARING OFFICER HANSTED: All right.

MR. COWHERD: Thank you.

MS. VOLPE: Hearing Officer Hansted, thank

you. Just for point of clarification on that, from our perspective, when it does come time for the Intervenor to make a statement, if they are making false statements in the record, we don't want to disrupt the proceedings, but we do want to object and not allow them to make false statements in the record.

HEARING OFFICER HANSTED: Well, counsel, you have the ability to Cross-Examine the Intervenor, okay? So if they make any statements, which you feel are incorrect, you can Cross-Examine on those.

MS. VOLPE: But they'll be allowed to make false statements in the record --

HEARING OFFICER HANSTED: Well I don't know if they're necessarily false statements.

MS. VOLPE: Okay.

HEARING OFFICER HANSTED: I mean that's why we're here. They're going to present their evidence, and you're going to present your evidence to rebut that, okay?

MS. VOLPE: Right, but just for point of clarification, our clients have had to attest to the testimony and the pre-file, whereas the Intervenor just has their lawyer making a statement, so, in terms of Cross, they haven't submitted pre-filed testimony by an

individual.

Some of the false statements were made by an attorney in a filing.

HEARING OFFICER HANSTED: Attorney Cowherd, do you have any witnesses here, who are going to make a statement?

MR. COWHERD: I do. I expect that the witness will be Cross-Examined on the testimony, the pre-filed testimony that was submitted by Stamford Hospital, and that’s perfectly appropriate.

Beyond the scope of that testimony, Stamford Hospital will object.

HEARING OFFICER HANSTED: Okay, counsel, so he has witnesses he’ll present to make statements, and you can Cross-Examine those witnesses at the appropriate time.

MS. VOLPE: Understand and appreciate that. Our concern is with false statements that were made by legal counsel, without an opportunity to address those. That’s why we asked that they be stricken from the record.

HEARING OFFICER HANSTED: Well and you’ve submitted a motion in that respect?

MS. VOLPE: Yes, we have.

HEARING OFFICER HANSTED: Okay and I'll reserve ruling on that. I'll make a written ruling on that, but, for today, I'll accept those statements.

MS. VOLPE: Okay.

MR. COWHERD: I'm sorry. What's the motion?

MS. VOLPE: Attorney Cowherd is pointing out that the title of the motion should have been a request to strike false statements that were submitted in a filing by Intervenor, as opposed to pre-filed testimony, just for point of clarification, and that was the filing that was submitted last night, just so there's no confusion.

HEARING OFFICER HANSTED: So just for the record, that is Exhibit V, V, as in Victor.

MR. COWHERD: Hearing Officer Hansted, I'm confused. I haven't seen a motion. Where is the motion of ONS?

HEARING OFFICER HANSTED: I don't believe it's specifically titled a motion.

MS. VOLPE: Correct.

HEARING OFFICER HANSTED: It's within that filing they made the request.

MS. VOLPE: Correct.

MR. COWHERD: But I believe that, again, the way we started was, and I don't want to belabor the point, is that they submitted a rebuttal to the reply to their objection for Intervenor status.

Where we started was that that issue was mooted by the ruling of the agency at 2:12 p.m., and correct me if I'm wrong, but we were told that that will be given no weight.

HEARING OFFICER HANSTED: Well it's moot at this point. Why don't we do this, just to clean up the record and to settle this issue?

Attorney Volpe, if you would put a motion in writing?

MS. VOLPE: Can I propose that we just rename what's before you, and we could submit it?

HEARING OFFICER HANSTED: Well what I'd like to you to do is submit a new motion.

MS. VOLPE: Sure.

HEARING OFFICER HANSTED: And I'll allow Attorney Cowherd time to respond to that motion. I think that's only appropriate. And if you could submit that motion -- how long do you need for that motion?

MS. VOLPE: We could have it over to you this morning, now, during the proceedings.

HEARING OFFICER HANSTED: I mean by the end of this week.

MS. VOLPE: Oh, sure.

HEARING OFFICER HANSTED: And then, Attorney Cowherd, I'll give you until the end of the following week to respond.

MR. COWHERD: Thank you.

HEARING OFFICER HANSTED: You're welcome. And just before we go forward, I would -- I mean, you know, we're all professionals here, and I would appreciate it, if any counsel feels that another counsel may be making statements that are incorrect, whether on purpose or in error, please reach out to each other ahead of time.

I would rather not have to deal with those issues at a hearing. It takes up time at the hearing, and I just don't like -- as professionals, I like to give each other a professional courtesy. I don't like people saying that there are lies being told before a Hearing Officer, so if we could, in the future, handle that in that respect, I'd appreciate it.

Mr. Lazarus, if you want to proceed?

MR. LAZARUS: All right. Moving on to the Table of the Record for Docket No. 16-32093, that's for

Advanced Radiology MRI Centers, Limited Partnership, we're taking into the record Exhibits A through T, and also taking administrative notice of Docket No. 16-32063 in this matter.

And going back to the other docket, 16-32063, the application of ARC that was filed under 16-32093, is also being administrative notice in that record.

HEARING OFFICER HANSTED: Okay. Counsel, any objections? Any concerns?

MS. GROVES FUSCO: This is Jennifer Fusco, counsel for Advanced Radiology. No objections, but similar to Attorney Volpe, I have a question, a clarification question, on Exhibit B, which is letters from the public in this matter.

I think it may be that our letters of support were sent -- we attached with our CON application, but may have been delivered to OHCA, as well. If it's something, other than that, I have not seen those letters. I couldn't figure out what that was referencing, so if you could just verify that for me? It doesn't have to be right now.

HEARING OFFICER HANSTED: Okay, we'll take a look at that and contact you.

MS. GROVES FUSCO: Not a problem. Thank you.

HEARING OFFICER HANSTED: You're welcome.

MS. GROVES FUSCO: Other than that, no objections.

HEARING OFFICER HANSTED: Okay. Any other, counsel? Any other issues concerning this?

MS. VOLPE: No.

HEARING OFFICER HANSTED: Thank you. Okay, with respect to today's hearing, what we're going to do is we'll first hear from the Applicants regarding Docket No. 16-32063-CON.

After that, the Intervenors may present their position on that particular project, followed by Cross-Examination by the Applicant in that matter.

Then we will hear from the Applicant regarding the second project under Docket No. 16-32093-CON, again followed by the Intervenor statements and Cross-Examination by the Applicant of the Intervenors.

Upon completion of those, OHCA will ask its questions on each project, and then, after that has concluded, we will hear any public comment.

And just before we proceed, are there any members of the public here at this point? I don't hear

or see anyone, so we'll move on.

And would all those individuals, who are going to testify on behalf of either the Applicants and the Intervenors, please stand, raise your right hand and be sworn in by the court reporter?

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER HANSTED: Okay. Just as a reminder for those of you who submitted pre-filed testimony, after you give your testimony -- I'm sorry. Before you give your testimony, please identify yourselves for the record and adopt your pre-filed testimony on the record.

And those individuals, who were just sworn in, I know space is tight, but if each of you could come up to the microphone and identify yourselves, I'd appreciate it at this time.

MR. CLARK YODER: Clark Yoder, CEO, Advanced Radiology.

HEARING OFFICER HANSTED: Thank you.

DR. ALAN KAYE: Alan Kaye, former CEO, Advanced Radiology, now a member.

DR. GERARD MURO: Dr. Gerard Muro with Advanced Radiology, Chief Medical Information Officer and

Neuroradiologist.

MR. DENNIS CONDON: Dennis Condon, COO for Advanced Radiology.

DR. JONATHAN WEISS: John Weiss, Medical Director of Radiology for WESTMED.

DR. IAN KAROL: Dr. Ian Karol, Radiologist, Radiology Executive Committee, Advanced Radiology.

MS. CAROL FRIIA: Carol Friia, Advanced Radiology, Director of Finance.

MS. RUTH CARDIELLO: Ruth Cardiello, Vice President Enterprise Risk Management for Stamford Hospital.

DR. RICHARD MOREL: Dr. Richard Morel, Medical Director for WESTMED Medical Group.

HEARING OFFICER HANSTED: Okay, do we have everyone?

DR. SCOTT SULLIVAN: Dr. Scott Sullivan, Neuroradiologist and President of Greenwich Radiology Group.

HEARING OFFICER HANSTED: Thank you. And anyone else on this side of the room? We got everyone, who was sworn in? You identified yourselves? Okay. All right, thank you very much, everyone.

And, at this point, we are ready to begin the hearing, and, as I stated before, we'll start with Docket No. 16-32063-CON, and the Applicant may proceed.

MS. VOLPE: Thank you. Michele Volpe, legal counsel for Orthopaedic & Neurosurgery Specialists.

I have here with me this morning Dr. Mark Camel, who would like an opportunity to speak before you and introduce Dr. Sullivan, who is with him.

HEARING OFFICER HANSTED: Thank you. Good morning.

DR. MARK CAMEL: Good morning. My name is Dr. Mark Camel, and I am the Vice President of Orthopaedic & Neurosurgery Specialists, P.C. I adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

DR. CAMEL: I'd like to begin by thanking you, Hearing Officer Hansted and all of the staff, for its consideration of our application to acquire an additional MRI scan to service, scanner, to service our patients in the region.

Here with me today is Dr. Scott Sullivan of Greenwich Radiology. Dr. Sullivan is a fellowship-trained neuroradiologist with decades of experience.

Dr. Sullivan and Dr. Kapil(phonetic)

decide, who is a fellowship-trained bone and joint radiologist, interpret and supervise the MRI services that we provide.

Dr. Sullivan, Dr. Desai are another radiologist that's physically present at ONS's office to interpret all MRI scans.

ONS has demonstrated a clear public need for an additional MRI scanner. ONS has met all of the standards and guidelines for approval of an additional MRI, based on a statewide health plan, as well as the statutory and regulatory requirements for CON approval.

Specifically, under any need methodology applied, as well as the statewide benchmarks, ONS is utilizing its existing scanner well above 85 percent capacity.

Therefore, based on this criteria alone in the statewide health plan, ONS's application should be approved. This is where the need review should end, and the ONS application should be approved.

But taking the needs analysis further and applying ONS's internal growth, as well as the lack of current capacity in the service area of the existing MRI providers, who are collectively operating well above 85 percent capacity limits, the result is the same. This

also shows tremendous need in the service area.

Utilizing OHCA's standard of 4,000 scans outlined in the statewide health plan, the capacity of the existing ONS scanner is operating at 132 percent capacity for 2015.

Every other provider of MRI services in the region is operating at above capacity or close to capacity, and they cannot be relied upon to absorb ONS patients.

For example, Stamford Hospital is operating at 161 percent of capacity, based on the last available data.

Looking to ONS's internal data, we are operating at 92 capacity, based on the number of slots we have available. To meet current patient demand, ONS operates its scanner far beyond normal business hours, which opens up availability to more than the OHCA standard of 4,000 scans per year.

Even with ONS's additional scan capacity, ONS is still operating well above 85 percent. The MRI volumes and hours described in ONS's application are not sustainable on an ongoing basis from either an operations or patient care perspective.

ONS has clearly demonstrated with its

recent growth and with its projected growth in our practice size, based on the growth and the number of physicians, as well as the growing patient demand for our services, this provides the need for an additional MRI scan.

As detailed in our application and my pre-filed testimony, ONS has grown considerably in both recent and past years and so has our MRI volume.

ONS is actively recruiting physicians to keep up with demand, and it follows that our patient numbers will grow, as we've demonstrated and they have done.

ONS has two new physicians starting this fall and is recruiting for two more physicians for the summer.

ONS's proposed MRI will positively impact access and, also, quality in the region. Adding more MRI capacity to ONS practice will increase access to the patient population serviced by ONS.

Approval of the ONS application will have a positive impact on the diversity of health care providers and patient choice in the region.

ONS is a private physician practice in a region heavily dominated by institutional facilities

providing imaging services.

Approval of the ONS application before OHCA will have no impact on the existing providers and will not create duplication of services.

Nearly all of the providers are at capacity or close to reaching capacity. ONS's additional scanner will not impact other providers.

ONS anticipates all of its additional volume will derive from ONS physicians, who, upon joining the practice, and physicians, who are still growing their own practice, as they ramp up to a full patient load, as well accommodate additional intrinsic volume that comes along with further time.

ONS is actively recruiting, as I mentioned, and will continue to employ more professionals as demand grows.

Further, I refer OHCA to the detail needs analysis spelled out in my pre-filed testimony outlining all of the MRIs performed by all of the providers in the region, as well as our application to the methodology, as outlined in the statewide health plan.

Therefore, there will be no unnecessary duplication of MRI services when the proposed MRI is approved.

The number of scans required for our ONS patients will always be more than the number of MRIs performed in ONS, because, for example, some patients require an MRI on a 3T scanner.

Many of our patients work not in our service region, but work either in New York City or further in upstate Connecticut. They choose to have their MRIs closer to home or closer to where they work for convenience.

Certain patients, for example, head injury patients, may require scans that are best done on a 3 Tesla scanner, which can provide diffusion tensor imaging, which is currently under study as an adjunct for assessing patients, especially those who have repetitive concussions.

As already stated, some New York patients receive their scans at New York providers for both professional and residential geographic preference.

There is tremendous consolidation in the health care marketplace. ONS works hard to position the practice to stay independent and physician-owned.

ONS offers patients a community-based private practice that is owned by physicians, offering a cost-effective alternative to institutional care.

Approval of the ONS CON application before you will allow ONS to continue to provide a community-based and independent service. Community-based practices offer more cost-effective services and options for payers in the marketplace, as well as more reasonable cost to patients, who are not otherwise required to absorb facility fees.

ONS complies with all of the policies and regulations adopted by the Department of Public Health. OHCA's approval of ONS's CON application will ensure access to needed MRI in the service area.

Approval of the CON will improve quality, accessibility and cost effectiveness for health care, as delivered in our region.

Advanced Radiology and Stamford Hospital would want OHCA to believe that ONS doesn't serve the Medicaid population. In fact, nothing could be further from the truth.

ONS has been serving the Medicaid and indigent population for decades. ONS provides hundreds of thousands of dollars of free care to Medicaid patients, uninsured, and other patients, who arrive in our area in need of care. ONS has never denied any service, including MRI, to a Medicaid patient.

ONS and Greenwich Hospital work together and have established, many decades before now, a successful coordination of care for the Medicaid and uninsured population.

This coordinated effort should not be interrupted or interfered with, as it has been effective and continues to meet the need of the Medicaid population in Greater Greenwich and surrounding communities.

The Medicaid and poorly or underinsured population usually presents for health care either at the Greenwich Hospital emergency room or to the Greenwich Hospital medical clinic, where they’re first evaluated by a primary care physician.

Once that primary care physician determines that imaging or an MRI is warranted and that MRI gives a diagnosis warranting consultation by an ONS subspecialist, then the patient is seen by an ONS physician.

Denying the ONS CON could have a negative impact on the diversity of health care providers and patient choice in the service area.

The fact that MRIs are obtained at Greenwich Hospital prior to referral to ONS should not be an impediment to approving a second MRI scanner at ONS.

Most important, if OHCA does not approve the ONS application, it could adversely impact the free orthopaedic and neurosurgical care provided currently to Medicaid and indigent patients by ONS.

ONS, though, also sees Medicaid and uninsured patients in its office, the Greenwich Hospital Emergency Room and the Orthopaedic Clinic at Greenwich Hospital.

ONS sees hundreds of Medicaid and indigent patients a year in these settings. Neurosurgery patients, whether they're Medicaid or uninsured patients, are seen in our private office.

The government patient volume and indigent patient numbers have all been outlined in detail in our application.

In 2015, for example, ONS saw 1,476 patients with Medicaid as their primary or secondary insurance. ONS writes off hundreds of thousands of dollars in care provided to these patients. All of the detailed numbers of the care have been provided by ONS and its physicians.

Finally, ONS also works with the ONS Foundation, a 5013c entity committed to orthopaedic research, community education and service.

Orthopaedic research, for both studies that have already been published in peer review journals and research, which is ongoing, MRI data is utilized to evaluate normal surgical approaches.

ONS produces better quality MRIs by having longer scan time for our patients, because longer scan time, both for individual sequences and additional sequences, can result in better quality images and more information for the surgeons making a decision whether to operate and then planning the surgery that's required. This is crucial when the doctor has to utilize these images particularly during surgery.

ONS patients are better served in-house, as patients will benefit from the enhanced communication coordination that occurs with our current in-office imaging.

Additionally, we can measure, monitor and guide treatment on an ongoing basis.

Lastly, ONS's proposal is financially-feasible. We're a financially-sound practice and anticipate that the new scanner will be cash flow positive in the very first year of operation.

This financial performance will allow us to continue to provide hundreds of thousands of dollars

in free care to Medicaid and uninsured patients.

In conclusion, ONS has demonstrated a clear need for an additional MRI scanner in its office, as well as demonstrating that the proposed MRI meets all of the requirements of OHCA guidelines and principles, including, but not limited to, the proposed MRI is consistent with the statewide Health Care Facilities and Services Plan.

ONS's proposed MRI will positively impact access and quality in the region and have no impact on existing providers.

ONS has demonstrated that the proposed MRI strengthens the health care system and cost effectiveness. ONS has demonstrated that the proposed MRI will improve accessibility.

ONS has demonstrated that the proposed MRI improves quality and, finally, demonstrates that this CON is financially-feasible.

We respectfully request that the application be approved. Thank you for your time.

HEARING OFFICER HANSTED: Thank you. Attorney Volpe, do you have anything further?

MS. VOLPE: No. That concludes our presentation. Thank you.

HEARING OFFICER HANSTED: Okay, thank you. At this point, Attorney Fusco, if you want to Cross-Exam, or, I'm sorry, give a presentation at this point on this application? I'm sorry. I'm ahead of myself.

MS. GROVES FUSCO: Yes, we would. On behalf of Advanced Radiology, I'd like to introduce Clark Yoder, the practice's CEO, who is going to begin our presentation, and he will introduce our other witnesses.

HEARING OFFICER HANSTED: Okay, thank you.

MR. YODER: Good morning.

HEARING OFFICER HANSTED: Good morning.

MR. YODER: My name is Clark Yoder. I'm the CEO of Advanced Radiology.

I would like to adopt my pre-filed testimony, including rebuttal testimony submitted in response to testimony of ONS and WESTMED, for the record.

HEARING OFFICER HANSTED: Thank you.

MR. YODER: I would like to thank Hearing Officer Hansted and the OHCA staff for their dedication and time in hearing our case here. I appreciate that.

I joined Advanced Radiology in 2005 as CEO. Prior to Advanced Radiology, I spent 13 years working for Westchester Medical Group in varying capacities, including Director of Ancillary Services, CFO

and Chief Operating Officer.

I hold an MBA and a BS in Radiology, and I am a member of various professional organizations, including the American College of Health Care Executives, Radiology Business Management Association and the Radiological Society of North America.

As you know, Advanced Radiology is a multi-site, full-service diagnostic and interventional radiology outpatient provider.

They have offices located in Stamford, Fairfield, Stratford, Trumbull, Shelton and Orange and provide advanced imaging, including MRI, at each site.

My testimony in opposition to ONS's request for a second self-referral MRI unit for Greenwich will focus on two issues, the first being the adverse impact that acquisition will have on ARC, and, two, ONS's failure to provide access to MRI services for Medicaid recipients, an appreciable number of indigent persons, and the impact that this has on the providers, like ARC, who serve both those populations.

With respect to the adverse impact on ARC, ONS has been a long refer of MRI services, primarily to our Stamford office.

Last year, we performed nearly 80 scans

referred by ONS physicians, and, this year, we are on track to perform 110 ONS-referred MRI exams. The value of these referrals to our practice is approximately 70 to $100,000.

We have very sophisticated business intelligence tools and systems that do track referrals, and we manage referrals throughout our practices in our offices down to the physician level.

ONS's projected volumes show a 1,200-scan or 22 percent increase in the first year of operation. This is entirely inconsistent with the historic MRI growth in that practice, and it is too large of a gain to be attributable to the recruitment of just two new physicians in that year.

It is clear from the projections, themselves, as well as the statements made by ONS in its CON submissions, that the practice intends to redirect the majority of scans it refers out back to the ONS units.

They typically refer out around 1,500 scans a year. Out of those, there are few that need to be referred outside. The rest will be directed back to ONS.

Note, also, there is nothing precluding

ONS from relocating the second MRI unit to its Stamford office, just miles away from the ARC office, without further OHCA approval. Although we are asking that this CON be denied, we join with Stamford Hospital's request that, if it is approved, ONS's right to relocate either of its units outside of Greenwich be limited.

This will mean a loss of revenue for ARC and other providers by approving this CON. Because ONS treats primarily commercial-insured patients, we assume that the majority of those scans we will lose from ARC are insured commercially-insured scans, and that they reimburse at a far higher rate than governmental payers do.

This will also further skew our payer mix towards governmental payers, making ARC less viable financially.

Many of the ONS patients for whom we provide MRI services are longstanding ARC patients. We have served them and continue to serve these patients, despite our own capacity constraints.

Please remember that our Stamford office is a full-service radiology center, providing mammography services and ultrasound services, as well as CAT scan services to the community.

Because ARC and the area hospitals are serving these patients already, an acquisition by ONS of a second unit is unnecessarily duplicative.

With respect to access for vulnerable populations, ONS does not provide access for Medicaid recipients and treats a minimal number of uninsured or self-pay patients.

As conspicuously absent on the ONS website, ONS does not participate with the Medicare program and has not provided a single MRI scan to a Medicaid recipient since its first open scanners eight years ago. No Medicaid scans are projected going forward in ONS's pro forma.

ONS states that it occasionally provides free care to Medicaid beneficiaries in its office. In fiscal year 2015, ONS saw 23 Medicaid patients out of almost 52,000 patients seen by the practice that year.

Compare that in ARC, where, in Stamford, 3.9 percent of our MRI payer mix is Medicaid. Practice-wide indicate MRI payer mix is more than seven percent.

ONS claims that it provides service call and clinical coverage for Medicaid members at Greenwich Hospital, however, as stated in the last rebuttal, they refer Medicaid patients, who need an MRI, only to the

Greenwich Hospital and not to their office.

ARC assumes that ONS does not participate with Medicaid, due to the lower rates of reimbursement. They allude to the fact that the Medicaid population of Fairfield County is low, but in states, like Stamford and Norwalk, it is growing to double-digit percentages, due to health care-related reform and Medicaid expansion.

The statewide health plan prohibits a provider from denying access to Medicaid recipients, and by failing to participate with Medicaid or to self-refer Medicaid patients for MRI scans, ONS is, de facto, denying these individuals access.

ONS's uninsured self-pay MRI percentages are less than one percent. They state that they will try to work with individuals, who cannot pay their bills, but their minimal historic and projected percentage on uninsured scans suggests that this does not happen often.

Compare that with ARC's Stamford MRI and the three percent uninsured and self-pay. By the numbers, ARC Stamford put forth 15 times as many uninsured self-pay scans as ONS, and ARC MRI overall provided nearly 57 times as many uninsured and self-pay scans as ONS.

We are proud of our commitment to serve

our individuals, regardless of their ability to pay. To allow a provider into a market that doesn't accept a full range of payers and patients is both unfair, injurious to ARC and to other providers that do.

In conclusion, ARC is asking that you deny ONS's CON request for permission to acquire a second MRI unit. They have failed to meet statutory decision criteria and State Health Plan guidelines around unnecessary duplication of services and access for Medicaid recipients and indigent persons.

Adding more self-referral MRI capacity to the Stamford market will be a detriment of ARC and to every other provider in the area committed to providing a full range of services to all patients, regardless of their ability to pay.

I want to thank you for allowing me to present. I would like to introduce my colleague, Dr. Alan Kaye.

DR. KAYE: My name is Dr. Alan Kaye. First, I'd like to thank you very much for the opportunity to present here, and I'd like to adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

DR. KAYE: I have been -- I am the former

CEO of Advanced Radiology Consultants since last year, and I have a long history of leadership in the practice, where I was the Chairman of the Department of Radiology at Bridgeport Hospital, the managing member of the LLC, and have also been involved in organized medicine, organized radiology, and state radiological issues, as well as state governmental relations.

I am currently the President, I'm sorry, the Legislative Chair of the Radiological Society of Connecticut, and I am on the Board of Chancellors of the American College of Radiology and serve on the Economics Commission, the Government Relations Commission, the Future Trends Committee, and the Radiology Integrated Care Network at the American College of Radiology.

My pre-filed testimony was largely devoted to the issue of self-referral and how that affects patient care and utilization and cost, and I would like to summarize that here.

What is imaging self-referral? Imaging self-referral is essentially when a physician in position to refer patients is also an owner in the equipment and gains financially from that referral.

Study after study has shown, have shown that this increases the utilization of imaging and

increases the cost of care, without any increase in the improvement in the quality.

Many of the studies cited are early on, but every time it has been -- early on, meaning in the 1980s and 1990s, but every time it has been duplicated, with the latest one being 2012 by the General Accounting Office, which I've shown, and to quote, or to paraphrase the title of the General Accounting Office report, self-referral of advanced medical imaging costs the -- raises utilization and costs Medicare millions of dollars.

As a result of that, President Obama in his 2014 budget asked that the ability, the loophole that allows in-office imaging by physicians, who own the equipment and refer patients, to be banned, and that is that it be closed.

The Office of Management and Budget has put a cost savings on that just for Medicare of $6 billion, recently revised down to $5 billion. We can get into that, if you'd like, as to why.

And, remember, that's just for Medicare, which is, A, only 25 percent of, in general, 25 percent of MRI volumes, and, B, at approximately one half to one quarter of the fees, so if you multiply by four, since it's 25 percent, if you adopted that nationally and

extrapolate that to Connecticut, you will have four times the $6 billion or $5 billion, which would be $20 billion, and then multiply that by the commercial general reimbursement, which is generally two to four times greater, you can imagine we're close to 75 to $100 billion of savings if that were adopted nationally and we could extrapolate that to Connecticut, so it does cost -- every study has shown that it increases utilization and costs a lot more money.

So what has been the policy reaction? I can go through that. I've gone through that in my pre-filed testimony. I'm willing to answer further questions on that, but the general reaction, at least in Connecticut, has been that the CON laws have been strengthened rather than attenuated, and, of course, the Obama budget and the GAO documents are very important in showing that this is a current contemporary issue and not a relic of the past.

What is the role of the CON process in this, and how does self-referral affect the CON process? Well the first thing we always talk about is need, and what everybody talks about is the volume.

First, let me just say that, having served on the Task Force for the State Health Plan for imaging,

the issue of volume is only one aspect of need. It is a necessary hurdle to reach, but not necessarily sufficient to be a criterion that one is entitled to a Certificate of Need approval.

So with respect to volumes, with all of the data that I've talked about and have submitted and will submit more if you'd like, the volume of an existing self-referring provider has to be called into question, at least as a valid number, or at least as the most cost-effective way, and I point you to the General Accounting Office study, as well. So with respect to volume, which is the big one, I think we have a question there.

With respect to quality and access, with respect to quality, a referral to an outside provider, who is not necessarily captive to that practice or dependent upon that practice for a reimbursement for an interpretation, creates an automatic second opinion, a virtual second opinion on the condition of that patient. That's one aspect of quality.

The other is that, in every one of our offices, we have a physician on site, a radiologist on site when the scans are being done. That's both a safety issue with respect to problems that might occur, but, also, it's a situation to be able to triage and modify

the scan criteria or answer technologists' questions during the course of exam, an important oversight. Part of what we get paid for is the oversight of the process and the technologies.

If you look at the CPT codes and the list of the things that we get paid for, imaging providers get paid for, it includes the oversight of the technologists and of the equipment and things like that.

The next thing is access. Well, as a full-service provider for imaging, we need to -- and, by that, I mean not only taking care of patients within our practice, which we do none of, we take care of patients from all types of referring practices, whether it be orthopedists, neurosurgeons, internal medicine, obstetricians, pediatricians, the whole list.

They rely on us to provide state-of-the-art services, and we need to make sure that we do provide that and that we don't make patients wait too long.

We also need to provide services to the broad range, the entire range of payer classes. That includes Medicaid.

We do not say we don't accept Medicaid. We do not say -- we do not discourage Medicaid patients from coming to us. We take care of all payers, and

access, particularly with the, A, the sharp rise of Medicare, of Medicaid beneficiaries in the state, and, particularly, in view of the recent reductions in Medicaid reimbursement that occurred in 2015, we need to make sure that we provide services to them, but, also, provide services to all payers, so that we cannot go out of business, which, if we only did Medicaid, we would, or if our Medicaid percentage went up, that's what would happen to us.

In addition, not only do we accept Medicaid, we have relationships with the clinics, federally qualified clinics, and they refer, as well, so we provide access to all payers.

So I think the last point has to do with competition, and we need to be competitive. Because we rely on referring physicians for referrals and not internally, we need to provide the best service.

That is a competitive situation, and to the extent that ONS and other vertically-integrated providers create their own volume, much like the trusts for the railroad in the old oil and railroad days and much like the Microsoft antitrust litigation, we need -- we are disadvantaged by vertically integrated, and we will additionally be disadvantaged the effect on existing

providers, component of CON, we will be at a further disadvantage if we lose referrals from community physicians, like ONS and others.

I want to thank you very much for the opportunity to do this, to present this, and I ask you to deny ONS's application, and that concludes my comments.

HEARING OFFICER HANSTED: Thank you, Doctor. Attorney Fusco, do you have anyone else?

MS. GROVES FUSCO: No, not for this proceeding.

HEARING OFFICER HANSTED: Can I ask you to -- we're going to have to do a little bit of musical tables here today. Can I ask you to vacate that table, so Attorney Cowherd and his witnesses can come up?

MS. CARDIELLO: Good morning.

HEARING OFFICER HANSTED: Good morning.

MS. CARDIELLO: Thank you for the opportunity to address the Office of Health Care Access in the CON application of Orthopaedic & Neurosurgery Specialists, P.C. to acquire a second MRI scanner.

My name is Ruth Cardiello. I am the Vice President of Enterprise Risk Management for Stamford Hospital, and I also hereby adopt my pre-filed testimony.

Stamford's position is that this

application does not promote the long-term viability of the health care system in lower Fairfield County. As outlined in my pre-trial testimony, there is an abundance of established high-quality MRI providers. This is about fairness in providing services to Medicaid and uninsured patients.

Stamford Hospital is one of the largest providers of charity care and other uncompensated care in the state. If the application is approved and ONS follows through on its ability to relocate, it will add unnecessary capacity and raise the risk of diluting the pool of commercially-insured and Medicare populations that the established providers are able to serve.

The Stamford, Darien and Rowayton market does not need another MRI provider, who does not increase access to health care for the underserved populations in the region in any meaningful way.

For these reasons and those outlined in my pre-filed testimony, Stamford Hospital respectfully urges OHCA, if it decides to approve the application of ONS, to impose as a condition that ONS may not relocate either of its MRIs to the Stamford Hospital service area of Stamford, Darien and Rowayton.

Thank you, and I'm happy to answer any

questions you may have.

HEARING OFFICER HANSTED: Thank you. Attorney Cowherd, do you have anything else at this point?

MR. COWHERD: Nothing further.

HEARING OFFICER HANSTED: Okay. Attorney Volpe, as long as they're up at this table, do you have any Cross-Examination?

MS. VOLPE: No, I don't.

HEARING OFFICER HANSTED: Okay, thank you. You're welcome to return to your seat, and, Attorney Fusco, if you want to bring your folks back up? We don't have any questions for you.

MR. COWHERD: Can I ask, respectfully? Counsel will stay until the end of the hearing, but if there are OHCA questions for Ms. Cardiello, is there a way that she might be able to answer those questions now rather than stay until OHCA's question?

HEARING OFFICER HANSTED: OHCA does not have any questions for your witness. Is there any objection from any of the other counsel to her leaving?

MS. VOLPE: None from us.

HEARING OFFICER HANSTED: Okay. Counsel, your witness is released.

MR. COWHERD: Thank you.

HEARING OFFICER HANSTED: You're welcome. Attorney Volpe, if you want to proceed with Cross-Examining a witness, you may do so.

MS. VOLPE: Yes. We're going to have an opportunity to make a presentation after ARC makes theirs on their application, so we're going to allow our time for that, and then we have an opportunity to Cross them on their application, so we don't have any questions for them as an Intervenor in our application.

HEARING OFFICER HANSTED: Okay.

MS. GROVES FUSCO: You'll do your Cross in ours?

MS. VOLPE: Correct.

MS. GROVES FUSCO: Okay, because we'll do the same. We'll do most of ours in this one.

MS. VOLPE: Correct.

MS. GROVES FUSCO: Would it just make it easier? Okay.

MS. VOLPE: Yeah. I think that is what's scheduled for D for you.

HEARING OFFICER HANSTED: Okay, so, you're all set, Attorney Volpe. Attorney Fusco, do you have Cross for the Applicant?

MS. GROVES FUSCO: I do.

HEARING OFFICER HANSTED: Okay. You may proceed.

MS. VOLPE: And, Hearing Officer Hansted, in terms of procedurally, when they ask Cross, in terms of our opportunity to Redirect --

HEARING OFFICER HANSTED: I would do it at this point.

MS. VOLPE: Okay.

HEARING OFFICER HANSTED: When they're done with their Cross, otherwise, it's going to get too confusing.

MS. VOLPE: Yes. Agree. I just wanted to confirm.

HEARING OFFICER HANSTED: Okay. Just make sure you speak into the microphone, so she picks you up.

MS. VOLPE: Yes. Attorney Fusco had the professional courtesy to state that she's going to direct her Cross to Dr. Camel, but if we have other witnesses that are better or more appropriate to answer, and we may. We have Dr. Sullivan, who is a radiologist, here with us today, and we'd like to take Attorney Fusco up on that, to the extent that they're technical --

HEARING OFFICER HANSTED: That's fine. I

think that works best. Also, if you could just let me know if you present any witnesses that have not been sworn in? Just let me know, so they could be sworn in before they testify.

MS. VOLPE: Sure. They both have been sworn in.

HEARING OFFICER HANSTED: Okay. You may proceed, Attorney Fusco.

MS. GROVES FUSCO: And we'll certainly do the same on Cross. We'll make all of our employees available to you, too.

Good morning, Dr. Camel.

DR. CAMEL: Good morning.

MS. GROVES FUSCO: I would like to start. I'm going to jump around a little bit, because there are so many filings in this matter.

MS. VOLPE: I'm just going to have him get it in front of him, in case you're going to reference pages.

MS. GROVES FUSCO: Okay, Dr. Camel. I would like to start with the rebuttal testimony, dated August 29th, which was admitted yesterday. Do you have that?

MS. VOLPE: Yes.

MS. GROVES FUSCO: In your rebuttal testimony --

MS. VOLPE: Can you just let him get there?

MS. GROVES FUSCO: Sure. Absolutely.

MS. VOLPE: Okay.

MS. GROVES FUSCO: In your rebuttal testimony on pages five and six, I believe are where the references are --

HEARING OFFICER HANSTED: Can you come up to a microphone, please?

MR. PATRICK MONAHAN: I don’t mean to interfere. Pat Monahan, counsel for WESTMED, an Intervenor in this proceeding.

If I might just kindly, because there’s a little trouble hearing in the back, ask you to both pull your microphones as close as you can?

MS. VOLPE: Sure.

MR. MONAHAN: Thank you very much.

MS. VOLPE: Is that what we entered into your file? Correct?

MS. GROVES FUSCO: No. It’s a rebuttal. It’s a rebuttal in your -- it was the rebuttal to my response, and you filed it yesterday. It should be in

your docket. It's dated August 29th. It says rebuttal of Orthopaedic & Neurosurgery Specialists in response to testimony of Advanced Radiology.

MS. VOLPE: Okay. I think we have it. Thank you. What page were you referencing?

MS. GROVES FUSCO: Pages five and six. So, Dr. Camel, on pages five and six of the rebuttal testimony submitted yesterday, you state several times, actually, that ONS does not refer patients to ARC, due to inferior scan quality, and, on page six, you say, as stated above, ONS does not refer scans to ARC, correct?

DR. CAMEL: ONS does not directly refer scans to ARC. Patients from ONS go to ARC to get their scans, either by their choice or because of a narrow network. For example, in certain workmen's comp networks, ONS patients have to go to ARC, based on their insurance. That's correct.

MS. GROVES FUSCO: Okay.

DR. CAMEL: But my statement, as I said it, stands otherwise.

MS. GROVES FUSCO: Okay, but you do order the scans for your patients? You write the prescription for the scan, correct?

DR. CAMEL: Correct.

MS. GROVES FUSCO: And then the patient gets that order filled at Advanced Radiology's office, correct?

DR. CAMEL: But that's different than saying I referred the patient or we referred the patient.

MS. GROVES FUSCO: Okay, well, I have some more questions. I mean, in our opinion, a referral is an order that is completed, and then images and results are sent back to you to use. That's what I mean a referral to be.

I'm not asking if you recommend one provider over another. I'm asking do you make a referral? Do you order a scan, for an MRI scan, which is then filled at my client's practice, and then you get those results?

MS. VOLPE: Just a point of clarification. You're using referral and order interchangeably, and I think that's what Dr. Camel is trying to clarify.

MS. GROVES FUSCO: Okay, yeah. Understood. I'm not asking whether you recommend Advanced Radiology over another provider. I'm just asking do you order MRI scans for your patients that are completed at Advanced Radiology and then receive the results of those scans?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Okay and, in fact, our records indicate that, in 2012, 64 of those orders were completed at ARC. In 2013, 80 of those orders were completed at ARC. In 2014, 64 were completed at ARC. In 2015, 79 were completed at ARC. And, in 2016, year-to-date, 79 have been completed at ARC. Do you have any reason to doubt that those numbers are accurate?

DR. CAMEL: I have no information either way.

MS. GROVES FUSCO: Okay, so, you don't keep track of where your patients go for their scans, other than getting the report back and putting it in their patient file?

DR. CAMEL: We have no method of tracking.

MS. GROVES FUSCO: Okay.

DR. CAMEL: Once we recommend a patient to have an MRI scan, there's no tracking method to know how many were done at which place, other than our own, of course.

MS. GROVES FUSCO: But would you agree that a radiology practice that relies on outside referrals, such as my client, might have a system to track those, so they can be aware of who their referral

sources are and make sure they're providing quality care to those referring physicians?

DR. CAMEL: I have no way of knowing if Advanced Radiology has a system, but I would presume, as the basis of a sound business practice, they would want to know that.

MS. GROVES FUSCO: Okay. If you say you don't refer, and maybe we'll use the word recommend instead of refer, if you say you don't recommend patients, based upon poor image quality at ARC, how is it that you've allowed for the last four years several hundred patients to get scans there, without ever raising those quality issues with Advanced Radiology?

DR. CAMEL: Well, actually, we have, actually, and one of the questions, and I don't know what we referred to Advanced Radiology before those dates, because I don't even know about the dates you speak of, but we do have.

It's not only the quality of the images, but it's the access to the images, and, so, as I said in my earlier testimony, we are very selective about where we can be and where we mostly are selective about who does our imaging in a way that's done in the way that provides us with the information that we need.

And one of our issues is, and I can only speak to the spine imaging, because I'm the neurosurgeon, I can't speak to orthopedic imaging in general, which is the bulk of our imaging, but, in spine imaging, we do more sequences, and we do continuous actual imaging, both in T-1 and T-2, and, traditionally, while ARC does that sometimes, it doesn't routinely do that, so that's an issue for us, in terms of planning our surgery.

The second issue is access to the scan, notwithstanding the quality, so, as surgeons, we require of each other, all of us, that, when we're operating, no matter where we're operating, those images are available.

And the issue is that, in the past and currently, from time-to-time, we have a difficulty accessing images from ARC. Even when the patient in the exam room gives us their access information to try and access those images, we're not able to see them, and, so, we ask those patients to go back to ARC to bring us a CD.

But, secondly, when we operate at Greenwich Hospital, there is no mechanism for, excuse the expression, pulling up those images on the computer in the operating room. We need those and won't operate without them, so, for both of those reasons, both access and quality, we refer elsewhere.

MS. GROVES FUSCO: Okay, so, a couple of things. I mean you raised the issue of the image sharing network having issues, and, in our response, we said that we were aware that there were some downtimes, some retrieval issues back in 2015. You're saying those are still current issues?

DR. CAMEL: Well it's not so much an issue for me, as I sit here right now, because I really have very few patients, who go there, and, when I go, when a patient goes there, before they come back, we ask them to go to the office, it's usually in Stamford, but sometimes it's in, I think, your Fairfield or Bridgeport office, and retrieve a CD, so we can upload the images into our system, so we take care of the access issue.

MS. GROVES FUSCO: Understood, but you're not personally aware of any current?

DR. CAMEL: No, I'm personally aware, based on my partner saying the same thing.

MS. GROVES FUSCO: And you continue to allow, whether you recommend or not, you continue to allow your patients, if that's what they want to do, to have their scans done at Advanced Radiology?

DR. CAMEL: That's an incorrect characterization, to say we allow it. We don't have any

control over it.

MS. GROVES FUSCO: Okay, well, understood.

MS. VOLPE: Can she let the witness answer the question?

DR. CAMEL: So, as I said before, the patients that I'm aware of that go to ARC in Stamford of mine, which I am very comfortable saying this, go, because of a narrow insurance network usually related to Workmen's Comp, so I have no ability to control or allow. That implies I have volitional control using the word allow. That's incorrect.

I don't allow it. The patients need their scans. It's the only place they can go, because of their insurance.

MS. GROVES FUSCO: Do you advise those scans, those patients that they're going to be getting inferior scan quality that might impact their treatment?

DR. CAMEL: I have no -- first of all, I don't speak badly when the patients come back directly to patients. That's number one.

Number two is I write an order on a Workmen's Comp patient for an MRI scan. This is how it works in real life. That patient then gets that MRI approved by Workmen's Comp, and Workmen's Comp refers

them to Advanced Radiology, not me. I neither allow, nor do I participate in that decision.

MS. GROVES FUSCO: Okay, so, even though you believe that you might be getting images that are not diagnostically sufficient, you will allow them to go there, based upon their interest? Is there no -- let me finish asking my question, Michele, please.

Are there no other providers in the service area, outside the service area, further in Fairfield County, you're telling me that there are situations, where ARC is the only provider that can provide the imaging to patients?

DR. CAMEL: For those patients --

MS. GROVES FUSCO: The only one. None of the hospitals?

DR. CAMEL: Okay. I'll answer it this way. One is I don't know what the Workmen's Comp carrier's network actually is. It's probably because that may be that you may be the closest one, since our patients, as you know, are focused in the Greenwich/Stamford area and the New Canaan/Norwalk area, which is our service area, so it may be the most convenient for the patient, and it may be the most convenient for the one that's allowed in that narrow

network.

MS. GROVES FUSCO: And you're saying that -- so you think the majority of these patients that continue to go to ARC, the 80 a year that go to ARC, are Worker's Comp patients?

MS. VOLPE: No.

DR. CAMEL: I have no way of knowing that.

MS. GROVES FUSCO: Okay, so, it can be for more than reasons of Worker's Comp limiting a place where they can get their scans?

DR. CAMEL: But it's a patient choice issue.

MS. GROVES FUSCO: Understood.

DR. CAMEL: Because, unlike certain networks, our patients choose where they go, just like they choose to come to us, so patients have a choice to go to ARC, and they may choose to do so themselves.

We don't sit and direct patients in the way that you're suggesting, like we sent them to ARC, or we send them to some other institution.

As I said in my testimony, patients choose, based on geography, and the geography is related to residence and related to work, related to hours and other ways of I guess other service, perhaps.

It may be related to cost. Those are all reasons why patients choose a provider.

MS. GROVES FUSCO: I do understand that.

DR. CAMEL: And, in fact, it's a very small number of patients percentage-wise, so even stipulating to your number of 90 it's a small percentage number, and it represents --

MS. GROVES FUSCO: Understood.

DR. CAMEL: -- only a percent --

MS. GROVES FUSCO: Dr. Camel, you're going beyond answering my question.

DR. CAMEL: Okay.

MS. GROVES FUSCO: What I just want you to tell me is that there are instances in which you've raised concerns with this agency about the quality of MRI images that my client provides.

You're saying that those images are not sufficient to be used during complicated surgeries, yet you let your patients, you let them do it. Whether they have to go there are not, that is the image they're giving you to use during surgery.

DR. CAMEL: Well that brings up -- that's a great question. Here's why it's a great question.

MS. GROVES FUSCO: It's really a yes/no

question. I'm not here to give you more opportunity.

DR. CAMEL: Well it's not, because you said a couple of different things in that lengthy question.

You said we let them go, despite knowing that it's going to be an inferior image. In fact, when we receive an image back that's not sufficient, we write a second referral for an MRI, and we call Workmen's Comp and have it done on another machine, and we will not operate, based on an inferior image.

Now sometimes, as you know, or you may know, or the radiologists know, that there are images that are good enough and there are images that are outstanding, and sometimes good enough images are okay, and sometimes those images are okay and, many times, they're not, but they don't represent the highest quality that are done routinely in the area.

MS. GROVES FUSCO: Do you agree that a 3 Tesla unit improves the quality of an image, generally speaking, over a 1.5?

DR. CAMEL: No.

MS. GROVES FUSCO: You don't think that a 3.5 Tesla provides better definition and image quality than a 1.5 Tesla?

DR. CAMEL: It can in certain circumstances.

MS. GROVES FUSCO: It can.

DR. CAMEL: But, in bone and joint imaging, and maybe Dr. Sullivan wants to comment on that, it hasn't been shown to provide better quality.

In fact, the comment from the bone and joint people and my orthopedic colleagues is that, often times, they prefer a 1.5 Tesla machine.

MS. GROVES FUSCO: What about with respect to neurological exams, to brain exams, to vascular exams, those things?

DR. CAMEL: Okay, so, for certain kinds of imaging, like diffusion tensor imaging, I think you need a 3 Tesla machine, so it's not possible to do it on a 1.5.

I'd like to ask Dr. Sullivan to comment, please.

DR. SULLIVAN: My comment would simply be that it's a complicated issue. You need to have an experienced technologist and patients, who cooperate, but, ideally, 3 Tesla imaging can do more robust imaging than a 1.5.

MS. GROVES FUSCO: Okay, thank you. Have

you ever communicated any of your concerns about quality directly to any radiologist at Advanced Radiology?

DR. CAMEL: Yes. I've called, but I can't speak of a specific instance, again, because --

MS. GROVES FUSCO: Okay, you can't say who or when?

DR. CAMEL: No.

MS. GROVES FUSCO: But you've spoken to radiologists there about it?

DR. CAMEL: Sure.

MS. GROVES FUSCO: Have you ever asked ARC whether they can work a certain protocol if the protocols they're doing don't fit your needs during surgery, like the ones that you do?

DR. CAMEL: Yes. Early on, we ask if they can do continuous actual imaging.

MS. GROVES FUSCO: And who did you ask?

DR. CAMEL: It was years ago.

MS. GROVES FUSCO: Again, you can't remember?

DR. CAMEL: No, I can't.

MS. GROVES FUSCO: You can't provide me any specifics. With respect to your ability to pull up images in the hospital setting when you're operating, is

it -- have you asked the hospital to help facilitate access, because, as you know, sometimes it's the hospital systems that block access, although legally now they're not supposed to, so have you asked the hospital to try to coordinate access for ARC images?

DR. CAMEL: I have not personally asked the hospital.

MS. GROVES FUSCO: In terms of sort of image quality issues, you're aware that Advanced Radiology operates the exact same MRI unit that you do, right, the 1.5 Tesla?

DR. CAMEL: Yes, I am.

MS. GROVES FUSCO: And, in fact, when you got your CON approval in 2008, the one you claim that ARC tried to obstruct, you asked if you could come to their office and see that unit, correct, before you purchased yours?

DR. CAMEL: I actually don't remember that, no.

MS. GROVES FUSCO: Okay. Someone else in your office was involved in that?

DR. CAMEL: That may be.

MS. GROVES FUSCO: Someone from ONS came to Advanced Radiology's office to see the unit, and are

you aware that they asked for and were given protocols for that unit for you to use on your own unit?

DR. CAMEL: No. I don't know who went. I know that Dr. Sullivan and Dr. Desai have designed the protocols at ONS.

MS. GROVES FUSCO: Okay, well, I can -- so you can't confirm, but I can tell you that someone from your office did come over to look at the unit and ask for those.

Moving on to some questions about patient access, I want to move on to some patient access issues. To confirm, and I think this has been confirmed in the CON application, but ONS does not participate with the Medicaid program for either physician services or MRI, correct?

DR. CAMEL: No. Correct.

MS. GROVES FUSCO: In your testimony, I think it's in the rebuttal testimony at page 11 -- maybe I have that wrong, because there is no page 11. Maybe it was your actual testimony on page 11. Oh, I'm sorry. It's in the rebuttal at page one. I can't even read my own notes.

In the rebuttal testimony at page one, you cite some of the CON decision criteria, the statutes that

include those decision criteria, and one of those statutes that you cite is 19a-639(5), which basically requires OHCA to consider how a CON proposal will improve the quality, accessibility and cost effectiveness of health care, including access to services for Medicaid recipients, correct?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Okay and what the statute actually says is that OHCA needs to determine whether the Applicant has satisfactorily demonstrated how the proposal will improve the quality, accessibility and cost effectiveness of health care delivery, including access to services for Medicaid and indigent persons, correct?

DR. CAMEL: Correct.

MS. GROVES FUSCO: Okay. The CON proposal that you have before OHCA right now is a proposal to acquire an MRI unit, correct?

DR. CAMEL: It is.

MS. GROVES FUSCO: And it’s a proposal for nothing more than to acquire an MRI unit to provide MRI services. Okay.

Is it fair to say that you have not provided a single MRI scan to a Medicaid patient on the

ONS scanner either through the Medicaid program or for free since 2008?

DR. CAMEL: It's correct, but not fair.

MS. GROVES FUSCO: Pardon?

DR. CAMEL: It's correct, but not fair.

MS. GROVES FUSCO: Okay, well, all I need to know is if it's correct. You have not provided a single MRI scan on your scanner to a Medicaid patient. Okay and you aren't projecting any Medicaid scans going forward on your scanner?

DR. CAMEL: Not unless the health care delivery system at Greenwich changes, that's right.

MS. GROVES FUSCO: Okay, but you've predicted in your payer mix projections you're projecting zero Medicaid scans?

DR. CAMEL: I'm not making a prediction about whether or not Greenwich Hospital will no longer provide it, so we will do it directly.

MS. GROVES FUSCO: Okay. You claim in your rebuttal testimony, and I think it's at page three, that, when you see Medicaid patients, and correct me if I'm wrong, but the number of Medicaid patients --

DR. CAMEL: Is this it? I'm just trying to get the right thing.

MS. GROVES FUSCO: Yeah, it's the same document we've been looking at, the rebuttal from yesterday.

DR. CAMEL: Okay. Sorry.

MS. GROVES FUSCO: That's okay. So you claim in your rebuttal at page three that, when you see Medicaid patients for physician services -- and just so I can confirm, last year, in terms of Medicaid patients, who you provided physician services for, where you wrote off their care, with Medicaid as their primary insurance, that was 23 patients, correct?

MS. VOLPE: That's in your office, but not in the clinic.

MS. GROVES FUSCO: In the office. ONS physician services in the office.

DR. CAMEL: But that misstates --

MS. GROVES FUSCO: But does it --

DR. CAMEL: It misrepresents the facts.

MS. GROVES FUSCO: It's Cross-Examination. You have to answer my question. It was a number that was put in your document. Is it correct that you provided -- that physician office services in your office you treated 23 Medicaid patients out of the 51,500 patient visits you had that year or patients you had that year?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Okay, probably more visits than patients. Okay. And, so, you claim in your rebuttal that you see Medicaid patients for physician services, who may have previously received an MRI at Greenwich Hospital, correct?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Okay. If Greenwich Hospital -- I assume, if Greenwich Hospital provides the MRI service, they get reimbursed by Medicaid, correct?

DR. CAMEL: I'm not aware of how they're reimbursed.

MS. GROVES FUSCO: Okay, but, certainly, if Greenwich Hospital is providing the MRI, you don't have to write off any costs associated with that MRI, because you didn't provide it, correct?

DR. CAMEL: I don't understand the question.

MS. GROVES FUSCO: The question is you're not providing -- when an MRI is done by Greenwich Hospital before that patient gets to you, you didn't have to provide MRI services to them and then write the cost off. Someone else did it for you.

DR. CAMEL: The MRIs that are done

elsewhere across the entire United States we don't write off the cost, so why does it matter whether Greenwich Hospital --

MS. GROVES FUSCO: It doesn't matter why it matters.

DR. CAMEL: -- in Boston.

MS. GROVES FUSCO: It doesn't matter why it matters. I'm asking the question. You don't incur any costs in association with an MRI provided by Greenwich Hospital before that Medicaid patient gets to you?

DR. CAMEL: So those are the patients that we -- those are those Medicaid patients that we see for free for Greenwich Hospital to which you're referring that haven't already had an MRI?

MS. GROVES FUSCO: I'm asking about costs specifically related to an MRI.

DR. CAMEL: Of course not. I mean that's a silly question.

MS. GROVES FUSCO: Okay, well, I apologize. If those individuals were scanned at ONS, you would either have to, I mean, if you participated in Medicaid, you could be reimbursed from Medicaid, but if they were scanned at ONS, you would have to write off the

cost of the scan, right?

DR. CAMEL: Well, before a patient gets scanned at ONS, they have to be referred to ONS, and patients can't be referred to ONS before they have a diagnosis.

Imaging, radiology, is what often gives the primary care physician in the clinic or the emergency room the diagnosis and provides the reason for the referral in the first place. We also --

MS. GROVES FUSCO: But you diagnose plenty of patients and then refer them for the scans afterwards.

DR. CAMEL: The clinic service and the emergency room doesn't do that. They don't diagnose things without imaging and then refer them. That's incorrect.

MS. GROVES FUSCO: Okay, but you're suggesting that's how it always works. One of these patients could have presented at your office for services versus the emergency room or a primary care clinic.

They could have presented at your office services if you were a Medicaid provider. You could have evaluated and diagnosed and referred them to your own scanner, correct?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Okay. That's all I needed to know. You say you intend to site the new unit in Greenwich where the existing unit is, correct?

DR. CAMEL: Yes.

MS. GROVES FUSCO: One of the reasons why -- is one of the reasons why you don't take Medicaid, from what your counsel has said in submissions, because you don't believe the Medicaid population in Greenwich is substantial?

DR. CAMEL: No.

MS. GROVES FUSCO: That's not why you don't take Medicaid?

MS. VOLPE: He answered the question.

MS. GROVES FUSCO: Okay.

DR. CAMEL: That is correct. My answer is as it stands.

MS. GROVES FUSCO: If you have no intention of moving the Greenwich MRI unit out of Greenwich, why are you fighting the request by Stamford Hospital to have a limiting condition in your CON, telling you you need to keep it exactly where you say you --

DR. CAMEL: That's actually a great question. I can't really anticipate the future of health

care. Maybe everybody else in the room can, but I think putting a limitation on it arbitrarily for reasons that Stamford Hospital may be worried about, it seems, given the fact that all of these scanners are full anyway, I don't know how putting another, even if we were going to do that, why it matters, but we have no intention of doing that, but you're asking a question that says I should agree, without objection, to forever a limitation going forward, no matter what happens in the health care system, no matter how health care becomes provided in the future, and I'm just not smart enough to make that prediction and agree, without objection, to Stamford Hospital's request to OHCA.

MS. GROVES FUSCO: Do you participate with any of the Connecticut Health Exchange plans?

DR. CAMEL: We do, actually. We do ConnectiCare. You can check. ConnectiCare and it's either Aetna or Anthem.

MS. GROVES FUSCO: We looked at your website, and we couldn't find any reference to you taking those Health Exchange patients.

DR. CAMEL: Well I can very clearly tell you, since I was the one who negotiated those contracts, that we do, and we have a separate rate schedule I know

for ConnectiCare exchange, as opposed to their ConnectiCare commercial that we agreed to participate in both.

We're currently in negotiations with Deremius Williams, who is the Vice President for Contracting for Aetna, excuse me, for Anthem to do the same.

MS. GROVES FUSCO: Well it isn't advertised on your website.

DR. CAMEL: It's not done yet.

MS. GROVES FUSCO: Okay, but might that limit people, who have those plans, who are looking for providers, might look at your website and pass you over?

DR. CAMEL: Well we can change the website. That's easy.

MS. GROVES FUSCO: Okay, well, maybe you should, because I know that there are plenty of --

MS. VOLPE: Okay. I think he's answered the question.

HEARING OFFICER HANSTED: Counsel? I would remind everyone it's Cross-Examination. Let's not get argumentative, either counsel or the witness. Let's just get to these questions.

MS. GROVES FUSCO: Okay. In your hearing

submission, so going back to your actual testimony here, the initial testimony, not the rebuttal --

MS. VOLPE: Pre-filed testimony?

MS. GROVES FUSCO: Yes, dated August 23rd. I think it's page 31. It's attachment D.

MS. VOLPE: Almost there.

MS. GROVES FUSCO: That's it. So in your hearing submissions on page 31, it shows that approximately 78 percent of the scans that you refer are done internally, correct? So, if I'm reading this correctly, you refer or order, let's use the word order, you order 6,769 scans, and, of those, 5,262 are done on the ONS scanner? Am I reading that correctly?

DR. CAMEL: Right. I think those are the '15 numbers.

MS. GROVES FUSCO: Yeah, I think those are the 2015 numbers. Okay, so, this means that you referred out, for lack of a better word, 1,507 scans, so 1,507 of the scans that you ordered could not be performed at ONS or were not performed?

DR. CAMEL: For our Connecticut patients, that's right.

MS. GROVES FUSCO: Okay. This is specific to Connecticut patients?

DR. CAMEL: To our service area.

MS. GROVES FUSCO: Okay, so, is this the total practice, or is this just the service area?

DR. CAMEL: It's the total. It's the total. I'm sorry.

MS. GROVES FUSCO: Okay, so, that would include patients from both states, okay.

DR. CAMEL: Yeah.

MS. GROVES FUSCO: You state, at several points in your pre-file, and I won't necessary bring us to the pages, but that, you know, one of ONS's goals is to increase MRI capacity, so that you can give all of your patients the opportunity to be scanned on your scanner, if that's what they choose, correct?

DR. CAMEL: Yes.

MS. GROVES FUSCO: So, arguably, you would want to scan any patient, except ones for which your scanner is clinically contraindicated, or who want to get their scan in New York, because they live there, or, you know, somewhere else, because they work somewhere else, correct? Everyone else you would like to do --

DR. CAMEL: Or for insurance reasons, as you pointed out.

MS. GROVES FUSCO: For insurance reasons,

okay. Approximately, how many patients each year fit into that category? How many scans a year do you say, would you say have to go out for those various reasons?

DR. CAMEL: You know, it's hard to know.

MS. GROVES FUSCO: Okay.

DR. CAMEL: We have no way of keeping that data.

MS. GROVES FUSCO: Is it all 1,500 scans you referred out?

DR. CAMEL: I would have to know why they went, because I don't know why the ones stayed, who stayed, so it's a combination factor, right? So maybe somebody from far away stayed, and maybe somebody from far away left, but I have no way of knowing that.

MS. GROVES FUSCO: Okay, so, you can't tell us whether those 1,500 patients have all gone elsewhere for the reasons you've indicated, meaning they can't be scanned on the ONS scanner?

DR. CAMEL: As I've already said, I have no data, because no patient gives us a reason why they weren't scanned at ONS.

MS. GROVES FUSCO: Are you referring patients elsewhere now, because you can't do the scans? You just don't have enough capacity to do the scans?

DR. CAMEL: That's an interesting question. I don't know that, because I don't know why they left, again, because patients choose, you know, many patients choose their provider for different reasons, and some patients choose us, and some patients don't, so I don't really know. We do have more capacity.

MS. GROVES FUSCO: Okay.

DR. CAMEL: Not much, but we have some.

MS. GROVES FUSCO: Okay, so, on page 32 of the CON, so you're projecting, in the first year of the unit, you're projecting an incremental increase, so between 2016 and 2017, you're projecting an incremental increase of 1,201 scans, correct?

DR. CAMEL: We are, yeah.

MS. GROVES FUSCO: And that's a 22 percent increase that year?

DR. CAMEL: The math is correct.

MS. GROVES FUSCO: Correct? Historically, and I did this math, so you can check it, or you can trust me, historically, your growth has been between four and a half and five percent a year, correct?

DR. CAMEL: For MRI imaging?

MS. GROVES FUSCO: For MRI.

DR. CAMEL: Yes.

MS. GROVES FUSCO: Okay, so, would you agree that a 22 percent increase is entirely inconsistent with historical growth at four to five percent or four and a half to five percent?

DR. CAMEL: I wouldn't agree. You're missing some of the facts, which you don't know, so I can explain that if you want.

MS. GROVES FUSCO: Okay, well, I have some questions that may get us to the answer, but I'm just asking, if you look just at the percentages going forward and you have four and a half, five, four and a half, five, 22, four and a half, five, that 22 is kind of an outlier, correct?

DR. CAMEL: I disagree.

MS. GROVES FUSCO: Okay.

DR. CAMEL: Am I allowed to say why it's not an outlier?

MS. GROVES FUSCO: I'm going to ask you some more questions now. You've answered my question. Thank you.

You claim your projections and how you arrive at that 6,675 number is based on 265, I'm sorry, 267 scans per physician, and you say that's your historical per physician average. Can you show me how

you arrived at that number?

DR. CAMEL: Sure. So here's what I was trying to say before, but I didn't get to say. So you have to go backwards a little bit to get to the growth number, okay?

Let's start back going back to the fall of 2014. I'll just have to walk through this in my head. We had a Dr. Sahler, who is a physiatrist. In March, we had a Dr. Kowalsky, who is an orthopedic surgeon. In September, we had a Dr. Wei, who is a hand surgeon. This September, we're adding Dr. Kaplan, who hasn't joined us yet, but he's coming in a couple of weeks.

We just made an offer to a new physiatrist, and we have an offer out to a joint replacement surgeon, so, when you look at the first person, so let's go back to Dr. Sahler, who started in '14 --

MS. GROVES FUSCO: With all due respect, I don't want to cut you off, because I know you want to --

DR. CAMEL: I just want to explain the math.

MS. VOLPE: He's answering. (Multiple conversations)

HEARING OFFICER HANSTED: Hold on. Hold

on.

MS. VOLPE: -- on the 22 percent growth.

MS. GROVES FUSCO: No, no. That's not the question. I didn't ask another question. I asked him how he arrived at 267 scans per physician, where he got that number. Are you going to do the math for me?

MS. VOLPE: And he's explaining it.

HEARING OFFICER HANSTED: I believe that's what he's explaining.

MS. GROVES FUSCO: Okay. Okay.

HEARING OFFICER HANSTED: Sort of the long way.

MS. GROVES FUSCO: I mean I'm looking for math.

DR. CAMEL: I'm a little bit known for that.

MS. GROVES FUSCO: I appreciate the story.

DR. CAMEL: I apologize, but you can ask a lot of people about that. So when you go back, and those numbers are derived probably from the 2014 data, because you don't count Dr. Sahler, because he just started, right?

So, if you do the math and go -- I can't do it in my head, but, before Dr. Sahler came, we had --

Dr. Crowe(phonetic) left, so we had an even number of doctors, so it was 22. You take 22 and do what the number is. You can do that math. I can't do it in my head.

Now the reason why we have this great projection is, when the '15 numbers were done, Dr. Sahler was just beginning his practice. He came at the end of '14. He's just ramping up. He's now full, and that's why we're hiring another physiatrist. He's a physiatrist.

We then added Dr. Kowalsky, who is a shoulder specialist, who joined us from Lenox Hill, and he is just now full. He's now been with us, well, since March of '15, whatever that is, 18, 17 months, and I talked about the other people we're about to add.

So we looked at what it takes to go from a zero practice to a 90 percent, 85, 90 percent, not 100, and we look at that, and we go, okay, if it takes 18 months and this process takes a certain length of time, we expect this many more MRI scans are going to be ordered, and the numbers work when you do the math, but you don't have all that information --

MS. GROVES FUSCO: Okay, well --

DR. CAMEL: -- and why we're growing.

MS. GROVES FUSCO: You're correct, but what I have is the information you put in the CON application, and that's what OHCA has, as well, and, so, if you look at your completeness question responses on page 94, I think it's page 94, it says, right at the bottom of the page, in 2012, the average number of scans for per physician was 267, okay?

So you're telling me that your story begins with this number being derived from Dr. Sahler coming in 2014.

DR. CAMEL: No, I didn't.

MS. GROVES FUSCO: Okay. In your own submission, you're saying, in 2012, the average number of scans per physician was 267, and now I will show you where I did the math. If you look at our submission --

MS. VOLPE: Is there a question for the witness?

MS. GROVES FUSCO: There's going to be a follow-up question.

HEARING OFFICER HANSTED: She's just setting up the question.

MS. GROVES FUSCO: I'm trying to figure out how we got to this math. I mean you've based your projections on a scan per physician number that you have

no basis for that I can find in your application.

MS. VOLPE: She's offering testimony. Please ask your question.

MS. GROVES FUSCO: My question to your client was can he show me how the math was done? I'm going to take him to the section in my client's testimony, where it shows that scans, divided by number of physicians, does not come out at 267 in 2012 or any year thereafter, so I would like him to show me how he arrived at the 267 scan per physician number that you were using to justify your projections. That's my question.

DR. CAMEL: So, in order to answer the question, you have to know how many physicians we had in the practice in 2012.

MS. GROVES FUSCO: Which I have.

DR. CAMEL: How many?

MS. GROVES FUSCO: Your attorney reported that it was 19.

DR. CAMEL: Okay and what was the number of scans?

MS. GROVES FUSCO: 4,565.

DR. CAMEL: And how does that work?

MS. GROVES FUSCO: That's 240 scans per

physician.

DR. CAMEL: What's the next year?

MS. GROVES FUSCO: Am I being Cross-Examined? Can you go to page 22 of our submission?

HEARING OFFICER HANSTED: Why don't you look at the document that she's --

MS. GROVES FUSCO: Page 22 of our submission.

MS. VOLPE: Which submission?

MS. GROVES FUSCO: Of Mr. Yoder's pre-file.

DR. CAMEL: I have the piece of paper.

MS. GROVES FUSCO: Okay.

DR. CAMEL: I'm on it.

MS. GROVES FUSCO: Okay, so, you have page 22? I'm asking how, and you can double-check my numbers, but I took these from your attorney's submission, each year, 2012 through 2016, the number of physicians you reported in the scan per physician volume, and nowhere in there does it show 267, and, in fact, as of 2016, it's 238, so 31 scans less per physician.

Multiplied by the number of physicians you have, that significantly skews your projections, doesn't it?

DR. CAMEL: I have to read. Can I have a minute to do the math?

MS. GROVES FUSCO: Yup. Sure.

DR. CAMEL: All right. Well there are a couple of skews here that go wrong with the projection, because, and this is the point I was trying to make before, so, in 2015, we added Dr. Kowalsky and Dr. Wei.

Dr. Kowalsky started in March, so he starts at zero, so for the first -- I think he started on March 20th or 15th, but I don't remember the exact date, so, for the first two months, he didn't refer any, and, for the next few months afterwards, he doesn't refer any, so it does change it, because it depends how you want to do the math.

If you take the absolute number, including people, who started yesterday, who refer zero, then it drops the number for a physician.

MS. GROVES FUSCO: I --

DR. CAMEL: And if you look at it on a mature physician basis, that is a physician, who has been with us for 18 months, who is now referring scans, and that's how we do our projections, because that's really what you want to know.

What about the guy that did zero when the

day started? It's not a meaningful statistic.

MS. GROVES FUSCO: Okay, so, how do you account for the fact that you say in 2012, because, again, you're talking about docs that joined in '14 and '15? You based the 267 number on 2012. In 2012, the average scan per physician was 267, and here it says 240.

DR. CAMEL: I think this says 240.

MS. VOLPE: That's theirs. That's theirs.

DR. CAMEL: Well --

MS. VOLPE: -- by the number of doctors. If you do the 267, multiplied by the number of doctors you have, that's an average per doctor.

DR. CAMEL: I have to go backwards to 2012 and look at who was hired when to get their real number.

MS. GROVES FUSCO: I understand.

DR. CAMEL: I just don't know that off the top of my head.

MS. GROVES FUSCO: The only question I'm asking and the only point I'm trying to make is that you're basing your projections on what you said to be an average number of scans per physician of 267 that occurred in 2012, and I'm saying, if you look at the information I put on page 22 of our filing, that the numbers don't add up. I can't get to 267 per physician

with the numbers you've given.

DR. CAMEL: I agree.

MS. GROVES FUSCO: Now, going back to your rebuttal document at page four -- actually, I'm sorry. It's page four and page five. So, on page four, you specifically state in the first full bullet point on that page that ONS is not taking back volume, okay? You're not taking back anything that currently goes elsewhere.

And, on the next page, in response to the questions we raised about the 22 percent increase in scan volume, you say the 27 projections are based on the fact that ONS will be accommodating backlogs for its own patients, okay?

So we're talking about a 1,200-scan jump that year. Are you saying you have 1,200 patients, a 1,200-patient backlog?

DR. CAMEL: With the projections, based on the new doctors, yes, so it won't affect ARC or other local providers, because that increase in scan -- if you think about it this way, if ARC sees 80 or something a year now and everybody else sees whatever they see and then we grow, then that growth accounts for that 1,200, and this stays the same while this grows.

MS. GROVES FUSCO: Okay.

DR. CAMEL: Now that may grow, as well. I'm not suggesting that. I'm just saying this grows. This stays the same.

MS. GROVES FUSCO: That raises two issues, one being sort of -- you keep referencing and you've referenced in here the growth, based on adding new physicians, right?

DR. CAMEL: Yeah.

MS. GROVES FUSCO: Okay, but at a 267 per physician scan volume, if you add two new physicians that year, that's not -- that doesn't give you your 1,000 scan jump.

DR. CAMEL: Well that's correct --

MS. GROVES FUSCO: Okay, that's --

DR. CAMEL: -- but it's not correct on what we're doing and what we've already done, so it's incorrect factually and correct math-wise.

MS. GROVES FUSCO: Listen to me. So it's correct math-wise that, if each new physician brings 267, that doesn't get you to 1,000, okay? And --

DR. CAMEL: How many physicians are you including in that?

MS. GROVES FUSCO: Two.

DR. CAMEL: Well that's not correct,

though. I don't want to stipulate to a fact that's not true.

MS. GROVES FUSCO: You say you're getting two new physicians.

DR. CAMEL: Again, you didn't hear everything I said.

MS. GROVES FUSCO: I did hear everything you said.

MS. VOLPE: Okay.

MS. GROVES FUSCO: I'm asking a different question, so maybe you're not hearing what I'm saying. I'm asking you your -- you've said, throughout your CON submissions, that the growth in volume is due to the addition of physicians to your practice, okay?

DR. CAMEL: Correct.

MS. GROVES FUSCO: Fair enough. In 2016 to 2017, you state that you will be bringing in two additional physicians.

DR. CAMEL: That's incorrect.

MS. GROVES FUSCO: Well that's what it states in your CON filing.

MS. VOLPE: Well for 2016, and he's talking about in 2017.

MS. GROVES FUSCO: I'm asking about that

one year. The growth for one year will be bringing in two new physicians.

DR. CAMEL: For --

MS. GROVES FUSCO: I'm asking --

DR. CAMEL: We don't do --

HEARING OFFICER HANSTED: Stop, stop, stop. Let her ask her question, and then try to answer. If you can't answer it, then do the best you can, and then she'll follow-up with another question.

DR. CAMEL: Okay.

MS. VOLPE: Just a point of clarification on the facts. When this was filed, okay, we provided the information on the number of doctors that were already committed to coming.

What Dr. Camel testified today is they've made offers to a doctor, who is starting in two weeks, and another doctor, so they have projected volume for the number of doctors they're going to have, and it was a per patient, per doctor scan volume.

Remember, this machine is not going to be implemented in 2016.

HEARING OFFICER HANSTED: So what you're saying is the number of physicians that you put in your application initially has changed, and that's going to go

up, based upon new information?

DR. CAMEL: Yeah. Based on our current offers and our projected offers that we're going to make.

HEARING OFFICER HANSTED: Okay.

DR. CAMEL: We're actively interviewing, and you can check.

HEARING OFFICER HANSTED: So two is no longer the accurate number?

DR. CAMEL: Correct.

HEARING OFFICER HANSTED: It's maybe four? Is that fair?

DR. CAMEL: For this year, I tried to outline. I'll do it really quickly one more time. We added one in the fall of '15. We count that as a '16 add, because they don't do anything in '15 from a production.

HEARING OFFICER HANSTED: Right. I get that.

DR. CAMEL: We're now adding a second hand surgeon and a physiatrist. That makes three for '16. For '17, we're recruiting, have ads out that anybody can check for a joint replacement surgeon and a neurosurgeon.

We are contemplating, but have not begun the recruitment process, for an additional foot and ankle

surgeon and another physiatrist. Until we finish, we can't recruit, because of our scale. We just can't recruit that quickly, so those are our current plans going forward.

MS. GROVES FUSCO: Okay, but at the time you filed your CON, you were justifying a 1,000 scan increase that year, based on the addition of two physicians, because that's all you knew at that time?

DR. CAMEL: Well it was in part that, but we also we filed that I think in, and I don't really know the date we filed it, February or March when it went back to, but here's what we -- so we already began to see '16 over '15.

What we saw was our patient volume was increasing by 20 percent, and, partly, that's because we, at the end of '15, we chose to go in network with Cigna, ConnectiCare and, to a degree, with Anthem.

And, so, we saw early, at the time, I think at the time of this filing, but I'm not sure what the date was, so whatever it is, it is, that's a matter of the record, we started to see this very large increase in our patient volume in the office, which has sustained itself now through July, which is the last place I have numbers for, and that rate of increase is tracking on a

year-to-date basis of 20 percent, so if scanning is proportional to patient volume and the 20 percent is, in fact, accurate, whether it is, in fact, proportional, I don't know, because you could envision it could be more or less, but it is a very reasonable estimate, which is all that represents.

MS. GROVES FUSCO: Okay, but you've done -- so this has all been going on in the last month, and, as of yesterday, when you submitted this document to OHCA, this rebuttal, you explained none of this.

Like, in fact, on page five of your rebuttal, you say that 22 percent increase is to accommodate backlogs for your own patients. That's what you say.

MS. VOLPE: It should say and growth.

MS. GROVES FUSCO: Okay, well, it doesn't. It says backlog.

MS. VOLPE: Okay, but he's correcting it.

HEARING OFFICER HANSTED: Right. He's correcting the record.

MS. GROVES FUSCO: Okay, so, you don't have a 1,000-patient backlog?

MS. VOLPE: We appreciate the correction on the record.

MS. GROVES FUSCO: Will you continue, going forward, so, last year, you referred 1,500 scans to area providers for whatever, you ordered scans. Can you attest that those 1,500 scans or thereabouts will remain where they are?

DR. CAMEL: Well, again, those scans really are people. They're not scans. To you, they're scans. To me, they're patients. Those patients we will have a whole new group of patients that come this year and next year, and I don't know what our volume is going to be, which I've just said to you.

I don't know where exactly those patients are going to come from, so if those patients come from further and further away, we will continue to refer those patients out, based on all the reasons I've already stated more than once.

But for me to make a prediction about patients and their choice and their insurance coverage and where they work and where they live, it is foolish, at best, maybe foolhardy is the better word, to speculate.

And there's no reason, as Michele was reminding me, there's no reason our distribution patients where they come from is going to change, so, assuming it

just gets bigger with the same kind of geography, so to speak, a market share increase, which is what we think we're seeing, not a zip code change, then the proportion should stay the same.

MS. GROVES FUSCO: Okay.

DR. CAMEL: Or perhaps even go up. I mean I don't know.

MS. GROVES FUSCO: Just one more question, then we'll wrap this line of questioning up.

DR. CAMEL: Sure.

MS. GROVES FUSCO: So this market shift is going to show a 20 percent growth the year you get a new unit, but then everything is going to level out again?

DR. CAMEL: No.

MS. GROVES FUSCO: Well that's how your projections go, so let's look at your projections, because your projections show a big jump from 16 to 17, and then they go back down to four to five percent.

This isn't a consistent 20 percent, 20 percent. It's a 20 percent jump the year you get the new unit, and then back to the historic averages, so how do you account for that, if you're going to have this growth going forward?

DR. CAMEL: So I've actually answered this

question already. We filed this application the beginning of ’16. We expected to put the application -- we expected to see the new MRI machine by the end of ’16. Maybe hoped would be a better word.

We, then, changed our growth pattern, based on what was happening in the office, which we couldn’t have predicted either at the end of ’15 or very early in ’16 before that increase happened, because, as you correctly point out, we’ve never seen a growth rate of this rate at ONS, not of imaging, but of the services we provide.

And as you also have clearly stated, this is an ancillary service, which we provide to our patients, so the volume is driven by our patient volume. It is not where you guys may market, or drop a price, or get in with an insurance company. All of the volume derives first from those patients, who show up at the office.

And it is reasonable to assume, maybe not correct, but reasonable to assume, as the patient volume grows in the office, our MRI requirements will grow at a similar ratio. Now that’s all I can say.

MS. GROVES FUSCO: Okay, so, before -- I do have one last question, even though I said that was my

last. Before you knew about all of this, which you said you just found out now in the last month or so --

DR. CAMEL: That's not true.

MS. GROVES FUSCO: Okay. Did you know about this before you filed your CON application?

DR. CAMEL: Yes, because remember what I said already, just a few minutes ago. I said, after we signed these deals with Cigna and ConnectiCare and partly with Anthem, we began to see a very early rise at the end of '15 and early in '16 at numbers we had never seen before in the office, so, when we were preparing this, the question to me is what do you think your growth will be, and I said to Michele I don't know for sure, because I only have this much.

Over these few months, a rate of growth of office patients is about 20 percent, so you'd have to go with that projection.

MS. GROVES FUSCO: But you don't expect that same rate of growth in 2018 and 2019, based upon your projections in the CON?

MS. VOLPE: Well, because they're just becoming --

HEARING OFFICER HANSTED: Let your client testify.

DR. CAMEL: I actually disagree with that. I can see a pathway to grow that, to grow, because we're continuing to expand.

MS. GROVES FUSCO: Well, then, your projections are incorrect, because your projections show modest growth in those subsequent years.

DR. CAMEL: Well --

MS. GROVES FUSCO: Okay. We'll leave that. If you look at your testimony on page --

MS. VOLPE: Is this the pre-file?

MS. GROVES FUSCO: You had mentioned in your comments and Dr. Kaye just noted to me that one of the docs you said you're recruiting is a joint replacement surgeon?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Correct? In our experience, joint replacement surgeons don't order a lot of MRI scans, so are you expecting that joint replacement surgeon to order at least 267 scans?

DR. CAMEL: We are, for the following reason. This particular person, who we have an offer to, is training at the Rothman Institute in Philadelphia, and he is actually an expert on ambulatory joint replacement, especially those patients, who need unicondylar knees or

reconstructive procedures of their hip at a younger age, and most of those patients undergo an MRI scan.

I think you're correct. In the Medicare population, most of those are treated without an MRI scan, because --

MS. GROVES FUSCO: I mean Advanced Radiology's docs do those, too, and they don't always result in MRIs. I'm wondering if the self-referral nature of the unit is going to bring up that MRI, that number of MRIs.

MS. VOLPE: He answered the question you asked.

DR. CAMEL: May I take that?

MS. GROVES FUSCO: Never mind.

DR. CAMEL: No, that's fine.

MS. GROVES FUSCO: I withdraw my question. Page 28 of your pre-filed testimony, on page 28, which is the section on the needs analysis, based upon population, would you agree that this analysis that you've done shows that, even with the addition of two new scanners in the Stamford service area, the entire service area would still be at 82 percent utilization, which is just three percent below the threshold for needing additional MRI capacity?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Okay. You claim in your testimony on page 18, and you said this in a number of places, but this is just where I was able to find it, that the number of ONS ordered scans that ARC performs, which is, you know, was 79 scans, $55,000, and about one percent of our Stamford volume, it says in here that that is a I think the wording used is extremely minimal and insignificant number. Is that what it says?

DR. CAMEL: Do you want me to read it?

MS. GROVES FUSCO: I'm just asking if you've said that that's an extremely minimal and insignificant number.

DR. CAMEL: Well it says these referred patients barely account for one percent of annual MRI volume at the Stamford office of Advanced Radiology.

In our opinion, that is economically and insignificant or minimal. It's both minimal and insignificant.

MS. GROVES FUSCO: The --

DR. CAMEL: One percent.

MS. GROVES FUSCO: The number of scans and the percent, okay.

DR. CAMEL: Yes.

MS. GROVES FUSCO: So, then, would you agree, and this is a yes/no question, that providing zero scans, zero MRI scans to Medicaid patients is an extremely minimal and insignificant number of MRI scans for Medicaid patients?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Would you agree that treating 23 Medicaid patients out of more than 51,000 in your practice at .0004 percent and writing off $88,000 is extremely minimal and insignificant?

DR. CAMEL: I would disagree.

MS. GROVES FUSCO: Is the number extremely minimal and insignificant?

DR. CAMEL: No. The amount of service we provide to Medicaid patients is much greater than that, and to ignore that misrepresents to OHCA what we actually do.

MS. GROVES FUSCO: I'm not ignoring that. I'm asking a specific question about the 23 patients and the $88,000. You've put the other information in your pre-file. Are the 23 patients as a percentage of your 51,500 patients an extremely minimal and insignificant number?

DR. CAMEL: I would never describe 23

people as insignificant.

MS. GROVES FUSCO: But you described the 79 patients that got scans at MRI as insignificant.

DR. CAMEL: That is incorrect. I described the economic impact on ARC as insignificant. You described the 23 patients as insignificant.

MS. GROVES FUSCO: Okay, well, in the filings, it lists the number and the percent of our total scans. Seventy-nine is a percentage of our total scans as being insignificant, and those scans, you said to me before, are not scans, they're people, correct?

DR. CAMEL: I said our patients are people. You referred to your business as scans.

MS. GROVES FUSCO: Okay. You cite the fact that, and I think it's on page 16 of your testimony, that 1.9 percent of the hospital for special surgery's MRI volume was Medicaid patients, despite the outreach efforts it's made, and you use that as proof that there's a low Medicaid MRI need in Fairfield County, correct?

DR. CAMEL: Yes, the number is correct.

MS. GROVES FUSCO: Okay, but you didn't reach out to any local FQHCs to see whether they report a need for MRI services for Medicaid patients, did you?

DR. CAMEL: I'm not aware of that

abbreviation.

MS. GROVES FUSCO: Federally Qualified Health Centers, like Optimus.

DR. CAMEL: Did I personally reach out?

MS. GROVES FUSCO: Yes.

DR. CAMEL: No.

MS. GROVES FUSCO: And you didn't reach out to any community health centers in the area to see whether they report a Medicaid MRI need?

DR. CAMEL: In Greenwich?

MS. GROVES FUSCO: In your service area, which includes Stamford and Norwalk.

DR. CAMEL: I did not reach out.

MS. GROVES FUSCO: High Medicaid populations. When you order an MRI, and this gets back to an issue we discussed earlier, about patient choice, in offering your patients a choice, do you provide them, do you actually hand them a list of alternate providers in the service area of MRI with contact information?

DR. CAMEL: We do.

MS. GROVES FUSCO: Okay. Do you disclose to your patients before they receive a scan on the ONS unit that you have a financial interest in that equipment?

DR. CAMEL: We actually do it better than that. We say we own it.

MS. GROVES FUSCO: Okay and you do that verbally or in writing?

DR. CAMEL: It's actually I think on that same piece of paper, but I don't have that with me.

MS. GROVES FUSCO: Okay. I have just a few more questions. Just a quick question about Worker's Compensation. I looked back at your CON for your original unit in 2008, where you had projected 6.6 percent Worker's Comp, and you have a payer mix in this CON. I think it's on page -- it's on page 33 that shows two percent MRI Worker's Comp, but then you state in your remarks that you can't refer Worker's Comp patients to your scanner, so how do you have scans and volume?

DR. CAMEL: I think that's maybe unclear language, and that actually goes, actually makes the point, so I think we do, and I don't have the exact number at my fingertips, but I think you're correct when you say that about six percent of our patient volume is Workmen's Comp, but, as I previously said, many Workmen's Comp carriers have narrow networks to which patients are referred, but not all of them do, so we actually can scan some Workmen's Comp patients, but we can't scan most of

them or the majority of them, and that's the discrepancy of MRIs, Workmen's Comp MRIs versus Workmen's Comp. patients.

MS. GROVES FUSCO: Okay, because you say in your filings that you cannot refer Worker's Comp. to your scanner. That's not correct?

DR. CAMEL: That's an overstatement.

MS. GROVES FUSCO: Okay. With respect to your rebuttal testimony about self-referral, you state that the studies we cite are older and that there are no new studies, but are you aware of the GAO study that Dr. Kaye cited in his testimony from 2012 that shows self-referral in advanced imaging is costing the Medicare program millions of dollars every year?

DR. CAMEL: I'm aware of that study.

MS. GROVES FUSCO: Okay, and are you aware of any recent studies that find self-referral for advanced imaging by orthopedists and neurosurgeons does not increase utilization or cost?

DR. CAMEL: We have the best study locally, because we actually can look at what we referred to before we put in our --

MS. GROVES FUSCO: Well, with all due respect, I'm asking published studies.

DR. CAMEL: I'm not aware of all --

MS. GROVES FUSCO: Peer reviewed published studies.

DR. CAMEL: I'm not aware.

MS. GROVES FUSCO: Okay. In terms of your physician recruitment efforts, have you had conversations with any other orthopedic or physician practices about joining ONS?

DR. CAMEL: You mean groups?

MS. GROVES FUSCO: Yes.

DR. CAMEL: No.

MS. GROVES FUSCO: Okay. In particular, have you spoken with Orthopaedic Associates of Stamford, now part of WESTMED?

DR. CAMEL: Never about joining.

MS. GROVES FUSCO: Okay. Have you had any conversations with WESTMED about joining their integrated delivery network?

DR. CAMEL: Can I just go backwards on that?

MS. GROVES FUSCO: Um-hum.

DR. CAMEL: They actually called us to have us start a conversation. We declined, so I'm not sure if that's a conversation.

MS. GROVES FUSCO: And that was OAS or WESTMED?

DR. CAMEL: WESTMED has not had a conversation with us.

MS. GROVES FUSCO: Okay, so, you've had no conversations with WESTMED about joining their integrated delivery network?

DR. CAMEL: No. No, not at all.

MS. GROVES FUSCO: Okay. Are you part of, along with any other orthopedists in the state, any national organization or group, like an MSO or similar contracting entity?

DR. CAMEL: No.

MS. GROVES FUSCO: Are you affiliated with or a member of any organization that might include other orthopedic practices in the state?

DR. CAMEL: I'm not sure what you mean.

MS. GROVES FUSCO: Are you in affiliation with any of the other orthopedic practices in the state, part of any joint membership association or things like that?

DR. CAMEL: Well there is the Connecticut Orthopaedic Associates, which is a professional group. They're professional groups. They're members of

professional groups.

MS. GROVES FUSCO: You don't have any sort of, other than professional entities like that, you don't have any sort of professional affiliation with any orthopedic groups in the Hartford area, and I mean for the service of patients?

DR. CAMEL: You mean like business entities?

MS. GROVES FUSCO: Yes, business.

DR. CAMEL: No, we have not.

MS. GROVES FUSCO: You're not in conversations about any of those?

DR. CAMEL: No.

MS. GROVES FUSCO: Okay, that's it. Thank you.

HEARING OFFICER HANSTED: All set?

MS. GROVES FUSCO: Yeah, we're all set. Thank you.

HEARING OFFICER HANSTED: Okay. Do you have any Redirect?

MS. VOLPE: I do. Do you want us to do it now, or would you like to break?

HEARING OFFICER HANSTED: How long do you think you'll be?

MS. VOLPE: Half hour, 40 minutes, maybe. Maybe less.

HEARING OFFICER HANSTED: Let's proceed now.

MS. VOLPE: Okay. Dr. Camel, can you -- it was represented that you see an insignificant number, I think that was ARC's, of Medicaid patients. Can you discuss your Medicaid service to the population in the region?

DR. CAMEL: Well, as I said in my original statement and I'll try not to be repetitive, because of the lunch hour, is that ONS and Greenwich Hospital, and Greenwich Hospital does this with all other subspecialists, as well, work together to provide care for Medicaid, indigent and underinsured patients in Greenwich, and there are, you know, significant numbers, and that's the reason every Thursday afternoon from 1:00 to 4:00 there's an orthopedic clinic that takes place at Greenwich Hospital, three out of four, staffed by ONS orthopedists.

Now there is no neurosurgery clinic, and, so, those patients to which the attorney referred are the neurosurgery patients from the clinic that are taken care of by the clinic, who are referred to us for care.

We choose to see them in our office, because along the spectrum of incidence of disease neurosurgical issues are far fewer than orthopedic issues, and, so, those 20-some patients you mentioned were probably all neurosurgery patients, but there may be other patients, who were operated on as emergencies without insurance, who are seen in follow-up as part of their routine postoperative care, when the scheduling with the clinic doesn't work out.

We also see a commensurate amount of emergency room call, and, like in most communities and not as much as Stamford, certainly, but, in Greenwich, there's a significant amount of trauma call that occurs, again, more on the orthopedic side and the neurosurgery side.

Some of those patients are insured. Some of those patients are not insured. We take all comers. And, in fact, we have orthopedists and neurosurgeons on call 365 days a year, period, whether we're on duty for the emergency room, and, most recently, I got called to see a patient from the New Haven area, which was not a trauma case, an intracerebral hemorrhage, and they called me it was literally 4:45 in the morning.

I woke up, I took the call, and I went in,

and then I went I'm not even on call. They called by error. This has gone on all the time, and our doctors take care of all of these patients in and around the Greenwich community, and that care, the in-office space delivery of care, it's correct. It was 88,000, but there was an additional hundreds and thousands of dollars of both office space care done at the hospital for professional services, surgery that was done, and postoperative care.

MS. VOLPE: Will the physician general practice always need to -- will you ever be able to accommodate all of the scans on your patients that are required in your practice?

DR. CAMEL: No. Again, we're being repetitive a little bit, but we don't for all those reasons that we haven't been in the past. We can't, because of geography. We can't, because of insurance. We can't, because of technological need and, also, patient choice.

So, for all of those reasons, which we've already been over, we won't and can't.

MS. VOLPE: So there is a discussion on self-referral and the studies and national studies. Has ONS conducted its own studies to determine its

utilization prior to acquisition of an MRI and after acquisition of an MRI?

DR. CAMEL: Yes. So we looked at that, because we've had discussions. At some point, I had a discussion with the Vice Chairman of Radiology at the Massachusetts General Hospital, and because this issue has been raised by radiologists, because it's a sort of driven question about self-referral, because the more self-referral there is there are fewer MRIs going to radiologists, who own their own their own imaging centers, so I understand the economic impact.

So we -- I, actually, through a connection, came into contact with a guy, who is the Vice Chairman of Radiology at Mass General, and we proposed a couple of different ways to do it.

We asked him to audit our indications, because Mass General has a list of proper indications for ordering studies.

We are all subspecialists in our group. Everybody is fellowship trained. It's an old fashioned system, where we are true partners. We're not individuals practicing together.

So, after a back and forth discussion, he sort of declined to be hired as the auditing person to

actually look at the charts and do the indication, so what we said, then, sort of we thought the next best thing is what was our number of scans done before we had our first MRI, and what are our number of scans per physician done after, and you can see, as our number of scans in the data that's already been presented and referred to by the other attorney, in 2012, the number was 240, and the latest year of that table, five years later, was 238. Intervening years were in the 220s, so we are actually doing -- our scan ordering per physician is perfectly stable and has been stable even when compared to before we owned our own MRI machine.

Why do we order so many? We're all subspecialists. By the time we see patients, if they haven't already been scanned, many of them get them, but many patients, as I said before, whether it's from the clinic, private physician's office, general orthopedists or general neurosurgeons, refer patients fully evaluated.

And, so, they come with their imaging already. Patients, who come primarily, are imaged at our office or surrounding scanners.

MS. VOLPE: Okay. One of the 12 factors for determining a CON, number 10, can you read that? Can you read what that says into the record?

DR. CAMEL: Yeah. Number 10?

MS. VOLPE: Yes.

DR. CAMEL: "Whether an Applicant, who has failed to provide or has reduced access to services by Medicaid recipients or indigent patients, has demonstrated good cause for doing so."

MS. VOLPE: Now would you state that your cooperation and coordination of that Medicaid population with Greenwich Hospital and the fact that it's been working for decades, is that good cause in your opinion?

DR. CAMEL: We provide really the same level of service to Medicaid and uninsured patients as we do to patients with the best insurance, or, you know, in our community, you can pay privately.

And what's fascinating, when you talk to people, who have insurance and have plenty of money, of which there are plenty in our community, make no doubt about that, they ask what happens to patients without insurance, because of the discussion in the news regarding President Obama's health care initiative about guaranteeing access to care, and I make the point all the time, I said, you know, the care you're getting from ONS is the same as everybody gets, and it doesn't matter what kind of car you drive, or how big your house is, or what

kind of insurance you have. We're all obligated, as are the radiologists, to provide the same level of service, no matter what the level of insurance.

And in Greenwich, at least, and I can't speak to all communities throughout the state, which I know is your charge, Greenwich Hospital and all of the private physician groups have provided this service since I arrived, well before I arrived in 1987, and it's worked great, and I would argue all of those patients have had access to some of the best physicians you can find anywhere, not just at ONS, but all throughout our community.

They're trained often in New York and Boston and other great places, so it's a fabulous level of care, and it's very different than you're going to see in more urban communities, just because the communities differ.

MS. VOLPE: We don't have any additional Redirect for Dr. Camel.

HEARING OFFICER HANSTED: Okay. All right, at this point, we're going to break for lunch. It's 10 after 12:00 now. Please come back here at 12:40. I want to get started right at 12:40. Thank you.

(Lunch recess)

HEARING OFFICER HANSTED: Back on the record, and we're going to begin with the Applicant's presentation on Docket No. 16-32093-CON.

MR. YODER: Good afternoon. My name is Clark Yoder. I'm the CEO of Advanced Radiology. I would like to adopt my pre-filed testimony, including rebuttal testimony submitted in responses to the testimony of ONS and WESTMED, for the record.

With me today are my colleagues, Dr. Gerard Muro, ARC's Neurology Section Director and Chief Medical Information Officer, and Dr. Alan Kaye, a former CEO of Advanced Radiology.

I joined ARC in 2015 as CEO. Prior to joining ARC, I spent 13 years working for Westchester Medical Group in varying capacities, including Director of Ancillary Services, Chief Financial Officer and Chief Operating Officer.

I hold an MBA and a Bachelor's of Science in Radiology. I'm a member of various professional organizations, including the American College of Health Care Executives, Radiology Business Management Association, and the Radiological Society of North America.

As you know, ARC is a multi-site, full-

service diagnostic imaging and interventional radiology provider. We have office locations in Stamford, Fairfield, Stratford, Trumbull, Shelton and Orange and provide advanced imaging, including MRI, at each site.

Our machines, including MRI, are fully accredited by the American College of Radiology, and our radiologists are subspecialty trained in various systems of the human body.

Over the course of the last year, we have been actively involved in the planning for an upgrade of ARC's technology. This has included ongoing evaluation of MRI capacity and planning for the acquisition of new equipment, as necessary.

One of the Intervenors criticized ARC for being slow to move on adding MRI capacity in Stamford, given how high our volumes have been since 2011, but, as mentioned in written testimony, we are deliberate on how we decide to upgrade and to add new equipment while making prudent business decisions in the best interest of the communities we serve and, also, take into consideration the 200 employees and their families.

Advanced imaging equipment is particularly expensive, and we want to make sure that we are expending our resources in ways that will benefit our patients, as

well.

The decision to add MRI in Stamford comes at a point where a majority of our MRI units are operating well over capacity; Stamford, 6,617 scans in 2015, which is 165 percent capacity, based on the statewide health plan; Fairfield, 6,685 scans, 167 percent capacity; Stratford, 5,433 scans, 136 percent capacity; and Trumbull scans 5,139, 128 percent capacity.

Our practice, in totality in 2015, performed 29,413 exams, which equates to 123 percent capacity.

We have worked hard to add capacity and to accommodate the increase in demand for our services by increasing hours and office locations, including Stamford.

Stamford MRI service now operates up to 92 hours a week, including weeknights and both weekends, weekend days. We pay technologists on average 17 percent more to work nights and weekends than we pay for daytime coverage, and, even so, we cannot easily find staff to work these hours.

We are limited, in terms of the types of exams that can be performed after hours, and patients are often reluctant to come to an inner city office, such as

Stamford, late at night.

Our Stamford office is the most geographically-distant of our scanners with the primary service towns that do not overlap with our other offices.

Stamford is located in the Southwestern most corner of our state, and I'm sure, as you know, traffic congestion from the Connecticut border through Stamford can continue to New Haven as some of the worst in the nation.

There are several reasons why we decided to MRI capacity our Stamford office at this time.

Despite the noise being made by our Intervenors about the validity of our projections and an unsubstantiated potential loss of some orthopedic referrals, there is, without question, a clear public need for this proposal.

The statewide health plan puts a capacity of an MRI unit at 4,000 scans per year and says an existing provider can upgrade once they fill 85 percent or 3,400 scans.

ARC performed 6,617 scans at Stamford last year, almost twice the amount required to justify an upgrade.

Based on the most recent available data

from OHCA, ARC's Stamford MRI is the busiest MRI of the 13 units operating in the service area.

This is especially significant, considering that at least one of these units is a hospital magnet that operates 24/7.

There has been a question raised about whether ARC can relocate its Shelton or Orange MRI scanner to Stamford, and the answer is no.

The units are well-utilized, and relocating them will cause great access issues in those communities. Although they are not as busy as our Greater Bridgeport area and Stamford MRI units, the ARC Shelton and Orange scanners are still busier than several of the MRI units operating in the Stamford area for purposes of comparison.

The Orange unit, which is a 3 Tesla unit, has seen a recent increase in volume and will reach capacity in the near future, and we've just upgraded the software on our Shelton scanner, so they can perform additional exams, which will result in increased volume on this unit, as well.

Furthermore, the Shelton and Orange offices have additional complimentary modalities, including ultrasound, x-ray, CAT scan, fluoroscopy and

mammography. By removing these services, it would affect the viability of these offices.

Adding a 3 Tesla scanner in the private practice setting in Stamford will, without question, increase the quality of MRI services in the area.

Dr. Muro will talk to you more about the benefits of 3 Tesla MRI and address the issues raised by WESTMED and refuted by ARC about whether this type of scanner can or should be used in an outpatient setting.

Dr. Muro can also tell you everything that there is to tell about health information advances and how these afford our physicians and patients unprecedented access to their images and reports and how ultimately this enhances the quality of care for so many.

More generally, I can tell you, by adding MRI capacity in Stamford, will reduce our now seven to 10-day backlog for MRI services, allowing more patients to receive their MRI scans sooner, leading to more timely diagnosis and treatment.

There is an additional need for MRI services in the Stamford area, generally, and adding this capacity at ARC is one of the most cost-effective solutions.

As a private physician practice, ARC is

typically reimbursed for MRI services at much lower rates than hospitals, health systems, large multi-specialty groups, and making our units more cost-effective than most.

We also don't charge facility fees. Moreover, as Dr. Kaye will discuss in greater detail, we do not self-refer patients to our scanner.

This ensures that all referrals are clinically-necessary and that overutilization has not artificially driven up the cost of care.

I know that both Intervenors have question of financial feasibility of this proposal. Just because there are initial incremental losses associated with acquisition of a second unit doesn't mean the project isn't feasible.

Advanced imaging often requires a ramp up period before it becomes profitable on its own. Fortunately, our practice has six MRIs spread among our offices and run through advanced MRI centers limited partnerships, which remains profitable, even with the projected incremental losses of the first few years of operation. For example, in fiscal year 2017, following the acquisition, ARC MRI will have a net income in excess of $1.5 million.

Lastly, I would like to touch on the very important issue of access. The addition of MRI capacity will increase access to our patients generally, which is critically important, but it will also increase access for some of the State's most vulnerable patients, including Medicaid recipients and indigent persons.

We are the only private non-hospital MRI provider in the Stamford area that participates in the Medicaid program.

Medicaid accounted for nearly four percent of Stamford MRI volume and more than seven percent overall ARC MRI volume.

We are also committed to serving the uninsured and underinsured. We remain committed to serving these patients in growing numbers in the future, unlike some of our competitors.

In conclusion, ARC has met all the CON statutory decision criteria for its Stamford MRI. Volume far exceeds the 3,400 scans required to justify acquisition of a second unit for the office.

We have shown that, without a doubt, this proposal will improve the quality of MRI services in our area, the cost effectiveness of these services, and the accessibility of MRI for underserved populations, such as

Medicaid beneficiaries.

ARC is proud of its commitment to providing the highest quality of care to all patients, regardless of their ability to pay.

We urge you to approve this CON, so we can adequately serve the Stamford community's MRI needs.

Thank you for allowing me to present, and I would like to ask my colleague, Dr. Muro, to come to the microphone.

DR. MURO: Good afternoon. I'm Dr. Gerard Muro, and I'd like to thank you for giving me this opportunity to speak this afternoon.

I'd like to adopt my pre-filed testimony, and I'd like to start just by introducing myself. I think it's relevant to my discussion.

I have been with Advanced Radiology for 17 years. I am a fellowship-trained neuroradiologist, two years of fellowship training, senior member of the American Society of Neuroradiology. I'm Director of our Neuro Section, and I read 3T MRI scans on a regular basis, so, based on that, I'm certainly qualified to speak on the benefits of 3T, as well as answer any questions anyone has.

I'm also the Chief Medical Information

Officer for the organization. ARC makes a huge investment in health care IT technology.

We believe it's one key to improving quality, service and controlling costs. It's certainly in keeping with many of the CMS initiatives, such as within the Affordable Care Act, MACRA, PAMA, and, for myself, it's just a personal passion of mine.

In fact, I'm just completing my Master's degree in Health Care Information Technology at Northwestern.

So I'd like to discuss two issues; our decision to acquire a 3T in Stamford, as well as talk about our mobile imaging sharing network and other health care IT technologies that is relevant to our 3T acquisition.

First, regarding the decision to acquire a 3T in Stamford, it's part of our commitment to providing the highest quality possible in a private physician office setting in the Stamford area.

We acknowledge the fact that Greenwich Hospital has a 3T MRI, however, it is on campus and less convenient than a private office.

It's less cost effective, due to the higher reimbursement and facility fees. It's currently -

- I'm sorry. Based on 2013 filings, it was at 82 percent capacity and likely above 85 percent, which is the threshold for acquiring a new MRI.

So what are the benefits of 3T? The higher strength of the magnet provides more signal, which translates into a higher definition image, just like the high definition televisions, so it's not just the resolution, but it's also temporal resolution, which means imaging changes over time, such as a beating heart, and there are certain applications or certain clinical conditions where this is very helpful.

It also allows us to provide some advanced imaging techniques that are not really feasible or practical with the 1.5 Tesla, and that includes diffusion tensor imaging, where there's a lot of interest in neurodegenerative disorders and traumatic brain injury.

Also, it allows us to perform functional MRI, which is basically imaging the physiology of the brain.

It also provides us with higher definition vascular imaging, imaging of the blood vessels, and this is particularly important with such diseases as brain aneurisms. They're more accurately characterized and easier to detect with 3T. We can better detect blockages

in blood vessels with 3T, and I think that anyone, who had a family member or themselves with a brain aneurysm, would rather have a 3T MRI, if it was possible.

It could also obviate the need for a CT scan, which would require the injection of dye and entails radiation.

I should also mention that we partake in several clinical trials, most of which are related to Alzheimer's disease, multiple sclerosis, and traumatic brain injury. These are performed at our Orange and Fairfield MRI units. All require 3 Tesla magnetic imaging, and it would be certainly a benefit to make these trials available in the Stamford area, as well, not just for the patients, but, also, for physicians, who want to engage in some of these clinical trials outside the academic centers.

I should also mention that it's much better for prostate imaging. There's better definition. The definition is so much better that we no longer require the placement of a probe in the rectum, which you can imagine is uncomfortable for the patient.

With extremities and joints, there is better definition and image quality, which can be a factor in certain situations, such as with the feet and

shoulders. And our physicians, many of our physicians or specialists, demand 3T imaging for certain clinical indications, and I'll just give one example.

We have a pediatric neurologist, who will only have his children imaged on the 3T magnets for seizure evaluation, looking for very subtle defects in the brain that could impact treatment and prognosis.

I would like to address some inaccurate assertions provided by Dr. Weiss of WESTMED, and we stated that 3T MRI is more appropriate in the acute care setting, and it's actually the contrary.

In an acute care setting, it's much more difficult to adequately screen patients for a 3T MRI. Often, there's attached devices, catheters, wires, etcetera, that are a contraindication to 3T MRI, and the truth is there's little added value with 3T in the acute setting, however, we, I think, we have proof that 3T MRIs in Orange and Fairfield that there is a huge benefit to a 3T in the outpatient setting. We offer almost the entire gambit of possibilities or capabilities of 3T at those units.

It was also mentioned by Dr. Weiss that there's issues with SAR. Basically, that's tissue heating that can occur with the MR, whether it's 1.5 or

3T. It is more problematic with 3T, however, our technologists are experienced, well-trained, and they could make subtle adjustments in the techniques, so it's not really an issue.

Dr. Weiss also made mention of susceptibility artifact as a problem. It's true that, with a stronger magnet, you get more artifacts from metallic devices, such as implants, hip replacement, for example, however, with careful screening, if we think it's a problem, some patients do the 1.5T, and, in fact, it's actually the susceptibility artifact is one of the benefits of 3T, because it allows us to -- provides more sensitivity in detecting micro-hemorrhages, old micro-hemorrhages in the brain that you might find with traumatic brain injury, metastatic disease, and other pathology.

I also would like to talk about ARC's state-of-the-art image and report sharing network. We call it AR Connect. It's the forefront of health care IT technology, both within our state and nationally.

Sort of central to it is our Intelerad PACS imaging platform. Intelerad is an industry leader when it comes to PACS, and we have a 100 percent up time.

Intelerad has their own viewer that the

radiologists use for their interpretations, however, we also provide that same viewer to our referring physicians. It's very powerful, yet intuitive and easy to use.

We have 3,800 physicians using this viewer, and there are frequent accolades from our referring community regarding this particular viewer, however, to enhance that access to images and reports, we have developed internally our mobile sharing platform that's now available nationwide through another vendor, not through us, but we did develop it, and this makes images and reports available from mobile devices, such as an iPad or iPhone.

It also includes a zero footprint viewer, and what that means a zero footprint viewer is a viewer that you can launch within your Internet Explorer, Firefox, Safari, without having to download software, and that's very important, because some of our physicians are in environments where they're not allowed to download software, so, basically, we've kind of done everything possible to increase access to images and reports for physicians. It kind of fulfills one of our missions, which is to provide access to images and reports anytime from anywhere.

I should also mention our patient portal, which is very unique nationwide. Not only do our patients have access to their reports within two days after the report is completed, but they have access to their images, and there are probably very, very few people or practices in the country that allow that or have that technology that we developed.

With that, they can not only view their images. They can share those images, so, if they have a physician in New York, they could share those images with that physician, so it's a very powerful patient empowerment tool.

And just some of our integration and collaboration technologies. We integrate -- our electronic medical record system integrates with several other EMRs throughout our service area. It's an HL-7 integration, where we can automatically insert reports into the front positions of EMR, and they could order directly from their EMR into our system.

It's a more timely, efficient and accurate exchange of information, and just one notable example is our integration with the Yale Epic system, where a physician, who is ordering out of Epic, their studies, if we perform those studies, those reports will be

automatically uploaded into the Epic EMR, and, with some very recent collaboration with Yale, we've upgraded that functionality, where it now appears in their inbox, that this report is now ready for review.

And I should mention that, you know, Greenwich is part of that Yale system and on Epic, so those physicians would also see that benefit, and we have, again, several of these types of integrations, including the Stamford area.

And just one last comment about integration. We host the PACS for St. Vincent's Hospital, and our two systems are very tightly integrated, where we each have an awareness of each other's studies and instant access to those studies, so if I'm reading an MRI at St. Vincent's, I will know instantly if there were prior studies at Advanced Radiology and vice versus, so you're less likely to have unnecessary repeat examinations.

The quality is better, because you have access to those prior examinations, and more timely, because you're not waiting for someone to deliver a CD.

So, in conclusion, I would urge OHCA to please approve ARC's request for permission to acquire a 3T MRI for the Stamford office. It will result in more

timely appointments, diagnosis and treatment, and, at the same time, bring state-of-the-art imaging technology to the Stamford area in a private setting that's not currently available, and it will be backed by our cutting edge image and report sharing network, which is patient empowering, enables our physicians with information in a timely and meaningful manner, and it's also a collaborative tool with our hospitals.

So thank you, again, for allowing me to speak, and I would like to now introduce my colleague, Dr. Alan Kaye.

DR. KAYE: Hello, again. Alan Kaye, Dr. Alan Kaye, former CEO of Advanced Radiology and now a member of the Radiology Executive Committee, like Drs. Muro and Karol, who are also here.

Much of what I have to say is somewhat duplicative of my remarks regarding the ONS application, and I will just mention the general category and then expand on some additional points.

Let me just introduce myself again, in terms of what some of my additional credentials are. As I've told you, I've been the Legislative Chairperson for the Radiological Society of Connecticut for now my 23 years. I have been the -- I am on the Board of

Chancellors of the American College of Radiology and serve on commissions that they are the committees of the Board, the Commissions for Economics, Government Relations, the Future Trends Committee, which deals with the future of alternative payment models and quality metrics, and the Radiology Integrated Care Network, which is a way of helping foster, move radiology and to participate in integrated models.

What I didn't mention before was that I'm also on the Executive -- I'm on the Board and the Executive Committee Board and now on the Contracting Committee for Community Medical Group, which is an association. It's a conglomeration of IPAs, Independent Practice Associations, that encompass physicians from Greenwich, the state border, to the eastern shore of Connecticut.

There are 1,100 providers participating, and we are involved in gain sharing models, in Medicare savings program, and are in the process of getting our Integrated Care Delivery Network designation, which is a fairly robust process.

One of the reasons that I serve on that is because, as a member of Advanced Radiology, they are impressed with our preparation for those alternative care

models, and we help guide them, not only with respect to radiology, but with respect to other ways that independent practices can participate in integrated care.

Now, that said, you don't have to be a single tax identification number one practice to become an integrated delivery network.

In fact, much of that has to do with technology, and that's why what Dr. Muro said, about how advanced we are, that's one of the reasons we're at the table with Community Medical Group.

And what Dr. Muro didn't say is that we have integrated with over 100, maybe even over 130 electronic medical records for over 130 physicians, and, actually, if you include the now Epic one, it's over 1,000 physicians, so we are technologically advanced, as well, and willing to provide a virtual integrated delivery network to our patients and to our referring physicians.

Now I've talked a lot about self-referral before and in my pre-file, and I'd like to adopt that pre-filed testimony, and, so, I won't repeat a lot of that, but I will just reiterate two things about it and then expand on it.

The two things I want to reiterate about

it are, number one, that it does cause increased utilization relative to those that I refer. Study after study shows it, and there have even been studies, multiple studies, that show, when a physician acquires the imaging technology, he or she changes his or her behavior, and those are peer reviewed studies, statistically significant, not anecdotal, although I could probably give you plenty of anecdotal examples.

And the other thing about it is that it does affect referral relationships, affect on other providers and competition, but let me just give you some examples and types of things that are not necessarily right on the surface of what self-referral does, which are among the things I mentioned before.

When a physician owns his or her own unit, there is clearly an incentive to do that. Much of the time, it's stated to be the convenience of the patient, and we've debunked that in our submissions, but, also, you don't necessarily try to overcome some of the obstacles in referring to another practice, even though there may be enhancements of it.

So, for example, let's take, quote, "quality issues." As the CEO and lead physician of Advanced Radiology for 22 years, I received hundreds of

requests for changing the way we do things, issues with respect to types of imaging, sometimes quality, which we address immediately, and, in fact, I had two employees, whose main job was to let us -- to canvas our referring physicians to help make us better and to help them take care of their patients better, so we might not hear about quality issues from a self-referring physician.

We might not hear about protocols that they would prefer, and I can tell you that we have structured reports. When you get a report from Advanced Radiology, it has structure, and the way that works is there are fields to be completed.

One of the fields is technique of the examination, and there are multiple neuro, orthopedic, urology, ENT, ophthalmologic protocols that we customize, as per the request of the referring physician.

Now if you have your own unit and you aren’t going to send anyway, you’re not going to tell us what those protocols are, so that’s one way that self-referral affects the general care of the population, and the incentives drive the behavior.

Not asking your hospital to provide access to a radiology, independent radiology practice’s electronic images in the operating room or on their work

stations might be another, so, for example, just to use the Stamford, OSSM, Orthopaedic Specialty and Sports Specialists of Sports Medicine, and OAS, Orthopaedic Associates of Stamford, both had problems in Stamford seeing our imaging tests in the operating room, and, as you can imagine, that would create significant issues.

They petitioned and asked Stamford Hospital to allow it, and guess what? Stamford Hospital allows it, so they have access to it, but before we were able to get the technology in place, that was the impetus for the app that you could download on the Apple Store the app for allowing access.

So anyplace you have an internet or even a cellular connection, you can see our images and our reports and comparisons with prior ones, so a self-refer might not be inclined to ask for those things or ask their hospital to facilitate that.

You might not be so inclined to use a 3 Tesla magnet, which, even by Dr. Sullivan’s admission, is the state-of-the-art way to image in many ways that are probably not being done in places that don’t have 3 Tesla, so the gray zone expands for benefit of, I’m sorry, contracts for the benefits of 3 Tesla.

If you’re a patient, and, as Dr. Muro

said, somebody in his family he would send to a 3 Tesla, unless there was a contraindication to it, that's what happens with self-referral.

Now with respect to integrated delivery networks and sending patients to New York from Darien for, you know, inconveniencing them to do that, so that they could be part of the integrated delivery network, as I've told you, as I've asserted before and as Dr. Muro has testified, we have an effective integrated delivery network, and, in fact, our strategy, a lot of the things we told you about how we provide service in our electronic strategy and our large footprint, geographic footprint and our diversity of types of scanners is based upon what we perceive may be the new paradigm for care, and that is larger entities covering a larger, and we believe that an independent radiology practice, who is an expert in one thing imaging, who has a large footprint, who has multiple types of imaging services available, and who is electronically integrated with Cerner, with Epic, with Allscripts, with almost all of the big ones, is the way to go, and we can do it more cost effectively, without inflating the utilization.

Now if an integrated delivery network says that it does fewer, does fewer, that can be -- I'm not

sure it's fewer than what we're doing. I think the 267 is probably larger than what we're doing, but if it has, they should talk to us about providing the services more economically and available to a wider geographic population, and we stand ready to do that, we have been doing that, and that's one of the reasons why we're at CMG, and we plan to do that from the state line all the way up to and past Essex and are ready to do that now.

So we urge you to please consider our application favorably. We are positioning ourselves to be the preferred provider for imaging services in the most cost-effective and high-quality way, and I thank you for the opportunity for hearing myself, Clark Yoder and Dr. Muro. Thank you.

HEARING OFFICER HANSTED: Anything further?

MS. GROVES FUSCO: Oh, I'm sorry. That concludes our presentation.

HEARING OFFICER HANSTED: Okay. All right. Attorney Volpe, if you want to proceed with your presentation?

MS. VOLPE: Sure. I'm going to introduce Dr. Camel again.

HEARING OFFICER HANSTED: Good afternoon.

DR. CAMEL: Well, hi. It's me again. I'm Dr. Mark Camel, as you know, and I adopted my pre-filed testimony in the docket. I'm here to speak in opposition to Advanced Radiology's CON application, and I will, in fact, keep my comments brief.

As outlined in the pre-filed testimony, Advanced Radiology has failed to meet the CON criteria. First, ARC has not demonstrated there's a clear public need in its practice for an additional MRI machine.

ARC has the ability to move underutilized scanners anywhere in the state, but it has chosen not to address the needs for individuals presenting for MRI at its Stamford location.

ARC scanners and its practice have significant service area overlap, and ARC, itself, has stated that it does not view the referral to us as a referral to a machine or a coil, but to us, as a practice or physician group.

ARC's assertion, that it's being forced to send Stamford area patients to Fairfield, is unfounded, as its Fairfield service area does not include the Stamford area.

ARC can manage the patients' needs by relocating an existing scanner. ARC already has an

underutilized 3T scanner in its own practice. OHCA should carefully consider whether ARC has appropriately identified a need for an additional 3T MRI in its practice.

Further, Greenwich Hospital last week opened its 3T MRI machine on Long Ridge Road, raising the question -- I'm sorry. In Stamford, raising the question whether we need a second 3T MRI in Stamford.

As indicated in the WESTMED pre-filed testimony, WESTMED is seeking to redirect its own patients in the region, who require MRI scans, away from Advanced Radiology, presumably to WESTMED scanner in New York, as well as to other underutilized MRI providers right in Stamford, owned by Greenwich Hospital, Hospital for Special Surgery, and Stamford Hospital's scanner in Darien.

This will significantly affect the projected numbers that ARC has set forth in its application. OHCA should carefully review the impact on ARC's projections, since WESTMED will no longer serve as a referral source to ARC and will not continue to send thousands of WESTMED patients to its Stamford location.

Further, the second, or I should say one other orthopedic group in Stamford, OSSM, has now

undergone dissolution. Two of those orthopedic surgeons have joined New England Medical Group, which is part of the Yale system, and will have offices on Long Ridge.

The physiatrist has joined the Hospital for Special Surgery at their Chelsea Piers Exit 9 location on 95, and the remaining two orthopedic surgeons I think have not yet decided what they're doing.

As previously stated, ARC can relocate its existing scanner. ARC has an underutilized high-level scanner in its Orange location, which can be moved within its practice to any address it needs.

As important, another MRI referral source in Orange is seeking approval to expand its MRI services in Orange, which will bring additional capacity to the Orange location and will also impact the referrals to ARC's underutilized Orange MRI.

As outlined in detail in my pre-filed testimony, as well as WESTMED's filing, ARC has put forth the GE study, which shows significant proposed Medicare growth, but does not properly account for its own projected increase in Medicaid population.

In its 2004 application to OHCA, they projected a Medicare percentage population, Medicaid, excuse me, of 5.92 percent, but recently showed that its

current Medicaid percentage population is about 3.9.

The ARC MRI is not -- the Advanced Radiology MRI is not proposed to be profitable. OHCA is required to consider the financial feasibility for a proposed CON. Advanced Radiology does not anticipate a profit.

Furthermore, it is questionable whether an additional MRI in Stamford will be profitable now that WESTMED, which accounts for over 2,000 referrals, is actively working towards redirecting those referrals to other underutilized MRI providers.

OHCA argues that self-referred MRIs are not beneficial and create overutilization. This cannot be further from the truth, and we've already reviewed the data.

Dr. Kaye noted national peer reviewed studies and journal, also noting anecdotal reports, but he discounts the anecdotal evidence that ONS has, demonstrating, and it's in this record, showing a stable to slightly decreasing number of MRIs referred per surgeon or physician at ONS.

Outside MRIs are not always beneficial to surgeons, and I'm here today to provide detail, as to how Advanced Radiology's technologists, for purposes of

sharing MRI images, has not worked, as stated.

I previously discussed this earlier this morning and won't review this piece-by-piece, but we find it often, not seldom, difficult to access using their online platform.

As I've also said before, ONS slot times are now 40 minutes. More sequences are done, which allow us to see anatomic detail in ways that we often don't see from outside imaging devices with much shorter scan times, even when the machines are identical.

Finally, this is not Advanced Radiology's first time seeking approval concurrent with other providers in the service area. Advanced Radiology has a history of being reactionary and failing to be proactive in upgrading technology or even adding imaging capacity until other providers spend resources, like we have, and come forward for CON approval to meet the public need.

Advanced Radiology received OHCA approval to upgrade its Stamford MRI nearly nine years ago, but it chose not to implement that approval.

Further, Advanced Radiology states it has been overcapacity for years, but just coincidentally commenced the CON process for an additional MRI after the ONS application was deemed complete.

OHCA should question whether Advanced Radiology will even implement on an approved CON, since it never implemented on the waiver approval nine years ago.

In conclusion, Advanced Radiology has failed to demonstrate a need for an additional MRI scanner.

For all of the aforementioned reasons, we respectfully request that you decline Advanced Radiology's application.

HEARING OFFICER HANSTED: Thank you, Doctor. Is that all?

MS. VOLPE: Yeah, that concludes our Intervenor presentation.

HEARING OFFICER HANSTED: Okay and if you and your client would take seats in the back, or somewhere back there, so Attorney Monahan and his witness can use that table, please?

MS. VOLPE: Sure.

HEARING OFFICER HANSTED: Good afternoon.

MR. MONAHAN: Good afternoon, Hearing Officer Hansted and members of the OHCA panel. I'm Patrick Monahan. I represent Westchester Medical Group, PC in an Intervenor capacity.

On behalf of WESTMED, we do appreciate the opportunity to offer what we believe is pertinent evidence.

I, as our Direct, am going to ask both witnesses to adopt their pre-filed testimony, and then ask Dr. Morel to my right to provide oral testimony in brief fashion, and, to facilitate the orderly proceeding of the hearing, we will rely on the written testimony of Dr. Weiss, however, to the extent there is any Cross-Examination of either witness that requires in my judgment Redirect, I would respectfully request the right to do some Redirect, if necessary.

HEARING OFFICER HANSTED: Yes.

MR. MONAHAN: Thank you. With that, I will introduce Dr. Richard Morel and ask him to identify himself, tell you a little bit about WESTMED and why we are here. Thank you.

DR. MOREL: Hello. My name is Dr. Richard Morel, and I am both Medical Director and Vice President for WESTMED Medical Group, and I want to thank you for giving me the opportunity to speak today.

I thought it would be helpful, since WESTMED is new to Connecticut, if I just give you a little background of who we are.

So we are a physician-owned and physician-run multi-specialty practice. We originated 20 years ago with 16 physicians. We've now grown to more than 420 providers. We have over 1,300 employees. We take care of 330,000 patients in both New York and Connecticut.

We operate on what's called a polyclinic model, so our average office size is between 70 and 110,000 square feet, in which we have a primary care base, with internal medicine pediatrics, OBGYN.

We have an urgent care system for extended access. We have pretty much every subspecialty under our care system right now, other than maybe cardiothoracic surgery, and we have onsite laboratory, pathology and full imaging radiology, including MRI and CT-PET.

That has really allowed us to provide the new model of health care, which is the value-based model, where we provide the highest quality care at the lowest cost.

We've been a successful MSSP through the CMS program, have multiple ACO like products with the commercial carriers.

About a year ago, we entered into Connecticut. We are quickly growing in Fairfield County. We now have 20 providers as members of WESTMED here in

Connecticut in four offices. We have two offices in Greenwich, we have an office in Darien, and we have the office in Stamford.

As of July 11th, Orthopaedic Associates of Stamford became members of WESTMED Medical Group. It's a large orthopedic group, with orthopedic, orthopedic spine pain management.

The reason that we are here today is we felt it was our duty to represent some information that was presented in ARC's application that we feel is not accurate, and that is the fact on their projected volume for MRIs as part of their application.

OAS, which is now part of WESTMED, formally in 2015 referred over 2,000 MRI scans to ARC. That is a major portion of their current volume.

It has been our experience and our growth from 16 providers to over 430 providers that those type of external referrals start to dissipate as time goes by.

The reason for that is we truly provide one coordinated network of care, so if you ask patients what's important to them and their health care, one of the things that they will tell you is I want my providers to talk to each other.

Most of health care right now is provided

in silos, so you get your radiology images here, you have your internists here, your orthopedist in another location, and you're lucky if there's communication between them.

Within WESTMED, we operate on one system. Your entire team is talking to each other. We have one EMR. We have a communication system within our EMR. Every provider can see what everyone else is doing, and that leads to higher quality and lower cost.

In addition, one of the things patients want you to be is respectful for their time. Traditionally, we've made patients wait too long in medicine, a lot of unnecessary waiting, right?

You get your mammogram done. You get a letter in the mail a week later what the results are. You're called back for additional imaging. You've got to schedule that a week later. You're told you need a biopsy. It's two weeks to see a breast surgeon, then you wait another week for biopsy results. That's five weeks of time, where you're nervous and you're worried about what your results will be, so we don't provide that for patients. We're respectful of their care. We take patients from screening mammogram to biopsy results in 48 hours.

I still see patients part-time. The patient that I saw last week was a 70-year-old woman, who is a smoker, who came in to see me for a 9:30 appointment, so she saw me for her Medicare wellness exam.

She had her mammogram pre-booked already and had her mammogram done. She had her full labs done. She had her bone density done, and she had her CT screening low dose for lung cancer. All of that done, and she was back in my office at 11:30 to go over the results.

That’s the level of care that we provide to patients, and that’s why those patients, who are presently getting fractionated care at different health systems, are going to be full WESTMED patients and receive that comprehensive care under the WESTMED umbrella, and they will lose their 2,000 referrals. Thank you.

HEARING OFFICER HANSTED: Thank you.

MR. MONAHAN: And, just formally, would you adopt your pre-filed testimony?

DR. MOREL: And I adopt my pre-filed testimony.

MR. MONAHAN: And Dr. Jonathan Weiss, if

you'd introduce yourself and adopt your testimony, please?

DR. WEISS: My name is Dr. John Weiss. I'm the Senior Radiologist at WESTMED Medical Group. I've been there for 15 years. Prior to that, I was at White Plains Hospital for 12 years. I would like to adopt the testimony I already submitted.

Our group does about 11,000 MRIs a year at this point. We operate four MRIs in New York State, none of which are 3 Tesla. A fifth is coming online shortly, and I'll leave it at that.

HEARING OFFICER HANSTED: Okay, thank you, Doctor. Does that conclude your presentation?

MR. MONAHAN: That concludes our presentation.

HEARING OFFICER HANSTED: Okay. Just stay there. Do you want to Cross?

MS. GROVES FUSCO: Sure. Good afternoon. Dr. Morel, I'll start with something you just said at the end of, right at the very end of your presentation.

So, you know, you talk about this desire to have patients receive comprehensive care under the WESTMED umbrella, correct?

DR. MOREL: Um-hum.

MS. GROVES FUSCO: And that includes all services, such as MRI, you know, advanced imagine service, as well. So right now, today, in order for a Connecticut-based WESTMED patient to get comprehensive care, including MRI services, they're going to have to travel to New York for that MRI, correct, because you don't operate scanners here?

DR. MOREL: Correct.

MS. GROVES FUSCO: Okay and you also mentioned that you're very respectful of patients' time. Is asking patients, who right now often receive their MRI services in the same town where their physician's office is located and, you know, once Advanced Radiology moves their office, they'll be two doors down, does asking those patients, instead of going two doors down for their scan, to get in a car and go down 95 in traffic through Greenwich and what have you to get that scan, potentially hours round trip, is that respectful of patients' time?

DR. MOREL: It's respectful of patients' time, because, A, they'll have the opportunity to receive other aspects of their care, and it's also respectful of their time, because they'll have access to higher quality care.

MS. GROVES FUSCO: Okay, so, are you

suggesting that the quality of MRI services that are provided by Advanced Radiology are not adequate?

DR. MOREL: No, I'm not.

MS. GROVES FUSCO: Okay, because you know that OAS refers them over 2,000 scans a year. They think they're good enough that they send 71 percent of their scans there, correct?

DR. MOREL: Yes.

MS. GROVES FUSCO: So these patients could get high-quality MRI services just a few doors away from their orthopedist's office.

DR. MOREL: But it's not just the MRI. So, for instance, we have -- I don't know if anyone is familiar with an IPU. So IPU is an Integrated Practice Unit, and we have one focused on spine care, and this is very similar to oncologic care, so what we do is we will have, in one room, you have spinal surgeons, pain medicine physicians, physical therapists, behavioral health, radiology, okay, physical therapy, all aspects of a team involved in that patient care.

Difficult patients will be presented. All members of that team will have their input, and a plan will be devised, based on all sides of that input, and, if scans are done outside, they don't have that quite

same level of access.

MS. GROVES FUSCO: Will you acknowledge that there are certain patients that will not want to travel to New York for scans?

DR. MOREL: Oh, absolutely.

MS. GROVES FUSCO: Okay. You've been able to quantify what that percentage is? Because you state in your papers that pretty much all 2,000 patients are going to be leaving.

DR. MOREL: So, based on our experience, so we've grown, remember, from 16 to 430 providers, so we've seen this multiple, multiple times in the past over the last 20 years, and what happens is patients like to have all of their care under one system, they like their providers speaking to each other, and doctors like their job to be easier.

When you're trying to pull together all types of outside resources, it's very difficult to provide the same level of care to patients.

MS. GROVES FUSCO: You are aware that OAS recently relocated their office to be closer to sort of the New Canaan/Darien side of Stamford, because they get the majority of their referrals from New Canaan and Darien, which are further to the east, correct?

DR. MOREL: Well I know they relocated. I do not know the reason they relocated.

MS. GROVES FUSCO: Okay. Assuming it's because they get a majority of their patients from that area, would you agree that traveling to New York from points east of Stamford is even more cumbersome than suggesting patients from Stamford or Greenwich go across the border, that you're increasing the travel time even more for these patients?

DR. MOREL: I'll agree it's increasing the travel time, but there are lots of people in this community, who work in Manhattan and travel to Manhattan for work every day.

MS. GROVES FUSCO: Understandable, but that's work.

DR. MOREL: And this is your health.

MS. GROVES FUSCO: That's not an MRI scan.

MR. MONAHAN: May I ask that counsel not be argumentative with the witness?

HEARING OFFICER HANSTED: Counsel, just ask the question.

MS. GROVES FUSCO: Okay. In your experience, you said, when I asked you if you could quantify how many scans we're talking about, you said, in

your personal experience, most patients want to do it. Does your personal experience include asking patients to travel from lower Fairfield County, from the Stamford area and points east to New York for MRI scans?

DR. MOREL: So I'll give you another example.

MS. GROVES FUSCO: No. It's a yes or no question. Does it include that particular --

DR. MOREL: Repeat the question, please?

MS. GROVES FUSCO: Does your personal experience involve asking patients to travel from lower Fairfield County, Stamford and points east to New York?

DR. MOREL: We have only been in Stamford for the last seven weeks.

MS. GROVES FUSCO: So it's not part of your experience?

DR. MOREL: But I would say that it relates to our past experience over 20 years, and, as an example, I have a patient, who I saw in my Yonkers office, and needed a hand specialist and traveled up to OAS in Stamford to see a hand specialist.

MS. GROVES FUSCO: Are you aware, and you raised the possibility of applying for your own CON unit here in Connecticut, are you aware that you can't prove

need for an MRI unit, based upon basically eviscerating the volume of an existing provider, taking what you would say would be 40 percent of another provider's volume to justify need for your unit?

MR. MONAHAN: I'm going to object to the question and the substance and form of the question, because we're not here on an MRI or an application in our proceeding, and --

MS. GROVES FUSCO: It's --

MR. MONAHAN: May I finish, please? And there is -- if the witness knows the answer, without having studied the legal components, that may be fine, but I believe it calls for a legal analysis, and I think it's inappropriate in this proceeding.

MS. GROVES FUSCO: With all due respect, the issue was raised by WESTMED in their petition. Will you let me now finish?

MR. MONAHAN: The issue --

HEARING OFFICER HANSTED: Let her finish.

MS. GROVES FUSCO: With all due respect, the issue was raised by WESTMED in their petition and in their filings. I can ask the question. If the witness cannot answer, it's fine for him to say he can't answer.

HEARING OFFICER HANSTED: It's fair game.

You raised it in your petition.

MR. MONAHAN: Fair enough. Thank you.

HEARING OFFICER HANSTED: If he can't answer, he can't answer.

MR. MONAHAN: Thank you.

DR. MOREL: So we are considering applying for our own Certified of Need, but we haven't gone through all of the aspects of the legality and questions about that, no.

MS. GROVES FUSCO: One of the things, and I'm not sure if it was in pre-file or if it was in a rebuttal written by your counsel, was that, you know, you, as WESTMED now and OAS, have every right to refer patients wherever you want in Fairfield County, and I agree. Patients have a choice in where they go.

Do you have plans to refer patients away from ARC to other lower Fairfield County providers, and, if so, which providers?

DR. MOREL: We do not.

MS. GROVES FUSCO: You're aware that a majority of the providers in the Stamford area are hospital-based and potentially more costly providers of MRI services?

DR. MOREL: I am.

MS. GROVES FUSCO: That Advanced Radiology is the only private physician practice, private radiology practice providing MRI?

HEARING OFFICER HANSTED: If you could just answer her verbally, just so it picks up on the record?

DR. MOREL: Oh, sorry.

HEARING OFFICER HANSTED: That's all right.

DR. MOREL: Repeat it again? Sorry.

MS. GROVES FUSCO: I'm sorry. That Advanced Radiology is the only private radiology practice in the Stamford area that offers MRI?

DR. MOREL: I am aware.

MS. GROVES FUSCO: How many of your -- I think you quoted 330,000 patients. How many of those patients are Connecticut residents?

DR. MOREL: I do not know the answer to that off the top of my head.

MS. GROVES FUSCO: And you quote a Medicaid percentage, which I assume is for your entire practice. Do you know what your Medicaid payer mix percentage is for Connecticut patients? I should say Connecticut Medicaid beneficiaries.

DR. MOREL: I do not.

MS. GROVES FUSCO: The profits from the ancillary services that are provided under the WESTMED umbrella, including advanced imaging, those are distributed among WESTMED physicians, correct?

DR. MOREL: Partially, they're distributed, and, partially, they're used to fund other aspects of care, which are not able to fund on a fee-for-service basis, such as we have a large behavioral health program, which would operate at a financial loss.

We have a palliative medicine program. We have case managers in each office, so we use those profits to provide what we believe is valuable care to our patients.

MS. GROVES FUSCO: I'm talking about after you reinvest, the true profit, what's leftover. That's distributed among the WESTMED physicians, correct?

DR. MOREL: Yes, it is.

MS. GROVES FUSCO: Okay, so, WESTMED physicians do benefit financially from referrals of patients to WESTMED-owned advanced imaging units, correct?

DR. MOREL: WESTMED physicians benefit from the profit of WESTMED Medical Group.

MS. GROVES FUSCO: Which includes revenue from practice-owned advanced imaging?

DR. MOREL: Which is partially funded from our imaging services.

MS. GROVES FUSCO: Okay. And I asked this question before, but I'll ask it to you. Have you had any discussions with ONS, Orthopaedic & Neurosurgery Specialists, about any arrangement that would bring their physicians or MRI units under the WESTMED umbrella or that would allow you to bring WESTMED MRI referrals to ONS?

MR. MONAHAN: I'm just going to object to that question. I'm going to allow the witness to answer, but for the record and to preserve the objection on the record, I believe it's inappropriate to delve into what may or may not be confidential communications, but I will allow, will ask the witness to answer, but I want to preserve that objection if we're going to start going down that road.

HEARING OFFICER HANSTED: Okay.

DR. MOREL: We have not.

MS. GROVES FUSCO: When you acquired Orthopaedic Associates of Stamford, did you make the requisite legal filings with the State of Connecticut,

Attorney General's Office, regarding the practice transfer, to be qualified for those?

DR. MOREL: We did.

MS. GROVES FUSCO: Okay, so, those are available, if OHCA needs to review them?

DR. MOREL: Yes.

MS. GROVES FUSCO: Is there a reason why Advanced Radiology can't integrate with your EMR the way that they've integrated with other EMRs, as we've discussed in our presentation?

DR. MOREL: No. We would be happy to investigate that.

MS. GROVES FUSCO: And would you allow it?

DR. MOREL: Yes.

MS. GROVES FUSCO: Okay. There's one last question. Are all WESTMED MRI scans read by subspecialist radiologists? That's a question for you, Dr. Weiss. Sorry.

DR. WEISS: We're all Board Certified diagnostic radiologists.

MS. GROVES FUSCO: Okay, so, they're Board Certified, but are they fellowship trained in subspecialties, Board Certified in subspecialties, like neuroradiology?

DR. WEISS: We have a fellowship trained bone radiologist. I don't know of any others.

MS. GROVES FUSCO: Okay, so, not every scan is read by a fellowship-trained subspecialist?

DR. WEISS: Correct.

MS. GROVES FUSCO: Okay. I have no -- I think I have none. No, I have no other questions. Sorry. All set.

HEARING OFFICER HANSTED: Do you have any Redirect?

MR. MONAHAN: I have no Redirect.

HEARING OFFICER HANSTED: Okay. If you could switch seats with Attorney Volpe and her client, I'd appreciate it.

MS. GROVES FUSCO: It will be short. I promise.

HEARING OFFICER HANSTED: I'm not rushing anyone.

MS. GROVES FUSCO: But I'm rushing myself. Hello, again. This will be much shorter. I do promise.

In your written testimony, you've claimed, and I think you stated it again in your remarks today, that there's no need for additional MRI within ARC's practice, correct? You stated that in your verbal

remarks today and in your submission?

DR. CAMEL: Correct.

MS. GROVES FUSCO: Correct. Okay, but you also stated in your remarks earlier today, when you were talking about your own application, that, when an Applicant exceeds 85 percent of the 4,000 scan benchmark per year, there's need, and the need review should end at that point, and the application should be approved. Do you remember saying that?

DR. CAMEL: I do.

MS. GROVES FUSCO: Okay and you do know that 85 percent of 4,000 scans is 3,400 scans?

DR. CAMEL: I do.

MS. GROVES FUSCO: Okay. We're doing more math. And you know that Advanced Radiology performs 6,617 scans?

DR. CAMEL: I do.

MS. GROVES FUSCO: Okay, so, that puts them at 165 percent capacity, based on that benchmark, correct?

DR. CAMEL: I do.

MS. GROVES FUSCO: And nearly twice the number of scans needed to justify an additional unit?

DR. CAMEL: I do, as long as we ignore the

intent of --

MS. GROVES FUSCO: Okay. I'm talking about current volume.

DR. CAMEL: Current volume, you're correct.

MS. GROVES FUSCO: Okay, so, then you would agree that ARC meets that same criteria in the State Health Plan justifying need, based upon utilization of their existing unit, correct?

DR. CAMEL: Yes.

MS. GROVES FUSCO: And you know that what the State Health Plan says at page 61 is that, if you operate a unit in the primary service area and you're applying for another unit in the primary service area, that you have to show that that unit is at 85 percent. You don't have to look at the unit that's 40 miles away in Orange?

DR. CAMEL: Honestly, I don't know that, but I'll take your word for it.

MS. GROVES FUSCO: Yeah, I don't know if your attorney has the State Health Plan.

MS. VOLPE: We have it.

MS. GROVES FUSCO: Okay. Would you also agree, based upon Section Table 8 of the State Health

Plan, but I think your attorney included it in your submissions, that Advanced Radiology's Stamford unit, at least as of 2013, was the busiest unit in the service area?

DR. CAMEL: I'm sorry. I don't have that data in front of me.

MS. GROVES FUSCO: Let me point you to -- I think it was in your -- I think we have it in ours. If you look at -- do you have -- Michele, do you have Table 8 of the State Health Plan?

MS. VOLPE: Yes.

MS. GROVES FUSCO: Or would it be easier to refer him to the chart you did with all the providers?

MS. VOLPE: Why don't you just ask your question? I have the --

MS. GROVES FUSCO: All I want to ask you is if you can confirm that it's the busiest unit of the 13 units in the service area. I don't want you to have to go through the whole table.

MS. VOLPE: Currently?

MS. GROVES FUSCO: As of 2013.

MS. VOLPE: As of 2013.

MS. GROVES FUSCO: As of the data available in Table 8.

MS. VOLPE: Yes, which was from 2012 data, but, yes.

MS. GROVES FUSCO: No. It was 2013 data reported in 2014.

MS. VOLPE: Reported in 2014. Yup, we have it.

HEARING OFFICER HANSTED: Can I just interrupt one moment? I want to give Attorney Monahan's clients the same courtesy I gave Attorney Cowherd's. Does anyone have any objection to his clients being dismissed? Do you have questions for them?

MS. GROVES FUSCO: No.

MS. VOLPE: Well, I mean, we don't have questions for them, but I think, if they don't mind staying.

MR. MONAHAN: We appreciate the courtesy. If people here and the panel don't mind, I think our clients are pleased to stay for the remainder.

HEARING OFFICER HANSTED: They're welcome to stay. I just wanted to give the same courtesy.

MR. MONAHAN: I appreciate that very much.

HEARING OFFICER HANSTED: Okay.

MR. MONAHAN: Thank you.

HEARING OFFICER HANSTED: All right. You

may continue.

MS. VOLPE: We have Table 8.

MS. GROVES FUSCO: Yeah, no. My question was just whether, based upon the information in Table 8, is Advanced Radiology's unit the busiest unit in the service area for that year?

MS. VOLPE: As of the 2013 data?

MS. GROVES FUSCO: Yeah, as of the 2013 data.

MS. VOLPE: Sure.

DR. CAMEL: Yes.

MS. GROVES FUSCO: Okay. As a physician, would you recommend that a patient with a back condition or some other sort of, you know, painful condition, or acute illness that made them uncomfortable sitting, driving a car two hours round trip to get an MRI scan?

MS. VOLPE: You know, I'm going to object to that, because she's asking him like a professional opinion. It's not really relevant to -- I mean she's asking him in his professional opinion as a doctor, and I'm going to object to that.

MS. GROVES FUSCO: He's raised the issue, that we should be sending -- they've raised the issue in their rebuttal, that we should be sending patients to

underutilized units in our practice, that all of our units are interchangeable, and that we should be shifting around, and I'm asking if it's clinically appropriate, and his credentials state that he's a doctor, to send a patient from Stamford to Orange for a scan when they're in pain. That's all I'm asking, and I think it's perfectly appropriate.

HEARING OFFICER HANSTED: I think it is, too. Just don't go any further into the medical question.

MS. GROVES FUSCO: It's one question.

HEARING OFFICER HANSTED: That's fine.

DR. CAMEL: Is it never appropriate? I think it's sometimes inappropriate.

MS. GROVES FUSCO: Okay. Would you agree, sort of as a referrer of MRI services, that certain patients require scans on certain types of units, either based on the clinical information you require, or patient-specific issues, like claustrophobia or obesity?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Okay and you did acknowledge earlier today that there are some patients, who do require or for whom 3T is preferable, correct, 3T MRI?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Okay, so, you know, given the fact that patients sometimes need to go to specific types of machines, and this may be for you, Dr. Sullivan, you can jump in, MRI machines aren't interchangeable, correct?

DR. CAMEL: Correct.

MS. GROVES FUSCO: Okay and just because it's a 1.5 Tesla unit doesn't mean it's interchangeable with another 1.5 Tesla unit, correct?

DR. CAMEL: Yes.

MS. GROVES FUSCO: They can have different applications, so the same thing. 3Ts aren't interchangeable with 1.5 or even among themselves. Some are closed. Some are open. Some have different applications. They're not interchangeable.

DR. CAMEL: That, I think, is a bigger question than you meant, because you asked a lot of questions.

MS. GROVES FUSCO: Sorry. I apologize.

DR. CAMEL: So I think that, as far as my knowledge is, all 3Ts are closed. There no such thing as an open 3T, so that specific question and answer is, no, they're all closed.

Two is, I don't know every model of 3T on the market, and I'm not an expert like the -- there are a lot more radiologists in this room, who can answer that question better. I'm a neurosurgeon, so I don't know what the answer -- I mean I don't know how to answer it.

MS. GROVES FUSCO: I'll ask a different question. So one of the things that's been raised in your testimony is that Advanced Radiology operates a number of, you know, 1.5 and 3 Tesla units, you know, located from Stamford to Orange, and that we could easily do some shifting of our patients among the units to better spread our patient balance, so we don't have capacity issues.

Is it fair to say you would need to know more about the capabilities of each unit to know if patients can be shifted and fix capacity issues?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Thank you. You mentioned in your written testimony and again here today that the proposed Connecticut Orthopaedic Specialists' mobile MRI unit could meet ARC's patients' needs in Orange if the Orange scanner was relocated to Stamford.

The proposed unit is not a 3 Tesla unit, correct?

DR. CAMEL: I don't recall saying that. I did say that?

MS. GROVES FUSCO: You did.

MS. VOLPE: For the Connecticut Orthopaedic Specialists, they have a pending application before OHCA.

DR. CAMEL: Of a 1.5?

MS. GROVES FUSCO: Well that's what I'm asking.

MS. VOLPE: Of a mobile unit.

MS. GROVES FUSCO: It's a 1.5 mobile. That's not comparable to a 3 Tesla fixed, is it?

DR. CAMEL: It is not.

MS. GROVES FUSCO: Okay. Is your group in any discussions with Connecticut Orthopaedics regarding any sort of professional affiliation?

DR. CAMEL: None.

MS. GROVES FUSCO: Would you agree, based on your submissions and some of the information that was raised today, about Greenwich Hospital having a 3 Tesla, would you agree that a hospital-based, a true provider-based unit is more costly, in terms of reimbursement rates and facility fees than MRI units, like you operate and my client operates in private practice?

DR. CAMEL: Yes.

MS. GROVES FUSCO: So it's not comparable? The 3T at Greenwich is not comparable to the proposed 3T from a cost perspective for patients?

DR. CAMEL: To be honest, I don't honestly know everybody's fee structure.

MS. GROVES FUSCO: But generally speaking?

DR. CAMEL: Generally speaking, that's correct.

MS. GROVES FUSCO: Okay. Just a few last questions. You state in your written testimony and again here that my client has a history of obstructing other people's CONs. When you -- you suggested that this first happened when they filed a waiver for an upgrade of their existing MRI unit in Stamford to a 3T, correct?

DR. CAMEL: You mean the one years ago?

MS. GROVES FUSCO: Yes.

DR. CAMEL: The nine years ago?

MS. GROVES FUSCO: Yes.

DR. CAMEL: Yes, I did say that.

MS. GROVES FUSCO: And do you claim that their failure to go forward with that waiver suggests that it was done just to obstruct your CON?

DR. CAMEL: No. I think they're two

related incidents. One is that I don't know why they applied for it in 2008 or '09, and I don't know why they, once they got the waiver, they chose not to put it in. I have no information, so I don't know what their intent was.

MS. GROVES FUSCO: You say you don't know why they applied for it, but, in your petition, you suggest that they applied for it to block your CON.

DR. CAMEL: No.

MS. GROVES FUSCO: Do you believe that?

DR. CAMEL: I said they applied for this one only after our -- it's just coincidence, and you can draw whatever conclusion you wish to.

MS. GROVES FUSCO: So the references back to 2008 and the suggestion, I believe the word you used was that there's a pattern of obstruction, you don't believe they tried to obstruct you in 2008, do you?

DR. CAMEL: Did we have an application pending 2008? I don't know what their intent was.

MS. VOLPE: We went for our upgrade in 2008.

MS. GROVES FUSCO: Did Advanced Radiology intervene in your 2008 proceeding?

MS. VOLPE: For the upgrade, no.

DR. CAMEL: No.

MS. GROVES FUSCO: They didn't intervene and oppose? You got the CON, correct?

DR. CAMEL: Yes.

MS. GROVES FUSCO: Even though Stamford also got their waiver, so they didn't oppose you then, so that is not evidence of a pattern of obstruction of your CON. They did not get involved in your CON in 2008.

DR. CAMEL: Not to my knowledge, no.

MS. GROVES FUSCO: Okay and I think we talked about this this morning, but, after that CON, you actually -- someone from your office went to ARC's office to look at their unit before you purchased yours.

DR. CAMEL: You said that earlier, but I'm not aware of it.

MS. GROVES FUSCO: And just one last question. Sort of the most recent CON request for MRI services that was filed in the Stamford area was filed by the Hospital for Special Surgery, and ONS put a letter into the record objecting to that, correct?

DR. CAMEL: Yes.

MS. GROVES FUSCO: But didn't formally intervene in the proceeding for purposes of Cross-Examination and all this, correct?

DR. CAMEL: Correct.

MS. GROVES FUSCO: And ARC didn't intervene in that proceeding, even though they were an existing provider in Stamford, correct?

DR. CAMEL: I wouldn't be aware of that.

MS. GROVES FUSCO: Okay. We didn't. That's it.

HEARING OFFICER HANSTED: Okay. Attorney Volpe, if you want to proceed with your Cross?

MS. VOLPE: Yes. I'm going to extend a professional courtesy to ARC and present questions and allow them to have whoever they feel appropriate address them, just in the interest of a fact finding proceeding.

MS. GROVES FUSCO: Can I ask for just a two-minute bathroom run before you start?

MS. VOLPE: Oh, sure. Go right ahead.

HEARING OFFICER HANSTED: Do you need a break? All right, we're off the record.

(Off the record)

MS. VOLPE: So my first question for ARC, the Applicants, is is ARC owned by only radiologists?

DR. KAYE: Yes.

HEARING OFFICER HANSTED: Please identify yourself.

DR. KAYE: Alan Kaye. Yes.

MS. VOLPE: Okay. Does anyone, but a radiologist, have any interest in any affiliate of ARC?

DR. KAYE: Alan Kaye, no.

MS. VOLPE: Okay.

HEARING OFFICER HANSTED: Just initially.

DR. KAYE: Okay. It will be me, unless --

MS. VOLPE: Unless otherwise stated.

DR. KAYE: Even if I change my voice a little.

HEARING OFFICER HANSTED: Thank you.

MS. VOLPE: Alan and I like to talk to each other. Okay. When ARC filed its application, this current application, was it aware of OAS's merger with WESTMED?

DR. KAYE: I don't think so.

MS. VOLPE: Okay. Fair enough.

DR. KAYE: No. No. I just asked the person, who was the person, who told us about it.

MS. VOLPE: Okay, so, your projections included the WESTMED volume?

DR. KAYE: Yes.

MS. VOLPE: Were you -- are you aware of OSSM's doctors' affiliation now with the Yale health

system, Northeast Medical Group?

DR. KAYE: Actually, not until I just heard it, but I believe some of my associates, yes.

MS. VOLPE: Okay. Are the volume referral projections of those orthopedists included in your numbers?

DR. KAYE: Yes.

MS. VOLPE: Okay. Do you consider 2,767 MRI referrals and scans a significant number?

DR. KAYE: Significant number of patients, of course.

MS. VOLPE: Significant number of scans?

DR. KAYE: Yes.

MS. VOLPE: Okay. He answered the question. The question is whether he considered it significant.

DR. KAYE: I do consider that that is not to be the number of scans that patients, who referred for scans to us.

MS. VOLPE: That came from WESTMED's testimony.

DR. KAYE: And we rebutted it earlier.

MS. VOLPE: Do you consider an excess of 2,000 scans a significant number of MRIs?

DR. KAYE: Yes, but it does not affect our profitability.

MS. VOLPE: He answered the question. So how does ARC propose to replace that volume from WESTMED?

DR. KAYE: We don't believe that they will be able to send that many of their patients through the traffic on I-95 to New York State. The patients won't stand for it. They've gotten great service from us, so I do not believe that's going to happen. We do not believe that's going to happen.

MS. VOLPE: Okay, so, in your application, did you state that ARC will have incremental losses in the first few years?

DR. KAYE: Yes.

MS. VOLPE: And will those losses be greater if ARC does not have a significant amount of referrals from WESTMED?

DR. KAYE: I would think so, although we can't predict whether we're going to pick up additional scans, and I would say that we will still be profitable, and we're in this for the long haul, so we can absorb a year or two of losses.

DR. KAYE: So do you attest that the Stamford location will still be financially viable with

two MRIs, noting testimony that's provided today with the loss of thousands of referrals?

DR. KAYE: I'm going to turn the financial-related questions over to our CEO, Clark Yoder.

MR. YODER: Hi. Clark Yoder for the record. Yes, we've ran pro formas subsequently looking at this potential loss of MRIs, and we are still profitable, and we're still financially feasible, even with that migration of some of those OAS patients, and even with the migration of all of them, we will still be financially feasible.

MS. VOLPE: Okay. My question is the financial feasibility of the Stamford location, specifically, not ARC's practice overall, so will the Stamford location be financially viable with two MRIs with the loss of potentially thousands of scans?

MR. YODER: ARC MRI partnership, we look at the whole profitability of the whole system and all of our MRIs together, not by location.

MS. GROVES FUSCO: And, just to clarify, they don't run their financials by office. They run their financials by service, so it's the entire ARC MRI service. That's how the profitability is determined.

MS. VOLPE: Will ARC -- are you placing

this second MRI at 1315 Washington Boulevard?

MR. YODER: Yes. Yes, at our new office, which is located on East Main Street, which is two buildings down from the current OAS office in Stamford.

MS. VOLPE: So are you moving your existing 1.5 there?

MR. YODER: Potentially, yes.

MS. VOLPE: So are you vacating the Washington Boulevard location?

MR. YODER: I think it's to be determined at this time, but, possibly, yes.

MS. VOLPE: So the new location I think you said it's on East Main Street. That has the physical composition to site two MRIs at that location?

MR. YODER: Yes.

MS. VOLPE: Okay. In 2008, did ARC apply to OHCA for approval to upgrade its existing 1.5 to a 3T?

DR. KAYE: I'll take that. I'm not familiar with the exact date, but, yes, we did around that time frame. Alan Kaye.

MS. VOLPE: Okay. Did ARC implement the approved waiver?

DR. KAYE: Alan Kaye. No, we did not.

MS. VOLPE: Okay. Did ARC factor in

Greenwich Hospital's 3T in Stamford when it was considering its projections for the proposed 3T now?

DR. KAYE: Yes.

MS. VOLPE: So when you filed your application in June, you were aware that Greenwich Hospital was locating a 3T in Stamford?

DR. KAYE: Yes.

MS. VOLPE: Okay.

DR. KAYE: Actually, I believe that unit already is in Stamford, so it's just moving from one Stamford location to another.

MS. VOLPE: I don't think so. I mean we can look at the statewide, Table 8.

DR. KAYE: There seems to be some confusion.

MS. VOLPE: We can look at Table 8 to clear up any confusion. Let's just, before we go any further, let's look at Table 8, which I pulled out earlier. It's our understanding from a 1.5 to a 3T, Greenwich Hospital.

HEARING OFFICER HANSTED: The Greenwich Hospital? And when did that occur?

MS. VOLPE: In Stamford. Like several weeks ago.

HEARING OFFICER HANSTED: Okay.

MS. VOLPE: A couple of weeks ago.

DR. KAYE: Are we talking about the unit that's going in Long Ridge?

MS. VOLPE: Yes.

DR. KAYE: And are we talking about the one that they upgraded from 1.5 to 3T, the one that was in Stamford? So, in other words, they're moving their existing service from one location in Stamford to another, and they're putting --

MS. VOLPE: But it's a different Tesla strength, so were you aware that it was going to be a 3T when you filed for your 3T?

DR. KAYE: I suspected that it might be, but I don't think it made a difference to us, because we need to service our patients, provide them with the range of service from 1.5 to 3T.

MS. VOLPE: Okay. I know we want to be done at 3:00, so, in the interest of time, ONS is limiting its Cross-Examination of representatives from Advanced Radiology. ONS would very much like to conclude these proceedings today, this afternoon, without the need for any additional day of hearings, especially since ONS has an application before OHCA since January.

We're confident that OHCA will put forth questions to ARC, and the staff will be responsive to any unopened issues in the deficiencies in ARC's application. To the extent that ARC's legal counsel has any Redirect, we'd like an opportunity to address those.

HEARING OFFICER HANSTED: Any Redirect?

MS. GROVES FUSCO: I just have one question.

HEARING OFFICER HANSTED: Okay.

MS. GROVES FUSCO: Dr. Kaye, can you explain why you didn't implement the waiver to upgrade your Stamford unit to a 3T in 2008?

DR. KAYE: Alan Kaye. At the time, that was in preparation for a possible move from our current location, 1315 Washington Boulevard, and we felt that it would be appropriate to upgrade at that point.

We were unable to find a suitable location. As you may know, it's very difficult to find a place in Stamford that has sufficient parking and structure to accommodate an MRI, let alone a 3 Tesla, and, so, we could not find a suitable location, so we did not do the upgrade.

MS. GROVES FUSCO: Thank you.

HEARING OFFICER HANSTED: Follow-up?

MS. VOLPE: Yeah, a follow-up to that. When you filed your waiver application in 2008 and they asked for the location for the waiver in 2008, what did you state it was going to be located?

DR. KAYE: I don't recall.

MS. VOLPE: Okay.

DR. KAYE: We did not have a location, so we may have had a placeholder. I don't recall.

MS. VOLPE: But you were already operating at 1315 Washington Boulevard in Stamford.

DR. KAYE: Correct.

MS. VOLPE: And the waiver, which I have in front of me, shows the approval of the upgraded replacement at 1315 Washington Boulevard.

DR. KAYE: Yes, but we were planning on moving once we got the waiver.

MS. VOLPE: But did you --

DR. KAYE: We were planning on moving anyway, we were unable to find one, and we were not able to find one that would be suitable for siting purposes for the upgrade, and we did not have a -- because we did not have a place, we used the 1315 as a placeholder.

MS. VOLPE: Okay, but when you filed with OHCA, you represented that you would be upgrading your

existing equipment at that location, at 1315 Washington Boulevard?

DR. KAYE: Yes.

MS. VOLPE: Okay.

DR. KAYE: We did not have a full siting.

MS. VOLPE: Okay. We have no further questions.

HEARING OFFICER HANSTED: Okay, thank you.

MS. VOLPE: Thank you. That concludes our Intervenor --

HEARING OFFICER HANSTED: You're both finished. Okay. Do we have anything further from the Stamford Hospital or WESTMED, besides a closing statement?

MR. COWHERD: No.

HEARING OFFICER HANSTED: Please come up to the microphone.

MR. COWHERD: Stephen Cowherd on behalf of Stamford Hospital. Stamford Hospital didn't seek Intervenor status in the Advanced Radiology hearing.

HEARING OFFICER HANSTED: Okay, thank you.

MR. MONAHAN: This is Pat Monahan on behalf of Intervenor WESTMED, and we have nothing further, and we thank you for the opportunity.

HEARING OFFICER HANSTED: Okay, thank you, both. All right, at this point, OHCA has some questions, so we'll begin with those. Who wants to start?

MR. LAZARUS: OHCA handed out a table and a map of the existing providers in the area, including the Applicants. It's labeled OHCA Exhibit 1, and OHCA is going to reference that in some of its questions. Does anybody want a couple of extra copies?

MS. VOLPE: I think we're good. Thank you, Mr. Lazarus.

MR. LAZARUS: Alla, do you want to start?

MS. ALLA VEYBERMAN: Alla Veyberman, OHCA staff, and I have a question for Dr. Mark Camel.

As we discussed today, there are several existing providers in the area. Can your patients be referred to other MRI providers, such as Hospital for Special Surgery, that is operating at approximately 50 percent capacity?

DR. CAMEL: So there are a couple of issues to sending them. As you know, first, we're west of Exit 3 off 95, and it's about a mile and a half off Exit 3, which is the closest 95 exit, where, if you know the area a little bit, you get off 95 at Exit 3 and then wind your way through Downtown Greenwich and then down

the Post Road until you get to our office, so that's where the starting point is from the ONS office.

The drive up 95, as we all know from living around here, and I don't presume to know where everybody lives, but the distance issue has become our biggest issue in growing our practice, and it's a great question.

So we recently opened up an office in Stamford, and that office is up on High Ridge Road, and one of the issues is getting patients back and forth during the day, because of what should take 20 or 30 minutes can take an hour or more now, and, you know, it's a problem that doesn't have an obvious solution.

There is the convenience issue for patients, because that's really almost on the Darien border, Exit 9. The Darien border is just beyond it.

Secondly, the Hospital for Special Surgery doesn't have any relationship to Greenwich Hospital or to ONS and honestly is a competitor, both not on imaging alone, but of all the people we compete with, they are, because they're really the only subspecialty practice in the area, previously in New York, they have this office, so it would be, honestly, awkward to refer directly to our competitor.

The third issue is that, you know, the Hospital for Special Surgery is a hospital. I know that sounds ridiculous to say that, but what I tried to say more succinctly is that, as we've already determined in this room, the reimbursement for an MRI at any hospital, including Hospital for Special Surgery, as compared to ONS, is significantly higher, and much of Special Surgery is not in network, so it would be even higher than that, so it is not a referral base of choice for us.

MS. VEYBERMAN: Okay. Also, today you mentioned that you're going to hire two more physicians for your office, and you said that one of them is coming from Philadelphia, and if you can please elaborate more about your new physicians?

DR. CAMEL: Sure.

MS. VEYBERMAN: Are they new to this area? Are they coming with their patient base? Just so we can get a better understanding.

DR. CAMEL: That's a great question. So it's been our practice, we've made one exception, to only hire orthopedists and neurosurgeons, who have just completed their fellowship, so these are surgeons or physicians, who have not begun practice anywhere.

For example, the hand surgeon, I think who

you speak, is training at Jefferson in Philadelphia, and I'm forgetting the name of the group he's actually with. I apologize for that. But he is a -- he's training in hand surgery. He did his residency at Columbia, and then went to Philadelphia for this. They call it now an upper extremity fellowship, because it includes the elbow on down.

We have an offer out, and I think he's going to take it, to a physiatrist. A physiatrist is a specialist in physical medicine rehabilitation. He will be our fourth physiatrist, and he trained in New York at Rusk, which is the NYU-affiliated rehab program, then did his fellowship at Mount Sinai.

For family reasons, which, honestly, I'm still not clear on, he went to the Naples area in Florida last year following his fellowship, and even though his family and his wife's family was in Brooklyn, they went, and he soon decided he didn't want to stay, so he's joining us, so he's an exception, but he doesn't obviously have any practice here.

The other, if you go backwards in our history, and I'll go back as far as you want me to --

MS. VEYBERMAN: Just a few years.

DR. CAMEL: Yeah.

MS. VEYBERMAN: So we can get a better understanding if your physicians coming includes their patient base or they come --

DR. CAMEL: Yeah, so, Dr. Wei, David Wei, also was a resident, orthopedic resident at Columbia, but did his hand fellowship in Boston at the Tufts program, and he joined us last September from Boston.

I'm going backwards, backwards in time, so I don't want to make a mistake. Dr. Mark Kowalsky joined us in March of 2015, and he's a very interesting guy.

He trained also at Columbia as his residency, but then subsequently did two fellowships, one of which was at Columbia, and the second one was actually in St. Louis at the combined Washington University/Barnes Hospital program.

He came back for family reasons and took a job at Lenox Hill Hospital. He's been our exception. I don't know, I didn't know him, but all of my orthopedic colleagues did, because they were senior residents or attendings when he was a junior resident.

He wasn't happy at Lenox Hill for pretty common reasons in my mind. His wife works as a pediatric emergency room nurse in Westchester County, and he wanted to make a move, so he came last March. Dr. --

MS. VEYBERMAN: -- not from the area.

DR. CAMEL: No, no.

MS. VEYBERMAN: None are from the area?

DR. CAMEL: None are from the area. Dr. Chris Sahler is a native of Rochester, New York. Now I'm going back to '14, the fall of '14. He's a physiatrist, went to college at the University of Vermont, did go to New York Medical College, but trained in New York City.

Okay. Michele was trying to get me to go shorter here, so I think I understand the point of your question, which I'm happy to do always.

Here's the thing. We don't, we haven't, and we have no plans to, and we have some business reasons, which don't matter here why we don't do that. We have a certain culture that we believe is unique and different, because we offer a team approach.

We're not individuals practicing together. In our group, everything goes in and comes out equally, and that's unique, even in not only in this area, but if you go across the country, you don't see that, and it allows us to do subspecialty care, which is the other reason I think we've grown so much and so fast.

We could have grown faster, but we were too reluctant to try.

MS. VOLPE: So they're not taking doctors from the area and adding them, and, therefore, they don't have existing MRI volume that they're capturing from other providers, who would otherwise get that volume.

DR. CAMEL: No.

MS. VOLPE: This is all new volume to the marketplace.

DR. CAMEL: New growth. Sorry. You should have answered.

HEARING OFFICER HANSTED: Doctor, your voice changed.

MR. LAZARUS: Just to follow-up and just to get a little bit of clarification, you had mentioned those two doctors you are in the process of recruiting. How many additional are you recruiting, and what's the time frame for those?

DR. CAMEL: Well, so, the two I mentioned are hired or almost hired.

MR. LAZARUS: Okay.

DR. CAMEL: The next three, which are the neurosurgeon, the joint fellowship, and the physiatrist, are the next three.

MR. LAZARUS: Okay.

DR. CAMEL: So we've identified a joint

replacement surgeon, who is doing his fellowship back to Philadelphia again, and he will be here -- well he finishes his fellowship on July 31st. They usually take a few weeks off to move. He's also -- so I expect him. Most of our guys start around Labor Day, typically. Sometimes, late August, but most choose to take the month off for moving and sort of decompressing from their fellowship.

The neurosurgeon we haven't identified yet. I've spoken to a highly-recommended woman at NYU, and we are in the process, but we're really just beginning that, and we currently are planning to interview current fellows in physiatry from I call it our usual suspects, which are Hospital for Special Surgery, Mount Sinai, and NYU, is where we typically get.

MR. LAZARUS: All right, thank you. OHCA handed out the OHCA Exhibit 1, and looking at the table with the existing providers in the area and the map, can you discuss the clear public need for acquiring this proposed MRI scanner for this population, and considering that there are approximately 10 other existing providers in the area, and does this proposal fill a gap?

DR. CAMEL: It does. It fills a gap in two ways, I think. I'll make this short. Most of these

scanners are at expected capacity.

We, honestly, overrun our scanner, and one of the issues is, by going seven days a week and nights five days a week, we have issues of keeping technologists, because you have to get people to work on weekends, you have to have other people there.

We're going to continue that service, because it's convenient to our patient, to try and contract it. That's one thing.

The second thing is, and I apologize for not remembering names, but the doctor from WESTMED made a very good point, and, when he talks about integrated care, even at times when we send patients, we try and send patients elsewhere, who are from far away, because we're a subspecialty-based practice, because of the nature of the service we offer, they choose to come to see us, and they want care integrated, and this is really an important concept, which really isn't pertinent here so much, but it is by managing people's care, whether in our case we don't do laboratory testing, but we do do physical therapy, and we do imaging, both x-ray and MRI, and we see our patients and operate on them.

Patients want that communication, so, for example, our physical therapists communicate to us not by

calling or sending e-mails, but through our medical record system. Their notes go into the same system, so every time they see a patient, we know it, and we know what they thought about that visit.

Similarly, Dr. Sullivan's reads come through our medical record system, and patients appreciate that integrated care. Secondly, we have no difficultly obviously accessing them, either from our office or from home.

MS. VOLPE: And just for point of clarification and direct to your question, the Applicant would direct OHCA to Dr. Camel's pre-filed testimony, specifically, Attachment B and Section 3, which is on page 28, and it shows -- it does the analysis under the Statewide Health Plan for the utilization of the existing providers, based off of that Table 8 data, which is published with OHCA, and looking at the volume numbers of all of the providers in the marketplace and the service area in the entire region and showing, taking that existing utilization on the 13 scanners in the service area and applying the Statewide Health Plan analysis to it I think is a very important analysis for OHCA's determination.

We did do that, and there's thousands of

pages in the file, so I do want to direct you to Attachment B to Dr. Camel's pre-filed testimony, which is on page 28, and it shows the need analysis, as applied to the Statewide Health Plan, with the utilization of all of the scanners in the marketplace.

MS. KAILA RIGGOTT: Kaila Riggott, OHCA staff. Can I just follow-up on that and actually ask the question of both Applicants?

Our Statewide Facility's Plan also focuses on unmet need and gaps in services, and I think maybe what Steve might have been getting at are there patients that are not being served now in the area, given the number of providers that are in that region?

In our plan, you look at care on a regional basis.

MS. VOLPE: I think what Dr. Camel testified today certainly is there will be. I mean we can't wait until there's no capacity in the marketplace. That's why we have the Statewide Health Plan.

So with the growth of ONS's practice alone and the doctors it's adding and the patient population, I mean, if we wait until every single provider meets this capacity limit, then it will be too late, so, actually, we're being prudent and projecting that we have the

volume now to meet it.

I mean that is why the Statewide Health Plan is in place. We're at 85 percent capacity. We should be allowed to get a scanner, based on the Statewide Health Plan Analysis.

And if you look at, like I said, if you look at our analysis, we took it even further, which the State doesn't want providers to do and didn't contemplate, and that is, if we wait until every single provider in this region is at excess capacity, it's too late.

I mean then we will have a significant backlog with the growth. And I think, if you look at the Connecticut population numbers, the only region in the State that has shown population growth is Fairfield County.

So when you combine the population growth, when you combine the internal orthopedic and neurosurgery patient population growth and you extrapolate that out and apply it to the marketplace, you know, we could have a problem with capacity issues very soon in this region with these 13 providers. I don't know if that's responsive to your question.

HEARING OFFICER HANSTED: Do you want to

add anything?

DR. KAYE: Yes. Definitely would like to add something. Alan Kaye. First, we have a unique position in the marketplace. If you look at every one of these, most of them are provider-based, that is hospital-based, which means that they charge, as Dr. Camel had pointed out, significantly higher fees, and they get that, and if you have a high deductible plan, as most do today, then you are going to come up with out-of-pocket, which could, within one or two MRI scans at most of these provider-based institutions, could end up taking up your entire deductible, so we are unique in that.

We are unique in -- almost unique in that sense, but we are unique, in that we're also an independent provider, and Dr. Camel had mentioned earlier about not wanting to send to competitors.

Well I think that we are probably the only one that's not a competitor with any of these, and, probably, if you're going to approve one and your Statewide Health Plan says let's see if we need it, it ought to be ours, because we have, first of all, we have the highest number of any of the providers here per MRI unit, we are accessible to all --

MS. VOLPE: I would just object to that.

DR. KAYE: Excuse me. Oh, I'm sorry. That's an objection. Can I finish?

MS. VOLPE: I mean he's asking to only approve one.

DR. KAYE: No, I'm not.

MS. VOLPE: If you're only going to approve one. Again, there's an issue, as to their volume, but we're not rehashing that. I think we're trying to be responsive to your question in the marketplace, and let's look at all the providers in the region. There's 13 of them.

This is what you all know. We don't need to tell you.

DR. KAYE: Who is testifying?

HEARING OFFICER HANSTED: I understand your objection. Dr. Kaye, hold on. Do you have a response?

COURT REPORTER: Microphone, please?

HEARING OFFICER HANSTED: What I want you to do, Dr. Kaye, is just answer the direct question. I don't want you to start getting into what should be approved and what shouldn't be approved.

DR. KAYE: The question was capacity.

HEARING OFFICER HANSTED: The question is

the populations that aren't being served, okay? So let's keep it to that, not how many machines. It's our job to decide how many machines get approved or if any.

MS. GROVES FUSCO: And there's just one thing I'll add that I know Michele has put in her CON application, as well, is that I think it was intentional that the State Health Plan was drafted in such a way that it gives sort of two avenues to proving need when you're talking about an MRI unit.

I mean if you are a new provider to the primary service area, you've got to go out, and you've got to do that application of the population and the demographics and the existing units and, you know, can they fill what you're saying you're coming into the market to fill?

This was a negotiated process, involving your agency and many providers and health care entities in this state, and they carved out almost an exception for people, who have an existing unit in a primary service area, and the health plan clearly states that that's what you look at.

You look at that provider's utilization within the primary service area to see if it triggers the 85 percent threshold. We all understand that that's a

myopic view, and, even if that's what the State Health Plan says, we all want to prove that there's need beyond that and there are other, you know, quality measures and things like that.

But even if you looked at the whole population, as if we were coming into this market anew, if you look at it based on the number of units and the scans those units are doing in applying 85, or if you look at the population statistics, which I believe Michele did, they're showing you 94 percent utilization in the market, so, even though there are some units that have low volume, those are far outbalanced by the number of units that are overcapacity at this point in time, so I think that's part of the basis for the need, as well.

MS. VOLPE: And I'm sure you're aware of this, but the one unit that has lower volume than the others, Hospital of Special Surgery, is the newest one in the market, and, also, by its own admission, does not anticipate doing more than 2,500 scans on its scanner, even though OHCA applies a 4,000 number.

And if you look at all of their scanners in their New York market, that's all they do. That's all they will do on their scans, and they represented in their filing they will only do 2,500 scans, so they're at

nearly 2,000 now, so it is important to highlight that, so there isn't a lot of room in this market for the population to access this service.

DR. KAYE: May I now finish?

MS. VOLPE: And we all have our views on how they should access it, but irrespective of how we differ on how they should access it, the point is is there access available?

And I think, if you don't approve, we're going to have an access issue. I mean the numbers don't lie, and these are numbers from, again, from 2014, and the population has grown.

DR. KAYE: May I finish?

HEARING OFFICER HANSTED: Go ahead.

DR. KAYE: I'll try to be very brief here. A final point. All scanners and all referral entities are not equal. You can't necessarily -- so there's all sorts of demand.

As Michele just pointed out, Hospital of Special Surgery only plans on doing 2,500 at the maximum, so you cannot necessarily compare their numbers with ours.

Likewise, an independent imaging practice is not equivalent to an internal in-office imaging

practice or to a provider base, because of economic or referral considerations, so the answer is, I'll borrow from the ONS, there is a crisis.

Sixty-seven hundred scans per year is a crisis, based on technologists, based on access, hours of availability, based on everything, and that is a crisis, and every other one on here, except ONS, is a provider base, which has an economic one, as well, and our economic one is, also, we take all payers, so I think you can't just apply there's X number of scanners, divided by 13.

And, lastly, 3 Tesla does imaging faster, so it can absorb a higher --

HEARING OFFICER HANSTED: Okay, thank you.

MR. LAZARUS: I only have a couple more questions for ARC. In your testimony, you had talked about, well, actually, even in your application I think, your offices in Fairfield, Stratford and Trumbull facilities. Patients over there they're saying they may not have timely access to imaging services. Are they being referred out, or --

DR. KAYE: Referred out, meaning to other practices?

MR. LAZARUS: To other practices, or to

other locations within your practice.

DR. KAYE: Our centralized scheduling does try and move patients around to available slots, yes. There are limitations, however.

MR. LAZARUS: Yeah, because those are 3 Tesla machine.

DR. KAYE: Well there's 3 Tesla. There's differences among the 1.5 Teslas. There are different software packages on the 3 Tesla. For instance, prostate imaging isn't available everywhere, etcetera, so there's one example, but there's also geographic and patient preference.

I think we mentioned earlier, but, if we didn't, to send a patient from Stamford to Orange is virtually saying find it somewhere else.

MR. YODER: I'm sorry. Just to add one more to that --

HEARING OFFICER HANSTED: Just identify yourself.

MR. YODER: Oh. Clark Yoder.

HEARING OFFICER HANSTED: Thank you.

MR. YODER: Advanced Radiology. We also do flex hours and address capacity issues that way, by adding schedules, as needed, into the evenings and to

weekends to accommodate this volume and this movement of shifts of these patients.

MR. LAZARUS: All right, thank you. For the proposed scanner, what's the time frame to get it up and running, including construction, for a 3T?

MR. YODER: I would say our projections would be early second quarter by the time to do that level of construction and purchasing.

MR. LAZARUS: And would that affect the other machine currently running?

MR. YODER: No.

MR. LAZARUS: No. Okay. And you can accommodate in the same location?

MR. YODER: Yes.

MR. LAZARUS: Okay. Dr. Kaye, you had talked about some subspecialties at your practice. Could you elaborate a little bit more on that?

DR. KAYE: Yes.

MR. LAZARUS: And how that can be offering an advantage.

DR. KAYE: There are different certifications for radiologists, so, for example, there's the Board certification, which historically has taken place after the residency program. That gives you Board

certification, but most radiologists and all the radiologists we take are subspecialty trained, which means they have at least one additional year of training in a subspecialty area.

I'm glad you asked this question, because I wasn't sure if it was getting across right. A brain scan is read by a neuroradiologist, which is why I asked the WESTMED people if they do that.

A brain scan in our practice -- every MRI scan is read by a subspecialty radiologist, so brain and spine are read by the neuroradiologists. Joints, tendons, bones are read by the musculoskeletal radiologist. Pancreas, liver, pelvis, gynecological organs are read by body imaging radiologists, all of whom have subspecialty training in that.

Currently, there are additional Boards required for neuroradiology, so you have to actually pass a test. That will probably be the case in the future for other subspecialties, but everybody, as I said, just to reiterate, every scan, every patient that's scanned has their images interpreted by a subspecialty fellowship-trained radiologist in that discipline.

We may be the only practice in the area, in south Connecticut that does that.

MS. VOLPE: Just for point of clarification, Greenwich Radiology, who we use, also has nine fellowship-trained radiologists, who also have subspecialty, as well, and those are the individuals reading the ONS scans, so I think that it is important, and I don't know that that fact has come out today, for both of the Applicants, but we wanted, you know, for the record to note that, as well.

MR. LAZARUS: Thank you.

DR. KAROL: Can I say something?

MR. LAZARUS: Sure. Can you identify yourself?

DR. KAROL: Hi. My name is Ian Karol, Dr. Karol from Advanced Radiology.

I did the scheduling for Advanced Radiology for 15 years, and, just to let you know, just so you have perspective, we have 32 radiologists. Of our 32 radiologists, there are only five, who read musculoskeletal MRIs.

If you have an MRI of your knee in our practice, only one of those five people read it ever, so it's a highly subspecialized read. Where most people in the country just have people that say they're fellowship trained, they cross-cover, and they do other specialties,

we don't. I only read MSK MRIs. We have five of us of the 32.

Of the 32 radiologists, we only have six that read the neuroradiology exams, and only two or three read the pediatric neuroradiology exam, so when you come to our practice and you have a brain MRI, it's not just any radiologist. It's only six of 32, who are specifically specialized to read that exam, so we're really super specialized, which most practices are not.

DR. KAYE: I just need to reiterate or clarify, because there's a difference between we have all subspecialty-trained radiologists, which I said we do, but there's a difference between saying everybody has a subspecialty and that every single scan is read by a subspecialist in that particular discipline.

So we don't have a fellowship-trained body imager reading pediatric neurological MRIs. Do you understand what I'm saying?

MR. LAZARUS: Yes. Yes, we do.

DR. KAYE: It's very different from saying everybody is subspecialty trained.

MR. LAZARUS: Got it. Thank you. I think the last question I have is that, and this might be a late file, can you provide us the most recent fiscal

year's volume by types of scans?

DR. KAYE: The most recent fiscal year?

MR. LAZARUS: Yeah, the most recent fiscal year.

DR. KAYE: What do you mean by types of scans?

COURT REPORTER: Mike, please?

MS. GROVES FUSCO: Sorry. So just like we submitted in the scan already, but per 2016 year-to-date?

MR. LAZARUS: Yes, exactly. Yes.

MS. GROVES FUSCO: Okay.

HEARING OFFICER HANSTED: That will be ordered as Late File No. 1, and how long do you need to get that in?

MS. GROVES FUSCO: We could get it in by the end of the week.

HEARING OFFICER HANSTED: Okay, end of the week, then.

MR. LAZARUS: I think that would probably be fiscal year 2015.

MS. VEYBERMAN: So we have a full 12-month --

MS. GROVES FUSCO: I think you have the full 12-month, but, if you don't, I'll give you that, as

well.

MR. LAZARUS: Okay.

MS. VEYBERMAN: Can you give us both 2015 and 2016 up-to-date?

MS. GROVES FUSCO: Yes, I can. I'll verify that what we provided for '15 -- what we provided for '15 should have been complete, because we submitted this in '16, right?

MR. LAZARUS: We can double check that.

MS. GROVES FUSCO: We'll double check, but I'll get you it anyway. I can send it again. Thank you.

HEARING OFFICER HANSTED: Okay. OHCA is concluded with its questions. I'll allow the individuals, I'm sorry, the Applicants and the Intervenors very brief closing statements, and we'll start with Docket No. 16-32063, so, ONS, if you want to give a brief closing statement?

MS. VOLPE: We do have closing remarks. I don't know if the Intervenors do, but we certainly have closing remarks.

HEARING OFFICER HANSTED: Okay.

MS. VOLPE: Would you like us to proceed?

HEARING OFFICER HANSTED: Yes.

MS. VOLPE: Okay, so, what OHCA is charged

with is reviewing the application for Orthopaedic & Neurosurgery that's before you, in accordance with the criteria for a clear public need and whether it's financially-feasible and in accordance with Connecticut General Statutes, 19a-639.

If you go through those 12 factors, which we have done at length during this proceeding in our application, we clearly satisfy the need for an additional MRI in our practice.

Also, if you apply the criteria and standards for the need methodology, as laid out in the Statewide Health Plan, we need every aspect of that, even though, as ARC counsel and I have pointed out today, based on the Statewide Health Plan, we merely have to show that we're at over 85 percent capacity in our existing machines, which we are well over that.

And when you factor in the capacity limits and restrictions on the other MRI providers in the region, we well exceed the need analysis under any formula that OHCA wants to apply.

If you look at the 12 criteria, we've met it, based on our own internal volume and projections, which we've shared with you, based on our existing capacity, based on the capacity of all the providers in

the marketplace.

ONS has demonstrated that we will have a positive impact on the diversity of health care providers in the region. Everybody has noted they're primarily institutional providers, with the exception of us and ARC, and we are both unique in that respect, so we will add a positive impact in the diversity of health care providers.

We have demonstrated that there will be no impact on existing providers in the marketplace. It has been clear in our testimony, in our pre-filed data that ONS will always -- ONS patients will always need more MRIs than we're going to provide in our office, whether because it's imaging capability, the type of patient, location, where they live. We're always going to have more MRIs being performed in the marketplace than we could handle within our office for all the reasons we've stated, so there will be no impact on existing providers.

I think it's important for OHCA that, you know, we've demonstrated that the proposed MRI that ONS is looking will strengthen the health care system, and it is cost-effective.

We have to keep in mind in Connecticut that there's tremendous consolidation in the marketplace

right now of all health care providers. You have to appreciate, if you look at the numbers of what's happened in Connecticut with physician practices being acquired by health systems that are institutional based, we went from 90 percent of the practices of doctors being independent community-based doctors.

You look at that number, and it's completely reversed. We have very few independent physician-owned community-based doctors in the marketplace, and imaging is just an extension of our practice, and it's an important one. It's an ancillary function.

It does allow us to absorb costs and financial harm in other areas. That's how we're able to give away lots of free Medicaid services, hundreds of thousands of dollars in that, so we, based on us being wholly physician-owned and community-based, we do strengthen the health care system.

You can't want, the State cannot want all of the doctors to be owned by health systems. That would be a bad move.

A lot of people would have you say that we're not servicing the Medicaid population, because they're not getting a Caid(phonetic) scan in our office.

The clear public need on the factors say you have to demonstrate good cause if you're not providing, like in this instance, an MRI to the Caid population.

We want to point out that the Caid population is being serviced in lower Fairfield County. It is being -- there's no Caid patient, who is going without an MRI that needs one.

We have a system in place in the Greenwich market, where there are highly-cooperative health care providers servicing that population and servicing it well.

We don't need to tell the State about how the Caid population accesses care, where they go for their care, how they evidence at the ER first, or at hospital clinics.

Sometimes, you know, I mean that is a pattern of utilization by that population that shouldn't be disrupted if the population is getting served, and they are.

I mean even by everyone's own admission, their Caid numbers are low. 3.9 is low. Hospital for Special Surgery, under all the OHCA conditions, requiring them to reach out to the Caid population, market the Caid population, if you look at the number they're serving in

Caid, it's very low, and it's not because these patients aren't being met. It's because there isn't an additional need for the Caid population in that marketplace.

The other thing is Hospital for Special Surgery was required to service the Caid population. You have to keep in mind that that is a tax-exempt hospital facility. These hospitals get lots of funding to service an indigent population to have access of care from the State. They get lots of funding.

They get funding from being their charitable mission. We're a private practice. We are not tax-exempt. We are not-for-profit, so we can't -- those aren't the type of conditions you can impose on us, however, we're servicing this population, you know, by hundreds of thousands of dollars that we're not making.

Could we scan Caid patients? Sure. If you look at the amount of money that is made in scanning from Caid, if you look at the volume of 3.9 and do the math on how much it is, you know, it's not a significant amount of anyone's cost structure, so we just want to point that out.

So ONS has demonstrated that the proposed MRI will improve accessibility. We've talked about that with the Caid population. It allows us to continue to

give away that free care.

We've shown that the proposed MRI that we'd like to have improves quality. We are not in the business of getting people in and out quickly in a scan, short slots, get the scan, get them off the table, get the next one on.

The doctors in our practice use these images to determine whether they're going to operate, and they use them during surgery, so they are not going to want to have a scan done that's missing sequences if you're operating on the spine.

There's a lot more at stake than a fee for an MRI when you are a neurosurgeon and you're operating on someone's back, so everyone needs to put that in perspective, so these quality images are very important to us.

And you know what they say; when you want something done right, you've got to do it yourself, so ONS has demonstrated that our CON is financially-feasible. That is a very important element in looking at clear public need. It's stated time and time again in the regulations and the statute.

So, in conclusion, we've met all of the criteria outlined in the statute. We've shown how our

proposed MRI is consistent with the Statewide Health Plan and actually goes beyond what's even qualified in the Statewide Health Plan for showing need, and we respectfully request that you approve a 1.5 Tesla MRI for ONS. Thank you.

HEARING OFFICER HANSTED: Thank you.

MS. GROVES FUSCO: First, I want to thank you guys for, on behalf of my client, for the time and effort involved in reviewing the voluminous submissions in this matter and then putting up with all of us today.

I know it's been a long day, and you've heard a lot of information, but we know that you give careful consideration to everything that's said in these proceedings, whether it comes in written testimony, whether it's mentioned at a public hearing, and we appreciate how difficult it can be to filter that information when you're faced with so many differing viewpoints and interests and agendas, such as you have in a joint contested hearing, where both parties are opposing each other and there are other Intervenors.

And, so, I think the focus of my closing, and I'm going to do a joint closing sort of for both proceedings, is to just try to bring us back to, much like Michele did to the issues that are at hand here,

which is whether Advanced Radiology and ONS have met the statutory requirements for the issuance of a CON, and I can say, unequivocally, that Advanced Radiology has met those requirements.

ARC has, without question, established a clear public need for the acquisition of a second unit for its Stamford office.

They have not just met, but far exceeded the State Health Plan utilization requirements. The guidelines in this regard are very clear, and I just talked about them a few minutes ago; an Applicant, who already provides MRI services and is looking to acquire an additional unit in the same service area, must show that its existing unit is operating at 85 percent capacity, based upon a benchmark of 4,000 scans a year.

So that means a provider must be performing at least 3,400 scans each year, and, in 2015, Advanced Radiology performed 6,617 scans in its Stamford office. This is nearly twice the amount of scans necessary to justify a second scanner, and, interestingly, it’s more than the 24/7 hospital unit Stamford provides.

They’re working unrealistically long hours to be able to meet the demands of their patients, and

they need a second unit for quality of care purposes. The unit is operating at 165 percent capacity. It's going to soon reach the limits of the patients it can serve, okay, so, it doesn't have -- that scanner doesn't have to complete a single other scan, in order to justify need for a second scanner. The need is clear, and the need is immediate.

My client's proposal will also enhance the quality of MRI services in the Stamford area by the addition of 3 Tesla MRI in a practice that's on the cutting edge of health information technology advances.

You heard Dr. Muro testify quite a bit today about what a 3 Tesla can do and the type of advanced health information technology the networks and such that ARC can provide that are different than what some other providers in the area are offering.

Despite the assertions to the contrary by one of the Intervenors in our proceeding, 3 Tesla represents the highest quality imaging and is preferred for vascular brain and prostate exams, just to name a few, and ONS's own physician has acknowledged the benefits of 3T, and their contract radiologist expert I believe said it's robust in the imaging of choice, so acquiring a 3 Tesla for our office is certainly going to

be a benefit to our patients.

Our would-be competitors suggest that we might save some money by purchasing a perfectly acceptable 1.5 Tesla unit to serve our patients' outpatient imaging needs, and while the ARC doctors could have easily chosen to make such an application, instead they're here before OHCA, opting to bring the best MRI technology to Stamford for the benefit of their patients, even if it means less money in their pockets at the end of the day.

These same would-be competitors have challenged the financial feasibility of the proposal. As it stands, even with the short-term incremental losses, Advanced Radiology MRI and, I think, as we explained, like their MRI services are all done under one entity, so you're looking at all six units, even with the short-term incremental losses, the net income of that entity is $1.5 million in the first year of operation.

If you factor in what you believe will be the actual cost of the unit, once we negotiate it down to $1.9 million, that net income goes up to $1.6 million in the first year of operation.

The practice has run every conceivable scenario since we've read these submissions that was

raised in opposition to our CON. We looked at the loss of 100 percent of the OAS scans, which obviously would be a tremendous financial hit and one that we would not want to see, but even with the loss of those scans, they still show close to $1 million in profit.

We've looked at an increase in Medicaid percentages. If we were to increase our Medicaid percentage by two percent, it would only drop our net income by $52,000 that first year, and we also looked at growing things at a slower rate.

If we wanted to grow it by two percent or three percent versus the five percent that was called aggressive and it still remains financially feasible, there's no scenario we've come across, whereby this doesn't work for us as a practice, so it's really a question of these physicians have the money, they want to make the investment for the benefit of their patients, and they should be allowed to do that.

Their proposal also represents the most cost-effective way of introducing this much-needed capacity in the Stamford area. As many people have talked about today, private physician practices are typically reimbursed at a much lower rate than hospitals. They don't charge facility fees. Advanced Radiology is

also the only private physician practice in the area that offers MRI and does not self-referral, the idea being that self-referral relatively inflates volumes, which makes it a less economical alternative.

And, last, but certainly not least, Advanced Radiology's proposal represents the addition of MRI capacity that's accessible to all referring specialties and all patients in our service area.

The practice participates with Medicaid and is proud of its long history of providing services to some of the State's most vulnerable patients.

With healthcare reform, there's been, as you know, like an expansion in Medicaid enrollment, and providers, like Advanced Radiology, stand ready to provide MRI and other services to these patients, regardless of their ability to pay.

Medicaid enrollment is expected to increase by 14 percent in the Stamford area over the next five years, and, as such, we believe OHCA should only approve CON applications by providers, who proactively participate with Medicaid and provide a meaningful level of services to this population, however, providers, who service Medicaid patients, like ARC does, end up being disadvantaged by those, who avoid it.

All of the above supports Advanced Radiology's request to acquire a second MRI unit for its Stamford's office.

And now compare this with a case put forth by ONS for the addition of a second scanner for use at its Greenwich office. Although ONS puts forth a case for need, based upon the volume of its existing unit, the self-referral nature of the unit and the financial incentives that ONS providers have to refer patients to it calls into question the validity of that volume.

From a perspective of quality, ONS is not offering to invest in the 3 Tesla technology that even one of their radiologists says would be beneficial to many of their neurological -- many of their patients, including their neurological patients, nor does the practice offer the imaging capabilities pioneered by Advanced Radiology.

Their pro forma shows it's financially-feasible, but when you're 100 percent in control of the volume of referrals to your scanner, it's easy to engineer a profit, and, despite the claims to the contrary, the fact that ONS self-refers for MRI scans does drive up the cost of care.

As Dr. Kaye told you, and I'll say it

again, study-after-study shows it, and ONS's rebuttal to this claim is just that some studies are older, but what I'm referencing are current reports, like the GAO study that Dr. Camel acknowledged was a current study that showed that the same concerns raised in the 1990s are still important today, and that's why there's now a push on the federal level to close the loophole that allows advanced imaging to be captured under the in-office ancillary services exception.

But perhaps for us, and we've said much about this, the most troubling aspect of ONS's proposal is its failure to provide even a minimal amount of access to MRI services for Medicaid patients.

As Dr. Camel acknowledged today, since ONS acquired its first MRI unit in 2008, nearly a decade ago, it has not provided a single MRI recipient, a single MRI scan to a Medicaid recipient either through the program or for free.

ONS does not participate with Medicaid. Although they provided nominal care to Medicaid patients in their office and they cover some clinic hours at Greenwich Hospital that they may or may not be compensated for and they wrote off care for 23 Medicaid patients out of, you know, 51,000 in their practice, the

reality is they're proposing to acquire an MRI unit, on which no Medicaid volume is projected and for which no Medicaid referrals will be made.

So regardless of the many ways in which ONS has tried to spin it, their failure to participate in the Medicaid program is a de facto denial of access for these patients, and the State Health Plan makes it clear, that a provider seeking CON approval to acquire an MRI cannot deny access to patients, including Medicaid beneficiaries, based on payer source.

And if the manner in which they've described providing access to MRI services for Medicaid patients meets the requirements of the State Health Plan or the CON statutes that were intended to increase access for these patient populations, then I would say those statutes are meaningless, of very little meaning.

We'd also be remiss not to point out that ONS does have the ability to relocate any approved MRI unit anywhere in the State of Connecticut without CON approval. They can also enter into an affiliation with another orthopedic group or an integrated delivery network, that, if structured in a certain way, could be done without further CON review.

This means that any MRI unit OHCA approves

for use by ONS and its patients can end up somewhere, other than Greenwich, serving patients, other than ONS's.

Approving ONS's CON would be a step backwards in the effort to provide equitable access for all residents in the State.

For all the reasons I've summarized, our position is that ONS's request for permission to acquire a second unit should be denied, and for the many reasons meticulously documented in our CON submissions regarding need, quality, access and cost-effectiveness, my client's request for permission to acquire a 3 Tesla unit for its Stamford office should be approved.

HEARING OFFICER HANSTED: Okay, thank you.

MS. GROVES FUSCO: Thank you.

HEARING OFFICER HANSTED: Attorney Cowherd?

MR. COWHERD: Yes, thank you.

HEARING OFFICER HANSTED: It's already after 3:00, so please be very brief.

MR. COWHERD: For the record, Stephen Cowherd, Jeffers Cowherd, P.C., on behalf of Stamford Hospital.

So I know the hour is late, and I want to thank you and OHCA staff for the opportunity to provide

closing remarks. I'm feeling a little fish out of water today. I'm the only attorney representing a hospital, the only guy wearing -- not wearing a dark suit. I'll do it.

So let me articulate for you Stamford Hospital's positions. I think it's clear. Stamford Hospital is not taking a position in the ONS application with regard to its approval or disapproval if that unit is sited in Greenwich.

What it is asking is that OHCA exercise its regulatory authority to impose conditions if the unit is approved, the second unit is approved, that neither the new unit, nor the existing unit, be moved into its primary service area of Stamford, Darien or Rowayton without a CON process that would allow Stamford an opportunity to oppose that relocation.

So we're not asking Dr. Camel to predict the future forever, but if there is a need and there is a need to move the unit on ONS's viewpoint into that primary service area of Stamford Hospital, Stamford Hospital would like the opportunity to oppose, if it chooses to do so.

There is no vehicle right now under Connecticut law that would allow it to do so. That's the

position that Stamford Hospital is taking.

There's been a lot of talk about fairness and meeting the statutory criteria under 19a-639 today, and I'd like to speak briefly to that on how it supports the relief Stamford Hospital is seeking here on imposing conditions, if there is approval.

What's in the record is that ONS provides no Medicaid scans to Medicaid patients. It is not projecting, providing any scans to Medicaid patients, and with respect to the completely uninsured, it treated 46 patients of over 51,500 patients in 2015, who did not have insurance.

They are also, with respect to Medicaid, 23 patients in 2015 were treated, and they are asserting to OHCA that they wrote off $87,000 in care to treat that patient population.

Look at just the profit that they are making on their MRI service alone. It runs between $2.6 and roughly $3 million in the last two fiscal years. Divide that by 23 physicians. $87,000 is not even one physician share of the profit of the MR, if, in fact, they divide it equally or how they divide it. That's an issue, and that is not a meaningful service to the Medicaid population.

Also, OHCA should not be distracted by 1,453 patients that have Medicaid as a secondary payer. Those are most probably Medicare dual eligibles. Twenty-four percent of ONS's volume is coming from Medicare, and ask the hospitals about the cost differential and the reimbursement differential even on the private side between Medicaid and Medicare.

The entire Greenwich Hospital argument that -- and ONS should be rightfully commended for doing its part with Greenwich Hospital, but here's the point. That's a straw man argument.

Greenwich Hospital is a tax-exempt, non-profit. It must provide community benefit, and, in order to do that, it has to use doctors to provide those community benefits.

Many times, I don't know Greenwich Hospital's bylaws, but I represent hospitals, and I know most hospital bylaws, coverage in the ED is required. Call coverage is required. That's part of your requirement to refer patients and admit patients into that hospital.

I don't know about clinics, but I represent hospitals that require, also, care of their clinics.

So the issue here is, from a fairness perspective, is it fair that a provider that is providing no meaningful service to the Medicaid and the uninsured populations be able to move its unit into a market, where there are five other existing providers, all of which are providing service to that population? Is that fair?

Turning now to the statutory criteria that have been talked about so much, again, the relationship of this proposal to the Statewide Health Care Facility Services Plan, I was struck by both pages 17 and 18 of ONS's application on that point.

One says that it is consistent with the Statewide Health Plan, because it promotes and supports the long-term viability of the State's health care delivery system, then, on the next page, they explain why.

The long-term viability of ONS will be increased, as it will be better equipped to adapt to the demands and needs of its patients to continue to receive the benefit of enhanced continuity of care, etcetera.

My point is ONS is not the health care delivery system. The delivery system and the safety net for that system resides with the hospitals and other providers. It's not ONS alone, who is that delivery

system, and that this certainly will help their financial viability should not be an issue that OHCA focuses under that part of the Statewide Health Care Facility Plan.

And then the third bullet on page 17, this will promote equitable access to health care services, e.g., reducing financial barriers, increasing availability of physicians and facilitate access to preventative and medically-necessary health care. For whom? Not Medicaid patients. Not the underserved on the record before you.

Whether there's a clear public need for the proposed service, one letter of support in this application. Greenwich Hospital is not supporting this application. There's one from Greenwich Radiology.

I also think that it is a, again, a false or misleading to rely on HSS in serving the Medicaid population here, and, to draw from that, HSS's reports to OHCA, that there's not a need for the underserved to have MRI, I don't see why Medicaid recipients, other poor people, wouldn't need MRIs just as much as others, so it's already been brought out in testimony here today. Let's ask the federally-qualified health centers. Let's ask the community health centers in lower Fairfield County whether there's a need. I think there is, and

Stamford Hospital certainly thinks there is.

Whether the Applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the State, again, we've spoken to that.

I'm not going to belabor areas 19a-639a-5 and 6, which specifically go to OHCA's charge to be looking at the interests of Medicaid patients in deliberating on CONs, but I do want to go to Sub 10, and that is whether the Applicant, who has failed to provide a reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so.

Okay. You just heard ONS say they have demonstrated good cause. The issue of covering a clinic, a free clinic of Greenwich Hospital for basically nine hours a month among a 23-physician practice to me is not meaningful service to this population, but they do, and they also cover the ED. Excuse me?

MS. VOLPE: Yes. You know, I --

MR. COWHERD: Excuse me. I didn't --

HEARING OFFICER HANSTED: Excuse me. Attorney Volpe --

MS. VOLPE: Our closing remarks are

supposed to be brief, and he --

HEARING OFFICER HANSTED: Attorney Volpe, you're just making this longer. Attorney Cowherd, I was just about to say I'd ask you to wrap this up. We still have to hear from Attorney Monahan.

MR. COWHERD: I'm wrapping up. I think I'm done, right where we need.

HEARING OFFICER HANSTED: Okay.

MR. COWHERD: My point on this is, actually, ONS has shown that no good cause exists. If they participated in Medicaid, which is a conscious choice to participate, those patients that they see in the ED, that they see in the free care clinic would be able to follow their doctor into their private practice.

So saying that it's referral patterns that are causing these patients to go into the free clinic and the ED is misleading. The referral pattern is they're not on, ONS is not on any of the lists as a Medicaid provider.

When a Medicaid patient calls, what I assume is said is, sorry, we don't participate in the Medicaid program, so that condition and that criteria clearly is lacking here.

For all those reasons, there is going to

be an impact on existing providers if, in fact, this application is granted and there is unfettered ability for ONS to move either of its MRIs into the primary service area of Stamford Hospital, and it is that relief that we are asking be conditioned, if, in fact, OHCA approves this application. Thank you.

HEARING OFFICER HANSTED: Thank you. Attorney Monahan? Sorry to cut you short, but you have two minutes.

MR. MONAHAN: Very briefly.

HEARING OFFICER HANSTED: Thank you.

MR. MONAHAN: I'm going to take a minute and a half.

HEARING OFFICER HANSTED: Excellent. I'm going to hold you to it.

MR. MONAHAN: Thank you very much. Two points. I'd just like to focus on what I think is a bit of what I would call self-denial or denial, in general, of what we're hearing from ARC about what has been described to you about the polyclinic model, what has been disparagingly referred to as a self-referral model, and the good value-based practices that have been provided by WESTMED and others like it.

The fact that there is going to be a

historical traditionally-based depletion in scans from ARC I do not think is properly recognized with that kind of rhetoric, and I think, when you do parse the record, you will actually find their own admissions of their financial -- why it is not financially-feasible for them to accomplish that, to make up for that loss.

Second, I think the whole idea of trying to create a vision of a wall between New York and Connecticut when it comes to travel time is a red herring.

The travel time that has been focused on the most here has been from Stamford to Fairfield, Stamford to Bridgeport, and the idea that one would consider going for quality health care from Stamford to Purchase, New York or anywhere else close to the border is a somehow different rationale is a red herring. Let's not be duped by the border issue.

Thank you very much, and thanks for the opportunity for us to intervene.

HEARING OFFICER HANSTED: Thank you.

And just one last time, is there anyone here from the public that would like to give comment on these matters?

Okay, hearing and seeing none, this

hearing is adjourned. Thank you, all.

(Whereupon, the hearing adjourned at 3:22 p.m.)

AGENDA

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 8th day of September, 2016.

Paul Landman
President

Post Reporting Service
1-800-262-4102

Greer, Leslie

From: Jean Weigert <jweigert54@gmail.com>
Sent: Friday, August 26, 2016 5:23 PM
To: User, OHCA; Fernandes, David; Lazarus, Steven; Hansted, Kevin; Kaila.Riggitt@ct.gov; mmv@bymlaw.com
Subject: ONS Docket #16-32063-CON
Attachments: RSC Orthopaedic & Neurosurgery Letter.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Please accept this attached letter from the Radiological Society of Connecticut.
Thank you
Jean Weigert MD FACR

August 26, 2016

Hon. Janet Brancifort, M.P.H.
Deputy Commissioner
Office of Health Care Access Division
Department of Public Health
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: Orthopaedic & Neurosurgery Specialists, P.C.
Acquisition of MRI Unit for Greenwich Office
Docket No. 16-32063-CON

Dear Deputy Commissioner Brancifort:

I am writing on behalf of the Radiology Society of Connecticut ("RSC") regarding the Certificate of Need ("CON") Application filed by Orthopaedic & Neurosurgery Specialists, P.C. ("ONS") for acquisition of a second MRI unit for the self-referral of patients of their practice for scans. RSC believes that if ONS's application is approved, there would be ramifications that are discordant with the intent of the CON program. Many of our reasons revolve around a situation known as "self-referral," which we will explain fully. The other issues revolve around access. We will argue in general that OHCA should look upon applications by self-referring physicians in the light of the effects of self-referral with respect to the criteria used to evaluate CON applications. Specifically, ONS will likely claim that their current volumes speak to a "need" to fill a demand for their services. That demand, however, may be inflated as it is significantly created by ONS physicians. When the State Health Plan was formulated with respect to the volume criterion, it was meant to be one of numerous criteria, and not a free pass to approval – i.e., necessary, but not in and of itself sufficient. Thus, RSC urges that OHCA deny ONS's application to purchase a second MRI scanner on the grounds that it does not conform to the intent of the CON statutes.

By way of brief background, RSC is the constituent state entity of the American College of Radiology responsible for setting standards for quality of radiologists within the state. It is a non-profit organization of approximately 400 radiologists having the organizational purpose, *inter alia*, of serving patients and society by advancing the science of radiology, improving radiological service to the patient, prescribing standards and guidelines regarding quality and

safety of medical imaging, studying the socioeconomic aspects of the practice of radiology, and encouraging improved and continuing education for radiologists and allied professional fields. Our member radiologists are physicians in private practice working in their own offices and/or providing and overseeing radiology services in hospitals.

First, we would like to address the issue of self-referral of imaging, its evolution in the health care environment, including the data regarding its effects, and the responses of policymakers to these effects. We will then extrapolate that information to the current situation with respect to CONs, with specific reference to Docket No. 16-32063-CON.

A. <u>What is imaging self-referral?</u>

Self-referral is the act of a physician sending a patient to a facility for health services when that physician has a financial interest and a potential financial gain from the referral. For centuries, physicians have been the advocates for their patients. Physicians have sought the best for their patients and were financially reimbursed by charging fees that compensated them for their direct participation and paid for their direct oversight of and involvement in patient care. With imaging self-referral, sometimes called "self-dealing in machine fees," physicians gain financially when they send patients for imaging. A direct linkage of examinations ordered and financial reward is created. Patients are unknowingly used in passive investment schemes in which physicians gain financially in the absence of active patient care. Self-dealing is compounded when "investor physicians" decide to farm out the interpretations of the images and pay the interpreting physicians for their services less than they charge patients. By arbitraging interpretation fees, physicians are increasing their financial returns and potentially depriving their patients of interpretations by the best available radiologists.

Advocates of self-referral claim that it is in the best interest of patients; for example, they suggest that self-referral is based merely on patients' convenience. Interestingly, one almost never sees physicians engaged in self-referral offering either mammography or plain x-rays. Both of these imaging studies are in short supply and in great demand by patients. Both examinations can be done without any patient preparation. This is because the financial returns on these examinations are very weak. Instead, magnetic resonance imaging ("MRI") and computed tomography ("CT"), which provide high rates of financial return, are offered. Self-referring physicians develop these business models even in a market already saturated with MRI and CT equipment.

Regarding convenience, the imaging examinations that are most often offered by self-referring physicians, such as MRI and CT, are usually scheduled examinations, frequently require preauthorization by insurance companies, and other administrative and clinical preparation work beyond this can be performed. Thus, patients must return on subsequent days

for these examinations. Hence, the convenience factor is very minimal. The above argument has been proven spurious by two studies. One, an unpublished analysis of Medicare data by the American College of Radiology ("ACR"), reported at its Board Meeting, showed that only 5% of cardiac nuclear stress tests were performed on the same day as the office visit. The second, published in Health Affairs journal showed that self-referral medical practice provided same-day imaging for 74 percent of straightforward x-rays, but for only 15 percent of more-advanced procedures such as CT and MRI. See **Exhibit A.**

Lest anyone doubt the key role of the financial incentive in motivation of referring physicians' acquisition of imaging equipment, we include two brochures by a major imaging equipment vendor prepared specifically for a potential self-referral situation. Prominent in the marketing is the profitability of providing imaging in one's own office. See **Exhibit B.**

B. History and Literature on self-referral:

Early studies from the late 1980s and early 1990s examined a wide range of services and health care businesses. Consistent findings indicate that self-referral: (1) increases utilization; (2) increases costs to consumers; (3) limits access for the uninsured and underinsured; (4) reduces quality of care; and (5) restricts competition among providers in the market area. Specifically:

- Doctors who owned machines ordered 4.0 - 4.5 times more imaging tests. Charges per episode of care were 4.5 - 7.5 times greater for self-referring physicians. See **Exhibit C.**

- Self-referring physicians employed diagnostic imaging 1.7 to 7.7 times more frequently than physicians referring to radiologists. Charges per episode were 1.6 - 6.2 times greater for self-referring physicians. See **Exhibit D.**

- Higher utilization and costs and lower quality in Florida Physician Joint Venture physical therapy centers. See Mitchell JM, Scott E, *Physician ownership of physical therapy services: effects on charges, utilization, profits, and service characteristics. JAMA. 1992;268(15):2055–9* available here**:** http://jama.jamanetwork.com/article.aspx?articleid=400630.

- Higher utilization and higher costs for Florida Physician Joint Venture radiation therapy services compared to rest of US. See **Exhibit E.**

- Higher utilization and higher costs in PJV clinical laboratory services. See Omnibus Budget Reconciliation Act of 1989, § 6204 and **Exhibit F.**

In the 2000's further interest in this topic was spurred by large increases in health care costs, in general, with disproportionately higher rates of rise in advanced imaging. Studies showed that the rates of rise in imaging utilization were significantly higher in self-referral situations. In 2009, Health Affairs, the most influential health economics and policy journal published some important articles with respect to self-referral. One demonstrated that orthopedic and neurology physicians changed their referral behavior for MRI after acquiring an ownership interest in the machines:

> *Study physicians ordered significantly more MRI procedures after they began billing for them. For orthopedists, the number of MRI procedures used within thirty days of the index visit increased by 23 per 1,000 episodes—an increase of about 38 percent. This was driven largely by increases in the number of episodes where any MRI was used, but there was also a small increase in the average number of MRI procedures used by patients who had at least one. Neurologists used more MRI and had larger increases associated with beginning to bill.*
>
> *The finding, however, that much of the observed increase in MRI use did not take place on the day of the initial visit seems to diminish the strength of the argument that convenience was the central driver. Another paper in this issue also makes the argument that this supposed "convenience" factor has not driven the change.*[23]
>
> *At the same time, it is worth noting that physicians who began billing for MRI could and did refer patients for MRI before they began billing, and the characteristics of their patients did not change substantially after they began to bill. This raises the possibility that the additional patients who came to receive MRI after their physicians began billing were those for whom use of MRI was less clearly indicated and for whom the possible benefits were smaller.*

See **Exhibit G.**

> *Imaging as a result of self-referral—when a physician refers patients for imaging tests at a facility owned or leased by the same physician—is widespread. The practice has come under much scrutiny because it is associated with higher volumes of imaging services. Proponents of such self-referral argue that the practice offers patients convenient same-day, one-stop service and allows treatment to start sooner. Our analysis of 2006 and 2007 Medicare data showed that self-referral provided same-day imaging for 74 percent of straightforward x-rays, but for only 15 percent of more-advanced procedures such as computed tomography and magnetic resonance imaging.*

See **Exhibit A.**

Then, in 2009, Atul Gawande, a well-known surgeon and writer with a national reputation on quality and ethics, published an investigative report in New Yorker Magazine that

shed light to a broad audience on rampant physician entrepreneurship. He presented the situation in the poorest county in the United States:

> *McAllen's (Texas) spending was almost identical to El Paso's in the early nineteen-nineties. By the late nineties, however, it had become one of the most expensive regions in the country for Medicare and it has continued that way. Yet, public data show no sudden decline in health status or income for the McAllen population.*
>
> *The biggest changes? A dramatic rate of overutilization during a period that saw a marked expansion in physician-owned imaging centers, surgery centers, hospital facilities, and physician-revenue-sharing by home-health agencies. Home-health agencies there, for example, spent more than $3,500 per Medicare beneficiary—not only five times more than in El Paso, but also more than half what many communities spend on all patient care. In the end, none of the criticisms address either the pattern of overtreatment found in multiple studies of high-cost communities or the specific instances I found of revenue-driven care among doctors and executives in McAllen.*

See **Exhibit H**. The article was widely read in political arenas - Congress, The White House, and among policy makers in Hartford – who cited the article as examples why reform was needed.

C. Policymakers' Reactions

In the 1990's, in response to the overwhelming data confirming excessive utilization of ancillary services, such as laboratory and imaging, Congress passed a series of laws (Stark I and Stark II) to curtail self-referral. However, an exemption to the law governing self-referral was made in an effort to provide immediate need laboratory and x-ray services. This loophole is referred to as the "in-office ancillary services exception (IOASE)." Today, in the era of Stark II, Phase II, it is possible for a physician, in his or her own office, to have imaging equipment and to send his or her own patients to this equipment. Paradoxically (and appropriately), if an independent imaging provider were to pay $1 to a physician to refer a patient for imaging, it would be a criminal offense (a "kickback"). However, a self-referring physician, because of loopholes in the Stark laws, is able to send patients to his or her own imaging center. steady passive income stream is established.

Maryland has dealt directly with self-referral, passing a law that outlaws it for advanced imaging tests. It has survived a challenge in the courts. See **Exhibit I**.

Clearly, the cost of health care has been a major focus of employers, who bear a large burden of the cost of care, and who had a lot to say in the debate over health reform. The National Business Group on Health represents primarily Fortune 500 companies and large public sector employers who provide health coverage for more than 55 million U.S. workers, retirees,

and their families. In 2009 and 2010, they weighed in on self-referral, calling for "a prohibition on Medicare physician self-referrals for the medical scans most prone to overutilization." See **Exhibit J**.

During the discussions prior to the enactment of the Affordable Care Act ("ACA"), Sen. Max Baucus was the Chairman of the Senate Finance Committee and also the leader of the "Gang of Six," consisting of Senators from both parties charged with leading the health reform process. Sen. Baucus published a white paper on health reform, in which he addressed self-referral:

> *Physicians, like most professionals, expect to get paid for the work that they perform. Some physicians, however, have found a way to game the system so that, in addition to getting paid, they reap additional financial benefits from the provision of certain health care services. Physicians can accomplish this by having ownership or other financial interests in equipment or facilities — such as an MRI machines. When those physicians refer their patients for services from which the physician reaps the additional financial benefits — a practice known as self-referral — there is reason to be concerned about the physician's motives. .....Self-referral creates conflict ting incentives for physicians, because the financial incentive to increase utilization of the financially-rewarding services may conflict with otherwise sound medical and professional judgment. Ultimately, this practice often results in an increased use of services and higher payments from third party payers..... The issue of self-referral must be reviewed in light of how health care is and will be delivered. No serious effort at reform can ignore the potential gaming that financial conflicts may create.*

See **Exhibit K**.

In the early part of the 2010's, after almost two decades of growth in health care costs, much of this imaging in the hands of self-referrers, and with the advent of the Affordable Care Act, pressure on cost of care became high enough to get the attention of Congress and the Executive branch. Congress asked the GAO to do a study on the effect of self-referral on advanced imaging procedures for Medicare beneficiaries. The GAO report was issued in 2012, and entitled, Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions," confirmed that the problem remains. See **Exhibit L**. As a result of the GAO's confirmation of the problems with self-referral of imaging and other reports, President Obama's budget recommends closing of the in-office ancillary services exception (IOASE) to the Stark self-referral law. The Office of Management and Budget (OMB) documents indicate that removal of advanced diagnostic imaging, radiation therapy, and physical therapy services from the IOASE could save the government $5 billion over ten years. See **Exhibit M**.

D. Relevance to CON Requirements

The byzantine (characterized by elaborate scheming and intrigue, especially for the gaining of political power or favor) political process with respect to self-referral, combined with

Congressional gridlock, has not approved the repeal of the IOASE, and self-referral goes on unabated. Connecticut legislature has dealt with the issue indirectly on multiple fronts, but has not yet duplicated the Maryland statute. Recognizing that the quality of care could be compromised by unrestricted ability to install advanced imaging equipment, Connecticut has successfully curtailed the spread of self-referral. In 2001, Connecticut became the first state in the nation to pass a law requiring that all MRI scanners needed to be certified with ACR Accreditation (Public Act 01-50). Then, in 2005, noting that the previous $400,000 threshold for requirement for CON was resulting in purchases of older, pre-owned scanners of lesser quality for $399,999, passage of Public Act 05-93, which required CON for all newly operational MRI, CT, and PET scanners, linear accelerators, and cine-angiography equipment.

In 2009, Sen. Williams had an aide who was a physician named Josh Rising. He was an advocate of the ACA, and was familiar with the body of data regarding self-referral and its inflationary effect on medical costs. He asked the RSC for information on the subject and what could be done with it. A Maryland-type law was considered and favored by him and Sen. Williams, but they wanted to move there in stages. Coincidentally, a new to circumvent the CON and Stark and anti-kickback laws was imminent in the state, whereby existing owners of scanners would lease time on their scanners to self-referring physicians, who planned to bill for the procedures done on patients they referred. The resultant first step was Public Act 09-206 which banned the leasing arrangements. Unfortunately, Dr. Rising left to take a job in health policy in the Obama White House, and "stage 2" lost a major driving force.

As the above narrative shows, while imperfect, CON laws have served as an initial deterrent to self-referral. They do so through the recognition on the parts of knowledgeable Commissioners and OHCA staff of the following effects of self-referral on the principles behind the CON laws:

1. ***Quality***

   a) When a physician refers a patient to an independent radiology provider or hospital radiologist, there is a value-add over internal imaging by a referring specialist. First, it is the equivalent of a second opinion – providing a different perspective on the patient's condition, a confirmation that the right test is being ordered, or an alternative suggestion, and the referral relationship is an incentive for the radiologist to provide good, high quality service. Second, since the separate physician's images and reports are going to be reviewed by the referring physician, both the imaging test and the report must be of sufficient and accurate information or the referrals will go elsewhere. Both of the above are important quality assurances to patients in need of care.

   b) In the case of imaging, the independent and hospital facilities are overseen by on-site professionals who are trained in imaging – technique, safety, technology. This is not the case in most self-referral situations.

c) It is common for self-referral centers to hire outside radiologists to interpret the images. The determining factors may be influenced by price or local politics, sometimes with price as a driving factor. It is fertile ground for an arbitrage situation, whereby the rates paid by the self-referrers are less than that which the owners are reimbursed from insurers – i.e., the non-radiologists profit from the interpretation in addition to the machine fees, creating a situation that there is very little professional service provided by the self-referrers.

2. ***Need***
   a) Volumes of procedures are inflated by the overutilization that is an irrefutable consequence of self-referral. This must cast doubt on the legitimacy of volumes presented in CON applications.
3. ***Cost***
   a) Increases costs to:
      i. consumers with deductible plans;
      ii. to employers who sponsor health insurance;
      iii. to governmental payers;
      iv. with the above frequently compounded by the need for follow-up of incidental findings on the imaging.
4. ***Access***

   a) Anything that drives up cost limits access. Self-referral by private physicians frequently is not placed in the most accessible locations for under-insured population. See No. 5, below.

5. ***Competition/Choice/Effect on existing providers***

   a) First, to the extent that private specialists are not taking care of governmental beneficiaries or under-insured patients, those patents go to the hospitals or independent radiology centers. In the case of RSC's independent radiologist members, their case mix gets skewed to the lower payers, making it more difficult to stay in business, particularly in view of the 2015 severe reductions in Medicaid rates.

   b) Second, self-referred imaging, almost by definition, has a negative effect on existing providers. It is anything but competition. In fact, it is anticompetitive, because the "vertically integrated" self-referrers create a captive referral system; non-joint venture firms cannot compete.

E. <u>Conclusion</u>

RSC strongly believes that the CON law and process have and, in the absence of a Maryland-like law, should continue to serve as a curb on overutilization, high costs, and anticompetitive practices and facilitators of quality care and access for all patients. In addition,

volumes provided in self-referred situations should not be given the same credibility as those from independent and/or externally-referred facilities. On these grounds, RSC expresses its strong opposition to the ONS application.

Very Truly Yours,

Jean Weigert MD FACR

Jean Weigert, M.D.
Immediate Past President
Radiological Society of Connecticut

EXHIBIT A

By Jonathan Sunshine and Mythreyi Bhargavan

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HEALTH AFFAIRS 29,
NO. 12 (2010): 2237–2243

TECHWATCH

The Practice Of Imaging Self-Referral Doesn't Produce Much One-Stop Service

Jonathan Sunshine (jsunshine@acr.org) is senior director for research at the American College of Radiology, in Reston, Virginia.

Mythreyi Bhargavan is director of data registries at the American College of Radiology.

ABSTRACT **Imaging as a result of self-referral—when a physician refers patients for imaging tests at a facility owned or leased by the same physician—is widespread. The practice has come under much scrutiny because it is associated with higher volumes of imaging services. Proponents of such self-referral argue that the practice offers patients convenient same-day, one-stop service and allows treatment to start sooner. Our analysis of 2006 and 2007 Medicare data showed that self-referral provided same-day imaging for 74 percent of straightforward x-rays, but for only 15 percent of more-advanced procedures such as computed tomography and magnetic resonance imaging. Policy makers attempting to make the use of imaging more responsible should consider narrowing Medicare's special provision allowing referrals to a physician's own practice so that the provision covers x-rays only.**

Referring a patient for imaging tests to a facility that the physician owns or leases—known as self-referral—is a controversial practice. Proponents say that it has multiple important advantages, most of them arising because it provides what might be called one-stop service.[1–3] In other words, in a single trip to a physician's office, the patient can obtain the following: an initial evaluation of his or her health problem; imaging that the treating physician feels is appropriate; and the initiation of well-informed, definitive treatment.

One-stop service purportedly has several advantages. It is more convenient for the patient, who makes just one trip to a provider instead of several. Because patients who are asked to make separate visits to different providers sometimes do not follow through, one-stop service also means that more patients are likely to get appropriate treatment. And episodes of illness are shorter because definitive treatment can start right away and can build on an information base that includes imaging.

Physicians who are not radiologists can bill and receive payment for self-referred imaging by buying or leasing equipment such as a computed tomography (CT) scanner and either interpreting the images themselves or contracting with others for interpretation.

Opponents of self-referral say that the practice leads to much greater use of imaging, which means that costs are needlessly high and patients are exposed to more radiation than is necessary.[4,5]

Empirical research has concentrated on the issue of use and does indeed show that self-referral is associated with much higher use of imaging, compared to referrals to radiologists.[6–9] This finding has drawn attention because imaging had repeatedly been found to be by far the most rapidly growing component of physician services.[10–12]

As noted, research on self-referred imaging has focused on use. There has been no empirical study of the purported advantages of the practice. To address that knowledge gap, we studied the prevalence of one-stop imaging.

Study Data And Methods

When self-referral is, in fact, a one-stop process, patients have an office visit and receive an imaging service on the same day. It is easy to ascertain from health care claims whether or not this actually happens. Accordingly, we analyzed claims to ascertain how often self-referred imaging is accompanied by a same-day office visit.

DATA The data primarily came from Medicare's 5 percent Research Identifiable Files for 2007 (the latest year available at the time of the study) and 2006. These are files of insurance claims for all services rendered by physicians and other noninstitutional providers to a random 5 percent of beneficiaries enrolled in fee-for-service Medicare. Among other things, the files contain the date of service, the physician's unique provider identification number and specialty, diagnosis and procedure codes, payment amounts, and information on the patient's characteristics.

ANALYSIS For imaging services[13] that took place in an office, we identified as self-referred the procedures where claims had the same unique provider identification number in both the referring physician and the performing physician fields. If either identification number was missing, we omitted the claim from the analysis.[14]

We grouped imaging services into types based on Berenson-Eggers Type of Service codes.[13] This classification groups each of the several thousand billing codes in the Current Procedural Terminology and Healthcare Common Procedure Coding System[15,16] into one of just over a hundred types of procedures, including twenty-three categories and subcategories of imaging.

For each type of imaging, we computed the percentage of self-referred imaging services that were accompanied by a same-day office visit to the same physician (Exhibit 1). We included only global claims, which charge for the entire imaging service, and technical-component-only claims, which charge for the use of the equipment, space, technicians, and supplies—in other words, for everything except the physician's role in supervising and interpreting the scan. We did not include claims that charge only for the physician's service (professional-component-only claims) because there is an accompanying technical-component-only claim and we did not want to double-count claims.

We examined differences in the rate of same-day imaging based on the specialty of the treating physician. That specialty is recorded on the claim.

In 2007 Medicare was shifting to a different physician identifier system, the national provider identifier. Therefore, to ensure that the 2007 data were not anomalous, we replicated our analyses using Medicare's 2006 Research Identifiable Files. We conducted all data analyses with the statistical analysis software SAS, version 9.1.

EXHIBIT 1

Types Of Self-Referred Imaging And Same-Day Office Visits, 2007

Type of imaging	BETOS codes	Number of self-referred images	Percent of all self-referred images	Number with same-day office visit	Percent with same-day office visit
Most straightforward x-rays	I1A, I1B	621,300	28.2	459,015	73.9
Chest x-rays	I1A	148,076	6.7	117,113	79.1
Musculoskeletal x-rays	I1B	473,224	21.5	341,902	72.2
Other x-rays	I1C, I1D, I1F	37,649	1.7	14,681	39.0
High-tech imaging	I1E, I2	1,079,739	49.0	163,744	15.2
Nuclear medicine	I1E	1,034,426	47.0	153,556	14.8
CT	I2A, I2B	29,241	1.3	7,797	26.7
MRI	I2C, I2D	16,072	0.7	2,391	14.9
Ultrasound	I3	434,159	19.7	149,689	34.5
Abdomen/pelvic	I3B	39,047	1.8	21,836	55.9
Echocardiography	I3C	246,911	11.2	83,878	34.0
Other	I3A-F	148,201	6.7	43,975	29.7
Procedural imaging	I4	29,765	1.4	7,222	24.3
All except most straightforward x-rays	All except I1A, I1B	1,581,312	71.8	335,336	21.2

SOURCE Authors' analysis of Medicare's 2007 Research Identifiable Files. **NOTES** Figures represent only global and technical component–only claims, as explained in the text. BETOS codes are Berenson-Eggers Type of Service codes, used by the Centers for Medicare and Medicaid Services to classify procedures. CT is computed tomography. MRI is magnetic resonance imaging.

Study Results

Provider identifier codes were present on 96.0 percent of 2007 claims and 99.5 percent of 2006 claims.

2007 RESULTS After we omitted claims that lacked provider identifier codes, there remained 2.2 million self-referred imaging services received by the 2.6 million Medicare fee-for-service beneficiaries in the 2007 Research Identifiable Files data set.

Of these images, 28.2 percent were relatively straightforward x-rays—specifically, chest x-rays and musculoskeletal x-rays (Exhibits 1 and 2). Of these, 73.9 percent were accompanied by an office visit on the same day.

In contrast, only 15.2 percent of high-tech images—nuclear medicine, CT scanning, and magnetic resonance imaging (MRI)—had a same-day office visit. Nuclear medicine accounted for 47.0 percent of all self-referred imaging services.

For ultrasound, sometimes thought of as "medium-tech," 34.5 percent of self-referred services were accompanied by an office visit on the same day. Abdominal and pelvic ultrasound had a same-day rate of 55.9 percent but accounted for just 1.8 percent of all self-referred imaging services.

Overall, 21.2 percent of patients receiving self-referred imaging services other than chest or musculoskeletal x-rays had an office visit on the same day.

Individual specialties vary greatly in the types of self-referred imaging that they predominantly perform. However, for each type of imaging, the percentage of patients with a same-day office visit was quite similar across specialties. It was also similar to the percentages given above for all providers (Exhibit 3).

For example, self-referred imaging of orthopedists, not surprisingly, consisted predominantly (95.0 percent) of musculoskeletal x-rays, although those x-rays were only 21.5 percent of all physicians' self-referred imaging. But the percentage of orthopedists' patients with a musculoskeletal x-ray and an office visit on the same day was 72.4 percent—virtually identical to the 72.2 percent for patients of all doctors.

2006 RESULTS For 2006 we analyzed 2.1 million self-referred imaging services (Appendix Exhibit A1).[17] For every moderately specific category of imaging, the percentage of self-referred images that had a same-day office visit was very similar in 2006 and 2007. For example, for high-tech self-referred imaging, the same-day office visit rate was 15.6 percent in 2006 and 15.2 percent in 2007.

However, the proportion of total self-referred imaging other than chest and musculoskeletal x-rays that was accompanied by a same-day office visit declined somewhat from 2006 to 2007, from 22.9 percent (Appendix Exhibit A1)[17] to 21.2 percent (Exhibit 1). The decline was due primarily to the growing role of nuclear medicine, whose low same-day office visit rate, approximately 15 percent, did not vary. Nuclear medicine increased from 42.0 percent of all self-referred in-office imaging services in 2006 to 47.0 percent in 2007.

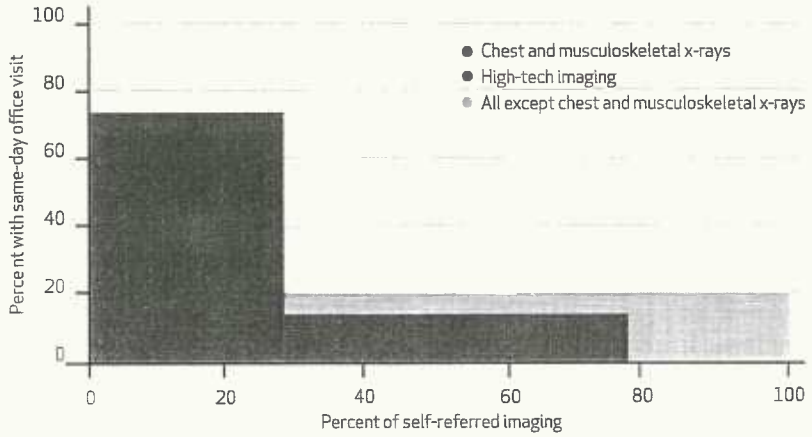
In 2006, as in 2007, the types of specialists who were chiefly responsible for self-referrals differed greatly in the type of self-referred imaging they primarily performed. However, their same-day office visit rate for any given type of imaging was similar to the all-physician average for the same service (Appendix Exhibit A2).[17] For example, in 2006, echocardiography constituted 30.7 percent of cardiologists' self-referred imaging, compared to only 12.1 percent of the self-referred imaging of all physicians. But the same-day office visit rate for echocardiography was 34.8 percent for cardiologists—very similar to the 34.1 percent rate for all physicians (Appendix Exhibit A1).[17]

STUDY LIMITATIONS For two reasons, our findings on same-day imaging may seriously overestimate the extent to which self-referral is truly a one-stop process, at least for high-tech imaging. First, Jean Mitchell[18] has shown that much self-referred high-tech imaging that supposedly takes place in the treating physician's office actually occurs at another location under what the Centers for Medicare and Medicaid Services (CMS) terms "abusive" leasing and other arrangements that the Medicare and Medicaid programs are just beginning to curb.[19–21]

Second, our methodology generally recorded a

EXHIBIT 2

Percentage Of Self-Referred Imaging With Same-Day Office Visit



SOURCE Authors' analysis of Medicare's 2007 Research Identifiable Files.

EXHIBIT 3

Main Types Of Self-Referred Imaging Services By The Most Common Self-Referring Specialties And All Physicians, 2007

Type of imaging	BETOS codes	Primary care		Cardiology		Orthopedics		All physicians	
		% of imaging self-referred	% with same-day office visit	% of imaging self-referred	% with same-day office visit	% of imaging self-referred	% with same-day office visit	% of imaging self-referred	% with same-day office visit
Most straightforward x-rays	IIA, IIB	37.7	75.4	—[a]	—[a]	95.1	72.4	27.8	73.3
Chest x-rays	I1A	18.0	79.6	—[a]	—[a]	—[a]	—[a]	6.7	77.5
Musculoskeletal x-rays	I1B	19.8	71.7	—[a]	—[a]	95.0	72.4	21.5	72.2
Nuclear medicine	I1E	35.6	17.5	67.0	10.8	—[a]	—[a]	47.2	14.7
Echocardiography	I3C	13.8	31.4	26.9	35.4	—[a]	—[a]	11.0	34.0

SOURCE Authors' analysis of Medicare's 2007 Research Identifiable Files. NOTE BETOS codes are Berenson-Eggers Type of Service codes, used by the Centers for Medicare and Medicaid Services to classify procedures. [a]Constitutes only a minimal percentage of the specialty's self-referred imaging.

same-day office visit when self-referral was, in fact, a two-stop process. For example, a patient might visit a treating physician and be scheduled for high-tech imaging several days later. If the patient has an office visit to start treatment on the same day that the imaging took place, we counted that as a same-day visit.[22]

Our study included only Medicare beneficiaries. However, as noted below, the limited published data for a younger population are similar to our findings. Moreover, the advantages of one-stop service are probably greater for the elderly, who more often than younger patients have mobility and transportation difficulties.

Our study did not address any advantages claimed for self-referral other than one-stop service.

Discussion

Our analyses of 2007 data and 2006 data produced very similar results. Specifically, same-day imaging was the exception, other than for the most straightforward types of x-rays. Overall, less than one-fourth of imaging other than these types of x-rays was accompanied by a same-day office visit. The fraction for high-tech imaging was even lower—approximately 15 percent.

A likely explanation is that the equipment required for high-tech imaging is expensive, typically costing $0.5–$2.0 million per machine, and it is inefficient for such equipment to be idle and available to patients on an essentially walk-in basis. Rather, the norm is to schedule appointments ahead of time, to maximize use of the equipment. It is ironic that a major justification for self-referrers' acquiring this expensive equipment is to provide same-day convenience to their patients—but, presumably to keep their costs down, the physicians inconvenience the vast majority of their imaging patients by scheduling scans for a later date.

Our results were similar to the very limited data previously published.[8] These data cover a few combinations of health problems and types of imaging in a population mainly under age sixty-five with health insurance through their employer. The data show very high same-day office visit rates (at least 85 percent) for chest and musculoskeletal x-rays and low rates (averaging 14 percent) for high-tech imaging.

Policy Implications

Medicare generally bans financially self-interested referral but allows it for designated "ancillary services," including imaging, if the service takes place in a physician's office.[23]

Previous research indicates that self-referral for imaging is associated with high use of imaging. This means that costs and radiation exposure are high. We have shown that self-referral is seldom a one-stop process (with the exception of relatively straightforward x-rays), although its purported benefits are heavily dependent on its being a one-stop process. Thus, relatively straightforward x-rays are the only form of imaging for which one main benefit of self-referral—one-stop service—seems likely to offset its apparent drawbacks.

Two policy implications emerge. First, Medicare should consider limiting its "in-office ancillary services exemption" for imaging to x-rays.[24] However, Medicare should first acquire two additional types of empirical evidence.

For one, evidence is needed as to whether the

Same-day imaging was the exception, other than for the most straightforward types of x-rays.

demonstrated relationship between self-referral and high use of imaging is actually causal. Possibly, some physicians who are not radiologists may acquire imaging equipment because their personal pattern of practice makes intensive use of imaging, and their use of imaging might not be affected by their acquisition of equipment.

Also, we need more information on the potential benefits of self-referral beside one-stop service. For example, does self-referral lead to better coordination and integration of care? Does it shorten episodes of illness? And does it offset the cost of higher use of imaging by providing information that can save money in the long run? We and other researchers are investigating these questions.

The second policy-related implication of our study is that in-office exemptions for ancillary services other than imaging—such as physical therapy, clinical laboratory tests, and durable medical equipment—should be analyzed as well. Are the exemptions associated with high use of these services, and do their purported benefits actually occur? Studies of self-referral for services other than imaging generally find increased use as well as other undesirable effects.[4,25–30] These undesirable effects include higher markups and "cream skimming"—that is, disproportionately serving patients with relatively mild illnesses or generous insurance, thereby increasing the burden on physicians who care for sicker and less remunerative patients. ■

A version of this paper was presented as a poster at the American Public Health Association Annual Meeting, November 7–11, 2009, in Philadelphia, Pennsylvania.

NOTES

1 American Urological Association. Talking points: physician self-referral [Internet]. Linthicum (MD): The Association; 2005 [cited 2008 Jul 15]. Available from: http://www.auanet.org/content/legislative-and-regulatory/imaging/selfreftalkingpoints.pdf

2 Williams KA. Testimony at the hearing on managing the use of imaging services, before the Subcommittee on Health of the House Committee on Ways and Means [Internet]. Washington (DC): US Government Printing Office; 2005 [cited 2010 Oct 15]. Available from: http://waysandmeans.house.gov/Hearings/Testimony.aspx?TID=905

3 Pontzer K. Statement at the hearing on managing the use of imaging services before the Subcommittee on Health of the House Committee on Ways and Means [Internet]. Washington (DC): US Government Printing Office; 2005 [cited 2010 Oct 15]. Available from: http://waysandmeans.house.gov/Hearings/Testimony.aspx?TID=6101

4 Casalino LP. Physician self-referral and physician-owned specialty facilities [Internet]. Princeton (NJ): Robert Wood Johnson Foundation; 2008 Jun [cited 2010 Oct 15]. (Research Synthesis Report No. 15). Available from: http://www.rwjf.org/files/research/062408.policysynthesis.physreferral.rpt.pdf

5 Levin DC, Rao VM. Turf wars in radiology: updated evidence on the relationship between self-referral and the overutilization of imaging. J Am Coll Radiol. 2008;5(7):806–10.

6 Hillman BJ, Joseph CA, Mabry MR, Sunshine JH, Kennedy SD, Noether M. Frequency and costs of diagnostic imaging in office practice—a comparison of self-referring and radiologist-referring physicians. N Engl J Med. 1990;323(23):1604–8.

7 Hillman BJ, Olson GT, Griffith PE, Sunshine JH, Joseph CA, Kennedy SD, et al. Physicians' utilization and charges for outpatient diagnostic imaging in a Medicare population. JAMA. 1992;268(15):2050–4.

8 Gazelle GS, Halpern EF, Ryan HS, Tramontano AC. Utilization of diagnostic medical imaging: comparison of radiologist referral versus same-specialty referral. Radiology. 2007;245(2):517–22.

9 Medicare Payment Advisory Commission. Report to the Congress: improving incentives in the Medicare program [Internet]. Washington (DC): MedPAC; 2009 Jun [cited 2010 Oct 15]. Available from: http://www.medpac.gov/documents/Jun09_EntireReport.pdf

10 Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2003 Mar [cited 2008 Jun 15]. Available from: http://www.medpac.gov/documents/Mar03_Entire_report.pdf

11 Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2006 Mar [cited 2008 Jun 15]. Available from: http://www.medpac.gov/documents/Mar06_EntireReport.pdf

12 Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2008 Mar [cited 2008 Jun 15]. Available from: http://www.medpac.gov/documents/Mar08_EntireReport.pdf

13 To define which services are imaging, we used the standard Berenson-Eggers Type of Service classification. Centers for Medicare and Medicaid Services. Berenson-Eggers Type of Service (BETOS) codes [Internet].

Baltimore (MD): CMS; [cited 2009 Dec 2]. Available from: http://www.cms.gov/MedicareFeeforSvcPartsAB/Downloads/BETOSDescCodes.pdf

14 Medicare's data system treats independent diagnostic testing facilities as a physician; the specialty of the actual physician in charge is unknown. We excluded from the analysis imaging performed in these facilities. Because Medicare rules generally preclude reimbursing radiologists for self-referring, we also excluded from the analysis their self-referred imaging. Such imaging, approximately 2 percent of the total, had a particularly low rate of same-day service.

15 American Medical Association. About CPT [Internet]. Chicago (IL): AMA; [cited 2010 Oct 15]. Available from: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.shtml

16 Centers for Medicare and Medicaid Services. Healthcare Common Procedure Coding System (HCPCS)—general information [Internet]. Baltimore (MD): CMS; [cited 2010 Oct 15]. Available from: http://www.cms.gov/MedHCPCSGenInfo/01_Overview.asp

17 To access the Appendix, click on the Appendix link in the box to the right of the article online.

18 Mitchell JM. The prevalence of physician self-referral arrangements after Stark II: evidence from advanced diagnostic imaging. Health Aff (Millwood). 2007;26(3):w415–24. DOI: 10.1377/hlthaff.26.3.w415.

19 The best-known of the abuses is the so-called per click lease, in which a referring physician or practice contracts with an off-site imaging center to perform imaging at a fixed fee per imaging examination. According to the contract, the referrer leases the imaging equipment and personnel involved in each examination. The equipment and its off-site location is thereby deemed—for however many minutes the examination takes—to be part of the referrer's office and thus to fall within the in-office exemption.

20 US Department of Health and Human Services. Centers for Medicare and Medicaid Services, 42 CFR Parts 411, 412, 413, 422, and 489. Fed Regist [serial on the Internet]. 2008 Aug 19;73(161):48713–21, 48742–3 [cited 2010 Oct 27]. Available from: http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf

21 US Department of Health and Human Services. Centers for Medicare and Medicaid Services, 42 CFR Parts 405, 409, et al.. Fed Regist [serial on the Internet]. 2008 Nov 19;73(224):69799–817, 69935–6 [cited 2010 Oct 27]. Available from: http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf

22 When imaging and an office visit take place on the same day, to distinguish this situation from actual one-stop service would require knowing whether the imaging had been scheduled when a previous visit took place. Claims do not include information about when the scheduling of an imaging took place. They provide only the dates of the imaging and office visits.

23 The "in-office ancillary services exemption" is found at 42 USC 1395 nn.

24 X-rays that are not chest or musculoskeletal x-rays are less than 2 percent of all self-referred in-office imaging (Exhibit 1). Thus, the desirability of excluding them from the exemption would probably be offset by the simplicity of an exemption for all x-rays.

25 Scott E, Mitchell JM. Ownership of clinical laboratories by referring physicians: effects on utilization, charges, and profitability. Med Care. 1994;32(2):164–74.

26 Swedlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California workers' compensation system as a result of self-referral by physicians. N Engl J Med. 1992;327(21):1502–6.

27 Mitchell JM, Sunshine JH. Consequences of physicians' ownership of health care facilities—joint ventures in radiation therapy. N Engl J Med. 1992;327(21):1497–501.

28 Mitchell JM, Scott E. Physician ownership of physical therapy services: effects on charges, utilization, profits, and service characteristics. JAMA. 1992;268(15):2055–9.

29 Strope SA, Daignault S, Hollingsworth JM, Ye Z, Wei JT, Hollenbeck BK. Physician ownership of ambulatory surgery centers and practice patterns for urological surgery: evidence from the state of Florida. Med Care. 2009;47(4):403–10.

30 Mitchell JM. Utilization changes following market entry by physician-owned specialty hospitals. Med Care Res Rev. 2007;64(4):395–415.

EXHIBIT B

Imaging Opportunities for Urology Physician Practices

Affordable In-Office Computed Tomography Solutions

SIEMENS

medical

urology

The introduction of Multislice Computed Tomography (MSCT) has changed the way urologists diagnose their patients. Today, CT has become the gold standard for many diagnostic examinations in urology.

Now Siemens Medical Solutions is making this fascinating imaging technology available to private practices like yours. Adding computed tomography can not only improve patient convenience — by combining diagnosis and care in one location — but it can also significantly improve the overall bottom line of your practice. Furthermore, in today's competitive marketplace, adding this service can help distinguish and grow your practice successfully.

If you are thinking about adding CT to your practice, Siemens will show you the way to realize your goal. We offer not only modern in-office CT scanners for every practice's specific needs, but we also support your decision and investment process every step of the way with our professional services. We will make it as easy for you.

We have developed a simple four-step approach that helps you to assess whether in-office CT is the right solution for your practice. And our Siemens Team will provide professional expertise to help you make the right decisions.

Now it is up to you! Explore new imaging opportunities with our convenient and easy to use four-step Information Guide.

NEW: Quick Start Package

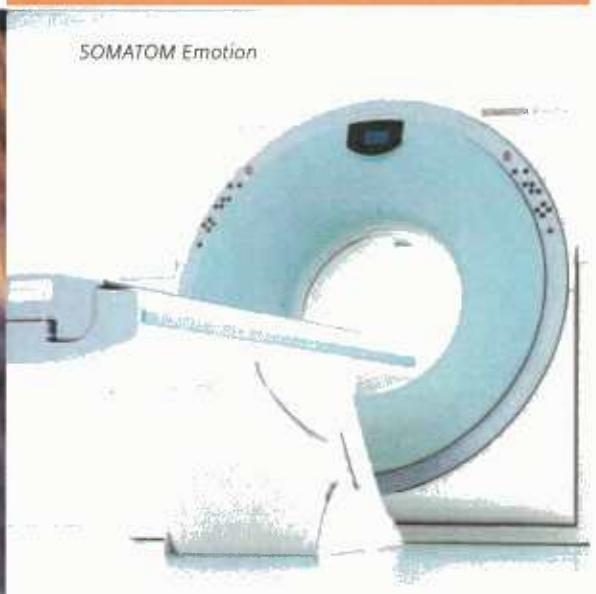
To get you started quickly, we will prepare your personal **"CT Quick Start Package for Urology."** Simply use the Quick Checks #1-4 and we will customize your personal information package with these features:

- Product brochures
- Quick Quote for financial orientation
- Financial feasibility study (pro forma) based on your practice numbers
- Cut sheets

"We are able to offer patients the full package – diagnosis and treatment – in one visit, which is an advantage over our competitors."

Terry W. Coffey, Administrator
Virginia Urology
Richmond, VA

SOMATOM Emotion



STEP 1
Know your clinical needs

The first step is to identify your clinical needs. This helps us to find out which scanner best fits your practice. The two basic determinants of your clinical needs are your practice patient volume and the type of examinations that you will be performing.

Patient Volume Simply count how many patients your practice is sending out for a CT scan in an average week (5 days). Add to this number an estimate of how many patients you anticipate scanning due to population and practice growth.

Type of Examinations In addition to the patient volume, the kind of studies that you will be performing matter. The routine clinical usage of CT in urological diagnosis revolves around three typical protocols:

1. Stone Protocol
2. CT Urography (Hematuria Protocol)
3. Renal Mass Protocol

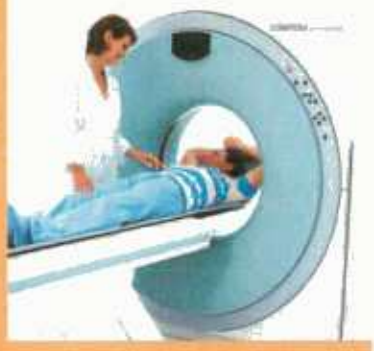
Depending on your practice model, you might plan to utilize your CT scanner for whole body imaging. In this case, tell us which other examinations you plan on offering.

STEP 2
Select the right product

Siemens has a broad family of CT scanners, ranging from entry-level CT to the leading edge scanner in speed and image quality, fitting all clinical needs and budget sizes. All our CT scanners are designed with state-of-the-art multislice CT technology. Our dedicated in-office CT scanners are the SOMATOM® Spirit and the SOMATOM Emotion. Unlike any other CT scanner, they offer what a physician practice needs: patient-friendly design, clinical flexibility, the smallest available footprint, and the most economical performance. For your choice, this means comfort and peace of mind that feels exceptional to the patient and the caregiver.

Your Choice The **SOMATOM Spirit** is a modern, entry-level 2-slice CT unit that performs routine applications and advanced post-processing, stretching the dollar of cost-conscious customers with a small practice size.

The **SOMATOM Emotion**, with more than 4,000 systems installed worldwide, focuses on clinical efficiency and comes in different configurations, including 2 and 6 slices. The SOMATOM Emotion 2-slice configuration gives you the power to routinely scan obese patients, while the 6-slice configuration fulfills all clinical expectations for urology and other full body studies, even at a high patient volume. The 6-slice configuration of the SOMATOM Emotion is setting the clinical trend for mid-size and large practices.



Quick Check #1:

	Patient Volume Practice/Week
Stone Protocol	#
CT Urography	#
Renal Mass	#
Other Examinations	#
Total Patients/Week	#

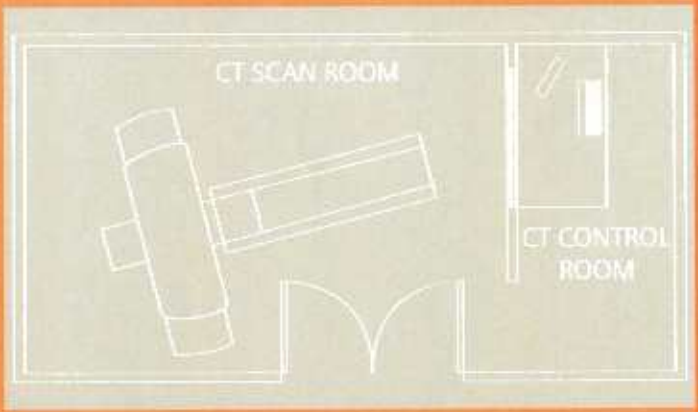
Easily determine your expected patient volume and study mix of your practice.

Quick Check #2:

	Small	*Medium*	*Large*
SOMATOM Spirit	X	X	
SOMATOM Emotion 2 slice	X	X	
SOMATOM Emotion 6 slice		X	X
Number of Physicians	#	#	#

Circle which product you think might best fit your practice, based on your practice size (add number of physicians).

STEP 3
Does it fit?



Minimum space requirement is 175 sq. ft.

Many private practices have limited space available. However, most physicians are surprised at how little space is actually needed to site a CT in their office. The dedicated Siemens in-office CT scanners are designed with the smallest possible footprint and have easy siting requirements — no matter where your practice is located.

Siting Both the SOMATOM Spirit and the SOMATOM Emotion are setting the industry benchmark with their compact designs and small footprints (as small as 175 square feet), making them ideal to site in a private practice. Both systems are air cooled, which eliminates the necessity for an extra water chiller typically found with other CT products. The actual installation can be done easily within one or two days.

A Siemens project manager will be glad to visit your site and assess whether the selected CT system can be installed or if room or power modifications are necessary. Literally any existing room can be modified to meet the criteria of a CT room and most medical buildings already have the necessary power supply.

Quick Check #3:

Potential CT room available? Yes No

What is the size of that room/area in square feet?

Take a moment to look around. Do you have a room or space where you can envision your new CT scanner?

STEP 4
Focus on your bottom line

In-office CT can be a significant new source of practice revenue. Let us show you how.

Siemens Financial Services offers you the flexibility to easily finance or lease your CT equipment as part of our one-stop shopping solution. Your Siemens financial analyst will provide you with a customized business pro forma, based on your actual practice numbers — free of charge.

Affordability Both the SOMATOM Spirit and the SOMATOM Emotion are uniquely affordable solutions. The SOMATOM Spirit offers a new level of cost-effectiveness reaching the break-even point faster than conventional scanners, thus maximizing your return on investment. This gives practices with limited budgets and low patient volume the opportunity to invest in their own CT technology. That's affordability.

The SOMATOM Emotion combines the best of both worlds, clinical performance and low life cycle cost, to make it an outstanding investment for mid-size and large practices with a higher patient throughput or broad patient examination mix.

Our CT system prices include: Shipping, Installation, Testing, one-year warranty and our unique Life Customer Care Services such as Application Training, Application Hot-Line Support, and much more.

	Procedures Per Day	Days Per Month	Average CPT	Income	FMVL Cost	ROI* Per Month	ROI for 5 Years
A	1.8	20	$220	$7,950	$7,950	Break Even	Break Even
B	5	20	$220	$22,000	$7,950	$14,050	$843,000
C	10	20	$220	$44,000	$7,950	$36,050	$2,163,000

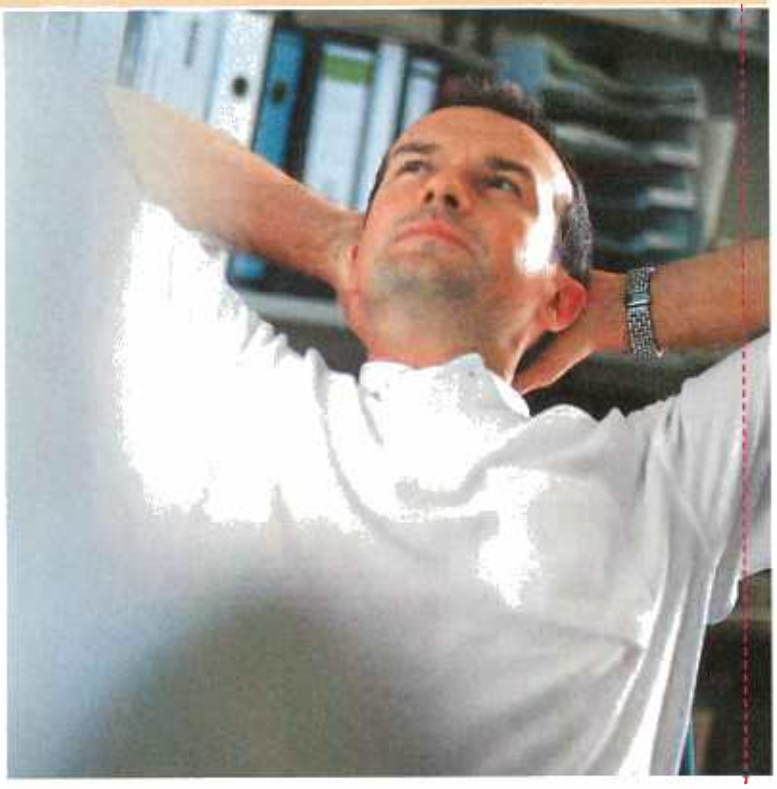
Sample computation – Basic SOMATOM Spirit configuration, based on a 5-year Fair Market Value Lease (FMVL). Prices will vary with additional options. Please consult your Siemens Account Executive for details.
**Return on Investment.*

Quick Check #4:

	Interest	
Business Pro Forma:	Yes	No
Siemens Financial Services:	Yes	No
Leasing Information:	Yes	No

We help you to calculate your bottom line.
Let us know your investment needs.

Siemens makes it easy



Sit back and relax. We help you step by step.

Siemens has a dedicated team of experts to help you step-by-step. Your team includes:

Business Development Manager Your local Siemens Sales Representative will be your personal contact partner. He or she will listen to your plans and advise you on the right products and solutions. In addition, he or she will introduce the right specialist at the right time and prepare the appropriate system quote.

Project Manager Your local Project Manager is responsible for assessing your site and supporting the installation process.

Financial Analyst Your Financial Analyst will prepare a business pro forma and calculate income, expenses, and profitability. He or she will also show you Siemens financing solutions that meet your financial and administrative needs.

Application Specialist Your Application Specialist will perform the application training at your site, so that you feel comfortable scanning your patients from day one.

Service Engineer Your local Siemens service organization will ensure highest uptime of your scanner and offer tailored service plans for every practice and budget throughout the life of your CT scanner.

Our professional team will make it easy for you!

Now it is up to you!

Are you ready to capitalize on new imaging opportunities? Simply call our contact phone number: 1-888-826-9702 and refer to "Imaging Opportunities" or send us an email to: CTopportunities.MED@siemens.com to request more information.

We will be happy to answer your questions and to schedule a meeting with your local Business Development Manager at your practice. Use our NEW Quick Start service and request you personal **"CT Quick Start Package for Urology."**

Explore your Imaging Opportunities today and join your many colleagues who are already successfully delivering high quality patient care with Siemens in-office CT solutions for Urology!

Contact Siemens

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Email: CTopportunities.MED@siemens.com

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06-15-PC-289 03-2006

Imaging Opportunities for ENT Physician Practices

Affordable In-Office Computed Tomography Solutions

SIEMENS

medical

capitalize on imaging opportunities in ENT

The introduction of smaller, more economical in-office computed tomography (CT) systems has changed the way many ENT group practices diagnose their patients today. Adding computed tomography can not only improve patient convenience – by combining diagnosis and care in one location – but it can also significantly improve the overall bottom line of the practice. Furthermore, in today's competitive marketplace, adding this service can help distinguish and grow your practice.

Siemens Medical has been a technology leader and clinical trendsetter in CT for more than 30 years. Now we have developed a dedicated CT scanner with the needs of private ENT practitioners in mind, the SOMATOM® Spirit.

If you are thinking about adding CT to your practice, Siemens will show you the way to realize your goal. We have developed a simple, four-step approach that helps you assess whether in-office CT is the right solution for your practice. And our Siemens Team will provide professional expertise to help you make the right decision.

Now it is up to you! Explore new imaging opportunities with our convenient and easy to use four-step Information Guide.

NEW: Quick Start Package

To get you started quickly, we will prepare your personal **"CT Quick Start Package for ENT."** Simply use the Quick Checks #1-4 and we will customize your personal information package with these features:

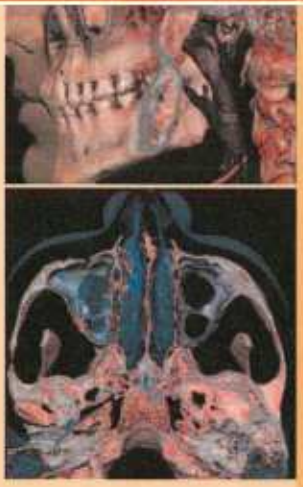
- Product brochures
- Quick Quote for financial orientation
- Financial feasibility study (pro forma) based on your practice numbers
- Cut sheets

"Siemens SOMATOM® Spirit helps us make rapid diagnosis and deliver accurate, prompt treatment. The ability to show a patient his own scan and immediately implement treatment is a luxury."

Samuel Girgis, MD
Dr. Girgis & Associates (ENT)
Hinsdale, IL

SOMATOM Spirit

STEP 1
Know your clinical needs



The first step is to identify your clinical needs. This helps us to find out which scanner type and configuration is the best fit for your practice's specialty. Simple determinants of your clinical needs are your practice patient volume and the type of examination that you will be performing.

Patient Volume Simply count how many patients your practice is sending out for a CT scan in an average week (5 days). Add to this number an estimate of how many patients you anticipate scanning in the future due to population growth and practice growth. Keep in mind, once you offer patients convenient, one-stop care, your practice will be able to differentiate itself from other ENT practices and hence attract more patients.

Type of Examination In addition to patient volume, the kind of studies you will be performing matters. The routine clinical usage of CT in ENT diagnosis revolves around three typical studies:

1. Sinus studies
2. Head & neck studies (with and w/o contrast)
3. Studies for image-guided surgery (IGS) preparation

Depending on your practice model, you might also plan to utilize your CT scanner for whole-body imaging. In this case, tell us what other studies you plan on offering.

STEP 2
Select the right product

Your second step is to select the right CT scanner – and we make it easy for you! The SOMATOM® Spirit is our dedicated in-office scanner for ENT physician practices. Unlike other CT scanner, it offers what a physician practice needs: patient-friendly design, clinical flexibility, the smallest footprint, and the most economical performance. And best of all, it is an affordable in-office computed tomography solution, which opens a new world of opportunities for you and your practice. You get peace of mind and your patients get exceptional comfort.

The **SOMATOM Spirit** is a modern 2-slice CT unit that handles routine applications as well as advanced post-processing, appealing to cost-conscious customers, regardless of practice size.

The system has a table load capacity of 450 lbs and is capable of doing examinations within seconds. The standard configurations include routine and advanced post-processing software applications, as well as the medical DICOM standard for image networking.

"The physicians are absolutely thrilled with the performance and quality of the SOMATOM Spirit. They are raving about the quality of the films that are produced."

Joanne Davis, Administrator,
Raleigh Ear, Nose & Throat
Raleigh, NC

Quick Check #1:

	Procedures Week
Sinus Studies	#
Head & Neck Studies	#
Studies for IGS Preparation	#
Other Examinations	#
Total Patients/Week	#

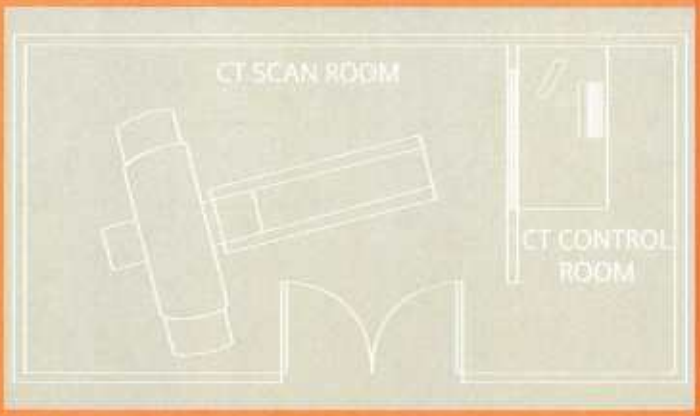
Use the Quick Check #1 to quickly determine your expected procedures volume and study mix of your practice. Depending on the group size, this number is usually between 10-50 patients/week (5 days).

Quick Check #2:

	Small	*Medium*	*Large*
Spirit	X	X	X
Number of physicians	#	#	#
Image Guided Surgery Yes / No			

Use the Quick Check #2 to highlight the number of physicians in your practice and to let us know if you do, or are planning to do, image-guided surgery imaging.

STEP 3
Does it fit?



Minimum space requirement is 175 sq. ft.

Many private practices have limited space available. But with the SOMATOM Spirit, there is no need to worry! Most physicians are surprised how little space is actually needed to site a CT in their office.

Siting The SOMATOM Spirit is designed with the smallest possible footprint and has easy siting requirements, no matter where your office is located.

It is setting the industry benchmark with its compact design and small footprint (as small as 175 square feet). The system is air-cooled, which eliminates the necessity of an extra water chiller, typically found on other CT products. The actual installation can be done within one day. It is that easy. Our Siemens project manager will be glad to visit your site and assess whether the selected CT system can be installed or if room or power modifications are necessary. Literally any existing room can be modified to meet the criteria to be used as a CT room, and most medical buildings already have the necessary power supply.

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	Procedures Per Day	Days Per Month	Average CPT	Income	FMVL Cost	ROI* Per Month	ROI for 5 Years
A	1.8	20	$220	$7,950	$7,950	Break Even	Break Even
B	5	20	$220	$22,000	$7,950	$14,050	$843,000
C	10	20	$220	$44,000	$7,950	$36,050	$2,163,000

Sample computation – Basic SOMATOM Spirit configuration, based on a 5-year Fair Market Value Lease (FMVL). Prices will vary with additional options. Please consult your Siemens Account Executive for details.
**Return on Investment.*

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What is the size of the room/area in square feet?

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Quick Check #4:

	Interest	
Business Pro Forma:	Yes	No
Siemens Financial Services:	Yes	No
Leasing Information:	Yes	No

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STEP 5
Siemens makes it easy

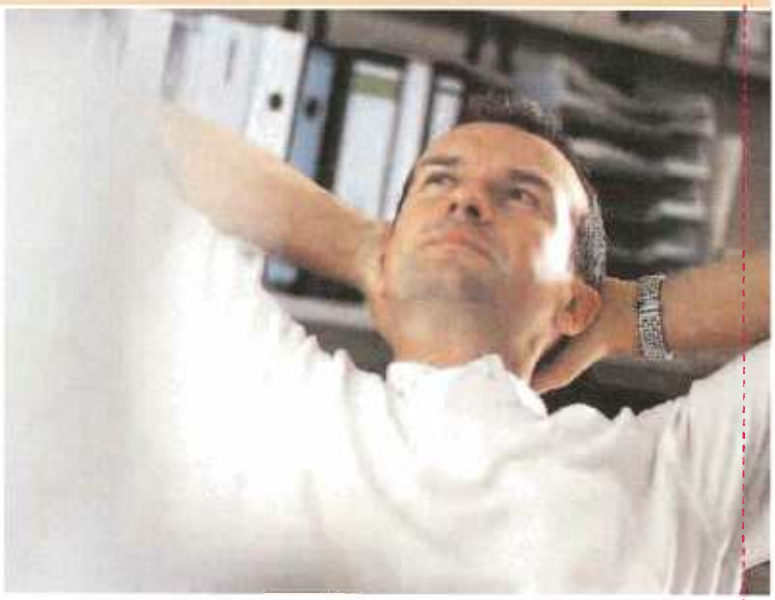

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EXHIBIT C

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Frequency and Costs of Diagnostic Imaging in Office Practice — A Comparison of Self-Referring and Radiologist-Referring Physicians

Bruce J. Hillman, M.D., Catherine A. Joseph, B.A., Michael R. Mabry, B.A., Jonathan H. Sunshine, Ph.D., Stephen D. Kennedy, Ph.D., and Monica Noether, Ph.D.

N Engl J Med 1990; 323:1604-1608 | December 6, 1990 | DOI: 10.1056/NEJM199012063232306

Abstract

Abstract

To assess possible differences in physicians' practices with respect to diagnostic imaging, we compared the frequency and costs of imaging examinations as performed by primary physicians who used imaging equipment in their offices (self-referring) and as ordered by physicians who always referred patients to radiologists (radiologist-referring).

Using a large, private insurance-claims data base, we analyzed 65,517 episodes of outpatient care by 6419 physicians for acute upper respiratory symptoms, pregnancy, low back pain, or (in men) difficulty urinating. The respective imaging procedures studied were chest radiography, obstetrical ultrasonography, radiography of the lumbar spine, and excretory urography, cystography, or ultrasonography.

For all four clinical presentations, the self-referring physicians obtained imaging examinations 4.0 to 4.5 times more often than the radiologist-referring physicians ($P<0.0001$ for all four). For chest radiography, obstetrical ultrasonography, and lumbar spine radiography, the self-referring physicians charged significantly more than the radiologists for imaging examinations of similar complexity ($P<0.0001$ for all three). The combination of more frequent imaging and higher charges resulted in mean imaging charges per episode of care that were 4.4 to 7.5 times higher for the self-referring physicians ($P<0.0001$). These results were confirmed in a separate analysis that controlled for the specialty of the physician.

Physicians who do not refer their patients to radiologists for medical imaging use imaging examinations more frequently than do physicians who refer their patients to radiologists, and the charges are usually higher when the imaging is done by the self-referring physician. From our results it is not possible to determine which group of physicians uses imaging more appropriately. (N Engl J Med 1990; 323:1604–8.)

Article

THE potential for conflicts of interest and higher costs for health care arising from the ownership by physicians of the diagnostic facilities to which they refer patients has attracted considerable attention recently in the medical literature[1,2,3,4,5] and lay press[6,7] and has been the subject of government study and legislation.[8,9,10] The ownership of imaging centers by physicians has received much of the media attention. However, most self-referral for medical imaging — in which physicians perform and interpret diagnostic imaging examinations of their own patients rather than refer them to imaging specialists — takes place in the physician's office.

The few previous studies investigating the effect of self-referral on the use and costs of imaging have been limited by methodologic flaws, small study populations, and lack of controls. To overcome these limitations, we analyzed a large data base of private insurance claims and evaluated the imaging done in physicians' offices during episodes of outpatient medical care. After controlling for differences in patients' clinical presentations and physicians' specialties, we compared the frequencies

with which the patients underwent imaging examinations during episodes of medical care for acute conditions, according to whether their physicians could perform those imaging examinations themselves. We also compared the resultant charges for the imaging examinations.

We purchased access to a data base (Medstat Systems, Ann Arbor, Mich.) comprising all the health insurance claims of 403,458 employees and dependents of several large American corporations. The insurance programs provided comprehensive coverage, including outpatient imaging services, with no copayments required. The data base was selected for its uniformity and completeness. Seventy-nine percent of the study population lived in the north central United States, 6 percent in the Northeast, 11 percent in the South, and 4 percent in the West. Fifty-one percent were female, and 49 percent male. Fifty-five percent were 0 to 34 years old, 33 percent were 35 to 54 years old, and 12 percent were 55 or older. Ninety-three percent of the physicians making claims for care provided to these patients practiced in metropolitan areas.

Using this data base, we compared the frequency of imaging and the charges for imaging among self-referring physicians and among physicians who instead referred patients to radiologists (radiologist-referring physicians) for four clinical presentations, selected for their variety and the volume of associated imaging procedures. The presentations, with the associated diagnostic inquiry, were as follows: acute upper respiratory symptoms (Was chest radiography performed?), pregnancy (Was obstetrical ultrasonography performed to assess fetal size and gestational age?), low back pain (Was radiography of the lumbar spine performed?), and (in men) difficulty urinating (Was excretory urography, cystography, or ultrasonography performed?).

We surveyed the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM),[11] selecting all codes that might reasonably represent diagnoses that would be entered by physicians whose patients presented with symptoms related to any of the four clinical presentations. A detailed tabulation of the codes is available elsewhere.*

We developed and applied to the claims data base a computer algorithm, modeled on previous methods, for defining episodes of outpatient medical care occurring in physicians' offices.[12] The date of a claim for an index ICD-9-CM code in an office setting was used to define the starting date of an episode. Episodes were considered to have ended after specified periods — four weeks for upper respiratory infection, nine months for pregnancy, six weeks for low back pain, and six weeks for difficulty urinating. Claims made between the initiation and termination dates of an episode were eligible for inclusion in that episode. Depending on the clinical presentation, a lag period of two to eight weeks followed the termination of each episode, so that follow-up visits for the original episode would not be counted as new episodes of care. The length of the episodes and lag periods was initially proposed on the basis of medical experience. We ensured that these durations were appropriate by evaluating the completeness of 600 randomly selected episodes and determining that the use of alternate durations for the episodes of up to two-thirds longer affected the number of episodes by only 1 to 6 percent in the case of the clinical presentations studied.

To be included in the study, episodes of care had to begin after January 1, 1986, and end before June 1, 1988. Episodes were excluded if the only physician involved in the episode was a radiologist or if the specialty of any physician involved was unknown. Within valid episodes, we deleted any claims for which no charge or payment was made, any claims for supplemental payments, and any claims for which the age or sex of the patient or the physician's identification number was unknown. We also excluded claims that were unrelated in terms of ICD-9-CM coding to the clinical presentations under investigation and claims made by physicians whose specialty codes indicated practices unrelated to the clinical presentations under study. A list of the specialties of the physicians included in the analysis is available elsewhere.*

The physicians who filed the claims included in the episodes studied were distinguished by their physician identification numbers; these numbers were coded to protect confidentiality. With regard to each clinical presentation, the physicians were grouped, according to their involvement in episodes for which they were the only nonradiologist physician to file a claim (one-physician episodes), into the following categories: self-referring physicians, who charged at least once for an index imaging examination; radiologist-referring physicians, who never charged for an index imaging examination and who were involved in at least one one-physician episode in which a radiologist performed such an examination; and physicians whose patients had no imaging in any one-physician episodes. One-physician episodes comprised 92 percent of all valid episodes.

We considered the possibility that some physicians categorized as radiologist-referring might actually be self-referring physicians who happened not to have performed any imaging in the episodes in our sample. We performed a correction to account for this possibility (details available elsewhere*). Since this correction did not alter the results, we report only our unadjusted data here.

The categorization of the physicians who participated in the one-physician episodes was used to develop six categories of similar and dissimilar pairs of physicians for the 7 percent of valid episodes in which two different physicians, neither a radiologist, cared for the patient (two-physician episodes). The 471 valid episodes (0.7 percent) in which more than two nonradiologist physicians were involved were not included in the analysis. We performed separate classifications of the one-physician and two-physician episodes on the basis of the categorization of the physicians and whether a claim for a related imaging examination was filed during the episode, as evidenced by the encountering of an appropriate diagnostic-imaging-procedure code (CPT-4 code; the table of index codes is available elsewhere*).

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For the one-physician episodes, our estimates of the frequency of imaging by the self-referring physicians and the radiologist-referring physicians were based on the observed frequencies for these two categories of physicians. Applying maximum-likelihood methods to the information we derived from our data about the imaging practices of self-referring and radiologist-referring physicians, we adjusted these observed frequencies to account for the episodes attributable to the physicians who had performed no imaging. This adjustment was based on the assumption that the imaging practices of the physicians within each category were homogeneous. However, this was almost certainly not the case. As a result, the correct adjustment of the observed frequencies is uncertain. For this reason, we report here the most likely estimates of the imaging frequencies for the self-referring and the radiologist-referring physicians. In addition, to account for heterogeneity in the physicians' imaging practices, we developed estimates biased upward and downward that show that our results are not affected qualitatively by the choice of the adjustment for the episodes involving the physicians who performed no imaging over the entire range of possible adjustments. The methods we employed, the initial categorization of the physicians and classification of episodes, and the upward- and downward-biased estimations of imaging frequencies are available elsewhere.*

For the analyses of both the one-physician and the two-physician episodes, we assessed the differences between self-referring and radiologist-referring physicians in terms of the proportion of episodes that involved imaging, the charges for imaging performed, and the average imaging charges per episode. To calculate the results for the group, we weighted the results for individual physicians according to the number of episodes in which they were involved. The significance of the differences between self-referring and radiologist-referring physicians was determined by the usual t-statistic for the difference in means between the two groups. We conducted a similar analysis based on the specialties of the physicians involved in the episodes, to compare differences within specialties. The null hypothesis of no difference was rejected at a P level of <0.05.

For each clinical presentation, we compared the complexity of the imaging examinations performed by the self-referring physicians with that of the examinations performed by the radiologists by calculating the mean (±SD) relative values of their procedures (i.e., a measure of the complexity of the procedure).[13]

The data base generated 62,880 one-physician episodes for the four study groups. After exclusions (see Methods), there were 60,829 valid episodes involving 6419 physicians. One-physician episodes represented 92 percent of all valid episodes. These were distributed as follows: upper respiratory symptoms, 47,794 episodes involving 3452 physicians; normal pregnancy, 1377 episodes involving 468 physicians; back pain, 9634 episodes involving 2001 physicians; men with difficulty urinating, 2024 episodes involving 498 physicians.

Table 1 shows the frequencies with which imaging was used during the episodes, the charges for imaging, and the charges for imaging per episode for self-referring and radiologist-referring physicians. The mean imaging charges of the self-referring physicians were significantly higher (P for all comparisons, <0.0001) than those of the radiologists for all clinical presentations except difficulty urinating. Depending on the clinical presentation, the episodes involving self-referring physicians resulted in imaging 4.0 to 4.5 times as frequently, with average imaging charges per episode 4.4 to 7.5 times higher than those for the episodes involving radiologist-referring physicians ($P<0.0001$ for each clinical presentation, for both frequency of imaging and average imaging charges per episode).

TABLE 1

Categories of Physicians and Episodes, Frequencies of Imaging, and Imaging Costs in One-Physician Episodes.*

There were 4688 valid two-physician episodes, or 7 percent of all episodes. The results for these episodes support the findings in the one-physician episodes. Depending on the clinical presentation, the episodes involving two self-referring physicians were 1.7 to 3.7 times as likely to result in imaging as episodes involving two radiologist-referring physicians ($P<0.01$ for each presentation). Complete results for all six categories of physician pairs are available elsewhere.*

For each specialty and each clinical presentation, the self-referring physicians performed imaging 2.4 to 11.1 times as often as the radiologist-referring physicians, and at a cost per episode for imaging that was 3.0 to 17.1 times higher, depending on the specialty and clinical presentation (Table 2) ($P<0.01$ for each specialty studied with regard to each clinical presentation).

TABLE 2

Frequency of Imaging and Costs per Episode in One-Physician Episodes, According to the Specialty of the Physician.*

The mean (±SD) complexity score for chest films was 3.02±0.14 for self-referring physicians, and 3.00±0.20 for radiologist-referring physicians. For obstetrical ultrasonography, the comparison was 11.24±1.14 versus 11.35±0.96; for lumbar spine films, 3.98±0.63 versus 4.14±0.52; and for the combination of urography, cystography, and ultrasonography, 8.46±0.70 versus 8.35±0.43. Thus, the differences in complexity ranged from 1 to 4 percent and do not account for the differences identified in the charges for imaging.

For the clinical presentations we studied, patients with similar sets of symptoms were at least four times as likely to have diagnostic imaging performed as part of their evaluation if they sought care from a physician who performed imaging examinations in the office rather than from one who referred patients to a radiologist. Because self-referring physicians performed imaging studies more frequently and generally charged more than radiologists for similar imaging procedures, patients seeking care from self-referring physicians incurred considerably higher charges for diagnostic imaging than patients whose physicians referred them to radiologists. These effects cannot be attributed to differences in the mix of patients, the specialties of the physicians, or the complexity of the imaging examinations performed.

Previously, Childs and Hunter[14] found that physicians other than radiologists who provided imaging services used imaging more frequently than their peers in caring for elderly patients in Northern California. In a 1978 survey of 5447 physicians, Radecki and Steele[15] determined that nonradiologist physicians with imaging facilities either in their offices or at the same site have higher rates of use than physicians without such facilities. A similar study of the effect ofthe site of imaging facilities used by family practitioners produced a similar result.[16]

The differences between our study and those performed previously include the relatively large number of patients and physicians we studied and the emphasis on specific clinical situations and episodes of medical care. Analyzing episodes of care permitted us to focus directly on the issue that seemed most pertinent — whether individual patients with specific symptoms were more likely to receive imaging examinations when their physicians operated imaging equipment. As compared with the global measures used in previous studies, this method controls better for other variables — physicians' specialization, the complexity of examinations, differences in the types of patients seen by physicians, and the number of patient—physician encounters that might occur during the course of a patient's medical care. Finally, the focus on episodes as the unit of analysis allows a more accurate assessment of the activities and costs of medical care, the chief focus of our study.[12]

We have attempted to account for what we perceive to be the major possible biases of our study. After assessing the effect of correcting our results to account for the small percentage of physicians who had probably been miscategorized, and evaluating alternative probabilistic models for assigning the episodes involving physicians whom we could not categorize definitively, we found that these considerations did not affect the results qualitatively (details of these assessments and the adjusted results are available elsewhere*). Our population of patients did not represent the American population, geographically or according to age. However, the geographic concentration tended to lessen the effects of regional differences in practice patterns, and it seems implausible that the large differences we identified in the use of imaging would be related to age. Although there is no assurance that the clinical presentations we studied represent the imaging practices of physicians in other clinical settings, the dimensions and consistency of our findings with regard to four very different clinical presentations and types of imaging examinations suggest that this practice pattern may be widespread.

We based our methods on those used by previous investigators,[12,17,18] but with adaptations to account for the large number of physicians and patients in our data base. Doubtless, the initial visits to physicians that triggered episodes of outpatient care occurred in an undefined context of patients' seeing their personal physicians, being referred by one physician to another, and seeking the specialist they believed to be appropriate. Although the manner in which the patients ended up seeing the physicians they did might potentially have affected the results, it is important to note that the results were uniformly sustained in our analysis of individual specialties. Also, with regard to our means of defining the index symptoms, determining the start of episodes, and including claims in episodes, there is nothing to suggest that our choices unequally biased the probability of imaging or the imaging charges in favor of either self-referring or radiologist-referring physicians. We believe that the differences between these two groups of physicians are so considerable that such issues have little relevance to the results.

Our findings of increased use of imaging and increased costs attributable to nonradiologist physicians who operate their own imaging equipment should be of interest to regulatory and reimbursement agencies. It is impossible to determine from our results whether the imaging practices of the self-referring physicians or those of the radiologist-referring physicians represent the more appropriate care. Nor is it possible to determine the extent to which financial incentives are responsible for the higher levels of use and charges among the self-referring physicians. These physicians may perform imaging more frequently because they have financial incentives to do so, because imaging is more convenient when performed in a physician's office, or because physicians who perform imaging more often are more likely to acquire imaging equipment. Nonetheless, the differences between the self-referring and radiologist-referring physicians in the use of imaging are so large that some concern over the role of financial incentives must be invoked. Schroeder and Showstack[19] have detailed the potent financial incentives for a physician to incorporate imaging into an office practice. More recently, Hemenway et al.[20] validated this concern by showing an increase in the use of imaging when a group of ambulatory clinics changed to a method of compensation that used the frequency with which physicians ordered imaging examinations as the basis for paying them.

The American Medical Association has stated that the referral of patients to facilities in which physicians have an ownership interest is permissible, provided that patients are apprised of this relation and have other choices, and provided that physicians always act in their patients' best interests.[21] With respect to diagnostic imaging, however, it is unlikely that patients, even if so apprised, will be able to assess the appropriateness of such referrals accurately or seek imaging elsewhere. Particularly in the office setting, patients cannot be said to have a meaningful choice when their physicians advise them to undergo imaging. The potential to self-refer patients for imaging must surely complicate physicians' decisions and perhaps jeopardize their obligation to place their patients' interests above their own.

*See NAPS document no. 04816 for 16 pages of supplementary material. Order from NAPS c/o Microfiche Publications, P.O. Box 3513, Grand Central Station, New York, NY 10163–3513. Remit in advance (in U.S. funds only) $7.75 for photocopies or $4 for microfiche. Outside the U.S. and Canada add postage of $4.50 ($1.50 for microfiche postage).

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EXHIBIT D

Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population

Bruce J. Hillman, MD; George T. Olson, MRP; Patricia E. Griffith, MPhil; Jonathan H. Sunshine, PhD; Catherine A. Joseph; Stephen D. Kennedy, PhD; William R. Nelson, MA; Lee B. Bernhardt

Objectives and Rationale.—For 10 common clinical presentations, we assessed differences in physicians' utilization of and charges for diagnostic imaging, depending on whether they performed imaging examinations in their offices (self-referral) or referred their patients to radiologists (radiologist-referral).

Methods.—Using previously developed methodologies, we generated episodes of medical care from an insurance claims database. Within each episode, we determined whether diagnostic imaging had been performed, and if so, whether by a self-referring physician or a radiologist. For each of the 10 clinical presentations, we compared the mean imaging frequency, mean imaging charges per episode of care, and mean imaging charges for diagnostic imaging attributable to self- and radiologist-referral.

Results.—Depending on the clinical presentation, self-referral resulted in 1.7 to 7.7 times more frequent performance of imaging examinations than radiologist-referral ($P < .01$, all presentations). Within all physician specialties, self-referral uniformly led to significantly greater utilization of diagnostic imaging than radiologist-referral. Mean imaging charges per episode of medical care (calculated as the product of the frequency of utilization and mean imaging charges) were 1.6 to 6.2 times greater for self-referral than for radiologist-referral ($P<.01$, all presentations). When imaging examinations were performed—including those performed in both physicians' offices and hospital outpatient departments—mean imaging charges were significantly greater for radiologists than for self-referring physicians in seven of the clinical presentations ($P<.01$). This result is related to the high technical charges of hospital outpatient departments; in office practice, radiologists' mean charges for imaging examinations were significantly less than those of self-referring physicians for seven clinical presentations ($P<.01$).

Conclusions.—Nonradiologist physicians who operate diagnostic imaging equipment in their offices perform imaging examinations more frequently, resulting in higher imaging charges per episode of medical care. These results extend our previous research on this subject by their focus on a broader range of clinical presentations; a mostly elderly, retired population; and the inclusion of higher-technology imaging examinations.

(*JAMA* 1992;268:2050-2054)

From the Department of Radiology, the University of Virginia School of Medicine, Charlottesville (Dr Hillman); Alta Health Strategies, Inc, Los Angeles, Calif (Messrs Olson and Nelson and Ms Griffith); Research Department, The American College of Radiology, Reston, Va (Dr Sunshine); Health Research Area, Abt Associates, Cambridge, Mass (Ms Joseph and Dr Kennedy); and Benefits Department, United Mine Workers of America Health and Retirement Funds, Washington, DC (Mr Bernhardt).

Reprint requests to Department of Radiology, University of Virginia Health Sciences Center, Box 170, Charlottesville, VA 22908 (Dr Hillman).

DURING the last decade, direct payments for physicians' services tripled, from $41.9 billion to $125.7 billion.[1] In large part, this has been due to an increase in the number of services provided to patients.[2,3] One phenomenon promoting greater intensity of care is physicians increasingly adopting more and more complex technologies into their office practices.[3] Physicians then can "self-refer" their patients to these technologies. Self-referral has been shown to be associated with higher-technology utilization than when physicians refer their patients to specialists employing these same technologies.[4-7]

See also p 2055.

Previously, we demonstrated that, for each of four common clinical presentations, self-referring physicians employed diagnostic imaging at least four times as frequently as their colleagues who referred imaging examinations to radiologists. Self-referring physicians also charged significantly more for performing and interpreting imaging studies in their offices than did radiologists.[7] This investigation employs similar methodology to expand upon our previous work assessing physicians' utilization of and charges for diagnostic imaging by studying a mostly elderly, chronically ill patient population that is of particular interest with regard to Medicare reimbursement; evaluating a broader array of imaging technologies and clinical presentations; more extensively portraying imaging charges; and assessing

patients with 10 common clinical presentations, including three of the four presentations investigated in our previous research.

METHODS

Insurance Claims Database and Clinical Presentations

Access to the insurance claims database used in this investigation was provided without charge by the United Mine Workers of America Health and Retirement Funds (Funds). Reimbursement for physicians' claims and the claims database are administered for the Funds by Alta Health Strategies, Inc (Alta). We investigated the portion of the database representing all physicians' claims for all Funds beneficiaries, regardless of age, rendered during the 2-year period January 1, 1988, through December 31, 1989. The claims history file records the billed charge for all line items for each claim.

Funds beneficiaries and their dependents receive full reimbursement, with no copayments, for outpatient diagnostic imaging examinations. The Funds administers both the Medicare and supplemental insurance components of physician reimbursements for Funds beneficiaries (84% of Funds beneficiaries are covered by Medicare Part B).

The Funds database details the health insurance coverage for their approximately 119 000 beneficiaries. Of these, 79% are 65 years or older. Thirty-four percent are male. Eighty percent live in the Appalachian coal-mining region.

Using this database, we compared the frequency of imaging and the imaging charges accrued during episodes of acute care of self-referring physicians with those of radiologist-referring physicians for 10 clinical presentations. The clinical presentations and their associated imaging examinations were chosen to obtain a broad distribution of anatomic locations, variety of imaging examinations, and sophistication of imaging technology, as well as for their frequency of appearance in the Funds' claims database and the imaging costs they represented to the Funds.

The 10 clinical presentations selected included three of the four clinical presentations investigated in our earlier research,[7] including (with the associated imaging examinations) acute upper respiratory tract symptoms (plain films, fluoroscopy), men with trouble urinating (excretory urography, cystourethrography, sonography), and low-back pain (plain films, myelography, diskography, computed tomography [CT], magnetic resonance [MR]). Additional clinical presentations investigated in this study were headache (CT, MR), transient cerebral ischemia (CT, MR, sonography including Doppler studies, angiography), upper gastrointestinal bleeding (plain films, barium studies), knee pain (plain films, arthrography, CT, MR), urinary tract infection (plain films, excretory urography, cystourethrography, sonography, CT, MR), chest pain (plain films, barium studies, radionuclide studies), and congestive heart failure (plain films, echocardiography, real-time and Doppler sonography, angiography, radionuclide studies). A complete list of the radiologic procedure (*CPT-4*) codes[8] counted in the analysis for each clinical presentation can be obtained from the National Auxiliary Publications Service (NAPS).

Development of Episodes of Medical Care

We previously have detailed the methods employed to define episodes of outpatient care.[7] Briefly, for each of the 10 clinical presentations, we defined all diagnostic (*ICD-9*) codes[9] that physicians reasonably might enter on their claims for services to these patients. The *ICD-9* codes selected for each clinical presentation (index *ICD-9* codes) can be obtained from NAPS. Each of the 10 clinical presentations was analyzed separately.

We applied to the database a version of the computerized algorithm we employed in our earlier work.[7] Briefly, an episode was initiated by a physician's claim for a service related to an index *ICD-9* code. The date of this service represented the starting date of the episode; the episode concluded after a fixed period of time, the amount of time depending on the clinical presentation. All claims from physicians with specialties relevant to the clinical presentation (see NAPS deposit), for office and hospital outpatient services, encountered between the beginning and end dates for the episode were eligible for inclusion in the episode. A lag period was observed immediately following each episode, during which neither an index *ICD-9* code nor index *CPT-4* code either counted as part of the previous episode or initiated a new episode. This restriction prevented the misclassification of a follow-up service as the initiation of a new episode. The durations of episodes and lag periods for each clinical presentation can be obtained from NAPS. The appropriateness of the durations of episodes and lag periods was established and tested by the same methods we have previously described.[7]

Episodes were eligible for inclusion in the analysis if they were triggered by an appropriate index *ICD-9* code, with a service date on or after January 1, 1988, and were completed by December 31, 1989. Because we were unable to determine which of two or more physicians decides whether to perform an imaging examination, we excluded episodes where multiple nonradiologist physicians cared for the patient or where services other than laboratory or radiology were provided in a hospital outpatient department (10% of episodes). Since we could not reliably categorize imaging services as self- or radiologist-referral when multispecialty group practices provided both radiologic and other services, we excluded episodes occurring in clinics and when a provider was involved in numbers of episodes greater than 2 SD from the mean. Following these exclusions, the episode files included 50% to 75% of the original episodes for the 10 clinical presentations.

Individual claims within valid episodes were excluded if the services were unrelated to the clinical indication or provided in nondesignated settings or if there was no charge for the claim.

Designation of Physicians as Self-referring or Radiologist-Referrinig

Each nonradiologist provider (defined by their primary specialty code and/or having less than 75% of their claims being for imaging procedures) was designated individually as "self-referring," "radiologist-referring," or "unknown," separately, for each clinical presentation in which he or she participated. A self-referring physician was one who at least once during the 2-year period submitted a claim for performing an index imaging study, even if he or she also referred a patient to a radiologist. A radiologist-referring physician never submitted a claim for an index imaging study and at least once participated in a valid episode in which the patient was referred to a radiologist for imaging. An unknown physician did not participate in a valid episode during which either he or a radiologist performed an index imaging examination.

Classification of Episodes and Estimation of the Frequency of Imaging

We classified the episodes of self- and radiologist-referring physicians on the basis of whether imaging was performed. This provided us with the observed frequencies of imaging for these two groups. These observed frequencies overestimate the actual imaging rates of self- and radiologist-referring physicians, since they do not account for physicians who were not involved in episodes where imaging occurred (the "unknown"

Table 1.—Primary Estimates of Imaging Frequency for Self-referring and Radiologist-Referring Physicians*

Clinical Presentation	Imaging Frequencies†		Ratio (95% Confidence Interval)
	Self-referring Physicians (No. of Episodes)	Radiologist-Referring Physicians (No. of Episodes)	
Chest pain	0.31 (4389)	0.16 (12 842)	1.9 (1.8-2.1)
Congestive heart failure	0.25 (13 588)	0.09 (24 840)	2.7 (2.5-2.8)
Difficulty urinating	0.11 (1111)	0.05 (5990)	2.2 (1.5-2.9)
Gastrointestinal bleeding	0.23 (1159)	0.13 (12 074)	1.7 (1.5-2.0)
Headache	0.30 (275)	0.07 (6674)	4.3 (3.3-5.4)
Knee pain	0.40 (2898)	0.05 (5191)	7.7 (6.6-8.7)
Low-back pain	0.21 (7381)	0.06 (21 179)	3.6 (3.4-3.9)
Transient cerebral ischemia	0.60 (334)	0.13 (2531)	4.7 (3.9-5.4)
Upper respiratory tract infection	0.30 (10 781)	0.13 (21 552)	2.3 (2.2-2.4)
Urinary tract infection	0.11 (1731)	0.05 (18 280)	2.4 (1.9-2.8)

*Estimates were rounded to the nearest percentage. All differences between self- and radiologist-referring physicians are statistically significant, $P<.01$.
†Imaging frequency is the number of episodes containing one or more imaging claims divided by the total number of episodes.

group). To correct for this deficiency, we employed the same method of maximum likelihood estimation as in our previous study[7] (detailed in the NAPS deposit) to estimate the imaging frequencies for all self-referring and radiologist-referring physicians, including those in the unknown group, as the proportion of episodes for each physician group in which imaging was performed. Our method of maximum likelihood estimation is based on the expectation that, within physician designations as self- or radiologist-referring, physicians' imaging practices are uniform. However, this may not strictly be the case. Thus, as in our previous study,[7] we performed upward and downward biased estimates to represent "worse case" scenarios, embodying the maximum departures from the primary estimate that could result if there were no similarities among the practices of self-referring or radiologist-referring physicians (described in the NAPS deposit).

Comparison of Physicians' Charges and Correction for the Complexity of Imaging Examinations

Our analysis of charges for imaging examinations included all global, professional, and technical charges in both the office and hospital outpatient settings.

We compared the total charges for imaging for all episodes in the database, whether or not imaging occurred. The result, termed "mean imaging charges per episode," is calculated as the product of the mean charges for diagnostic imaging claimed during episodes in which imaging occurred and the frequency of imaging.

To assess the influence of differences in the complexity of examinations on differences in mean imaging charges per episode, we assigned to each imaging service its relative value (in relative value units [RVU]), according to the relative value scale used through 1991 for payment for imaging services provided to Medicare patients.[10] Dividing the mean charge by the mean RVU provided the measurement "mean charge per RVU," which we used to compare the charges of self- and radiologist-referring physicians for comparable work. Because hospitals apply high technical charges to imaging performed in their hospital outpatient departments and because financial incentives to perform imaging examinations usually differ in office and hospital outpatient practice, we performed this analysis separately for episodes involving imaging solely in physicians' offices.

Analysis

Differences between self- and radiologist-referring physicians' estimated frequency of imaging and imaging charges were tested for statistical significance by unpaired t tests of the difference in means between the two groups. Differences were considered statistically significant at $P<.01$.

We also conducted an analysis of imaging utilization for selected individual physician specialties, investigating the imaging practices of a specialty for a clinical presentation if the number of episodes was large enough that the error of the estimate of the frequency of imaging for all physicians of that specialty was less than one fourth the magnitude of the estimate and there were at least 25 self-referring and 25 radiologist-referring physicians in the sample for each such analysis.

RESULTS

The claims database yielded 174 800 episodes for the 10 clinical presentations (Table 1).

The Frequency of Diagnostic Imaging

The primary estimates of imaging frequencies for self-referring physicians were significantly greater than the imaging frequencies of radiologist-referring physicians for all 10 clinical presentations (all presentations, $P<.01$). The ratios of the frequency of imaging varied considerably with the clinical presentation. Self-referring physicians employed imaging 7.7 times as frequently as radiologist-referring physicians for knee pain but only 1.7 times as often for gastrointestinal bleeding (Table 1).

Upward biased estimates sustained the essential result of significantly greater imaging by self-referring physicians for all clinical presentations ($P<.01$). However, in three clinical presentations, the downward biased estimate resulted in differences between self- and radiologist-referral that were not statistically significant (difficulty urinating, gastrointestinal bleeding, and transient cerebral ischemia). In two other clinical presentations, the downward biased estimates indicated imaging utilization by radiologist-referring physicians significantly greater than that of self-referring physicians (headache and urinary tract infection). A table of biased estimates is available from NAPS.

Twenty-one clinical presentation–physician specialty combinations met the screening criteria for investigation of specialty-related imaging practices. Six clinical presentations were represented in general practice, four each in internal medicine and family practice, two in general surgery, cardiology, and orthopedic surgery, and one in pulmonology. In all cases, the primary estimates indicated that self-referring physicians employed imaging significantly more frequently than radiologist-referring physicians (all specialty–clinical presentation pairs, $P<.01$) (Table 2). The ratio of the frequencies of imaging (self-referring/radiologist-referring) ranged from 1.5:1 to 4.8:1 for different clinical presentations and specialties. The finding that self-referring physicians employ imaging significantly more frequently than radiologist-referring physicians was sustained

Table 2.—Primary Estimates of Imaging Frequency by Selected Physician Specialties*

Physician Specialty and Clinical Presentation	Imaging Frequencies†		Ratio (95% Confidence Interval)
	Self-referring Physicians (No. of Episodes)	Radiologist-Referring Physicians (No. of Episodes)	
Cardiology			
Chest pain	0.38 (390)	0.19 (1327)	2.0 (1.6-2.4)
Congestive failure	0.30 (2195)	0.13 (1314)	2.4 (2.0-2.5)
Family practice			
Chest pain	0.30 (784)	0.16 (2442)	1.8 (1.5-2.1)
Congestive failure	0.20 (2472)	0.10 (5036)	2.1 (1.8-2.3)
Low-back pain	0.20 (1289)	0.05 (4475)	3.8 (3.1-4.6)
Upper respiratory tract infection	0.31 (2834)	0.13 (4216)	2.3 (2.1-2.5)
General practice			
Chest pain	0.30 (2025)	0.16 (5058)	1.9 (1.7-2.1)
Congestive failure	0.25 (4985)	0.09 (10458)	2.7 (2.5-3.0)
Gastrointestinal bleeding	0.20 (618)	0.13 (4081)	1.5 (1.2-1.8)
Knee pain	0.25 (691)	0.05 (1946)	4.8 (3.5-6.1)
Low-back pain	0.19 (2542)	0.05 (8448)	3.5 (3.0-4.0)
Upper respiratory tract infection	0.28 (4352)	0.11 (8721)	2.4 (2.2-2.7)
General surgery			
Low-back pain	0.23 (545)	0.07 (1350)	3.1 (2.3-3.9)
Upper respiratory tract infection	0.30 (726)	0.15 (1660)	1.9 (1.6-2.3)
Internal medicine			
Chest pain	0.33 (990)	0.14 (3533)	2.3 (2.0-2.6)
Congestive failure	0.25 (3715)	0.09 (7866)	2.8 (2.6-3.1)
Low-back pain	0.16 (1274)	0.05 (5693)	2.9 (2.3-3.5)
Upper respiratory tract infection	0.33 (2030)	0.16 (4581)	2.0 (1.8-2.2)
Orthopedic surgery			
Low-back pain	0.28 (1666)	0.12 (511)	2.3 (1.6-3.0)
Knee pain	0.58 (1307)	0.30 (135)	1.9 (1.3-2.5)
Pulmonology			
Upper respiratory tract infection	0.34 (360)	0.20 (184)	1.7 (1.1-2.4)

*Estimates were rounded to the nearest percentage. All differences between self- and radiologist-referring physicians are statistically significant, $P<.01$.
†Imaging frequency is the number of episodes containing one or more imaging claims divided by the total number of episodes.

in all 21 upward biased estimates and 19 of 21 downward biased estimates ($P<.01$). In two cases—general practitioners seeing patients for gastrointestinal bleeding and internists for patients with low-back pain—the differences in the downward biased estimates were not significantly different.

Imaging Charges

Mean imaging charges per episode—for all episodes, including both office and hospital outpatient department settings and regardless of whether an imaging examination occurred—are detailed in Table 3. For all 10 clinical presentations, mean imaging charges per episode were 1.6 to 6.2 times greater for self-referral than for radiologist-referral ($P<.01$, all clinical presentations).

When all episodes with imaging were considered—including office and hospital outpatient examinations—charges per RVU for self-referral were 0.8 to 1.0 of the charges per RVU referable to radiologist-referral, depending on the clinical presentation. However, the comparison of charge per RVU for examinations performed in office practice indicates that these differences are attributable to the technical charges billed by hospitals and the fact that almost all imaging examinations in hospital outpatient departments are performed by radiologists. For examinations performed in office practice, self-referral results in charges per RVU 0.9 to 1.3 times the charges per RVU of radiologists.

Table 3.—Imaging Charges per Episode of Care*

Clinical Presentation	Charges per Episode, $†		Ratio
	Self-referral	Radiologist-Referral	
Chest pain	29	19	1.6
Congestive heart failure	41	7	6.2
Difficulty urinating	19	8	2.3
Gastrointestinal bleeding	38	24	1.6
Headache	117	36	3.3
Knee pain	31	5	6.2
Low-back pain	34	13	2.5
Transient cerebral ischemia	242	65	3.7
Upper respiratory tract infection	19	9	2.2
Urinary tract infection	32	13	2.4

*Charges were rounded to the nearest dollar.
†Charges were calculated as the product of the percentage of episodes in which imaging occurred (ie, imaging frequency) and the mean imaging charge in episodes with imaging.

COMMENT

This investigation both extends and confirms our previous research into how physicians' ownership of diagnostic imaging technology in their office practices affects imaging utilization and charges. The major differences between our previous and current research include the nature of the patient and physician

populations. Also, the present investigation evaluates a broader range of clinical presentations and assesses utilization of both conventional and more advanced imaging technologies. Finally, we were able to extend our evaluation of charges for imaging examinations to include the hospital outpatient setting. Despite these differences, the essential result remains unchanged: physicians who own imaging technology employ diagnostic imaging in the evaluation of their patients significantly more often and, as a result, generate 1.6 to 6.2 times higher average imaging charges per episode of care than do physicians who refer imaging examinations to radiologists. This result is reinforced by the consistent result of significantly greater utilization associated with self-referral in our specialty-based analysis.

In this study, differences in imaging utilization between self- and radiologist-referring physicians were more varied with respect to clinical presentation than in our previous research. Almost certainly, this is attributable to characteristics of the patient population. The Funds' beneficiaries are, overwhelmingly, elderly and, because of their work histories, prone to a variety of chronic ailments. As such, they are very different from the generally healthy, younger, working individuals we evaluated in our initial research.

The large differences between self- and radiologist-referring physicians' mean imaging charges per episode are almost entirely attributable to differences in utilization. Differences in charges for imaging examinations and the complexity of examinations are largely referable to the setting in which the examinations were performed. Examinations performed by radiologists in hospital outpatient departments usually generate higher overall charges because of the high technical charges filed by hospitals. Medicare, on average, pays 58% of these charges.[11] In office practice, self-referring physicians generally charge higher fees than radiologists for comparable examinations.

In recent years, physicians' referral of their patients to medical technologies in which they have a financial interest has gained increasing attention as a significant problem promoting increasing health care costs. Investigations demonstrating that self-referral promotes greater frequency of technology utilization,[4-7] studies indicating that a financial incentive may motivate the higher frequency of self-referral,[12-15] and articles in the lay press discussing these findings have negatively affected public perceptions about the medical profession (*Wall Street Journal*. March 1, 1989; *Christian Science Monitor*. December 8, 1988). Although it is difficult to determine what proportion of the higher utilization associated with self-referral might be inappropriate, it has not been shown that more frequent application of office-based ancillary technologies provides a consonant benefit in improving patients' health.

These considerations motivated the United Mine Workers of America Health and Retirement Funds to participate in our continuing research into the effects associated with self-referral for diagnostic imaging. The Funds face a difficult financial future. While the cost of health care for the Funds' beneficiaries continues to increase, contributions to the Funds' financial base from the participating coal companies are declining. Thus, the Funds must identify means of controlling their expenditures that still sustain the high quality of care their beneficiaries receive. This research has provided information that may guide the Funds and other payers in developing new policies with respect to payment for self-referred imaging. One possible policy would be to deny payment for self-referred imaging, or to deny payment to specific specialties or individual physicians shown to utilize imaging technology at significantly higher rates than other specialties or their peers. The Funds could choose to reduce financial incentives for self-referral by reimbursing self-referred imaging at a lower level than it pays for referred examinations or bundling payment for imaging as part of the reimbursement for an office visit. Alternatively, the Funds might develop standards for image quality and physician training for different examinations, much as standards have been developed for reimbursing claims for mammography under Medicare. Nonqualified practices would become ineligible for reimbursement of their claims.

Each of these alternatives is accompanied by potential political consequences and might potentially affect patient care. The activation of policies regarding self-referral by a payer such as the Funds may provide a demonstration for government and other payers of the effects of restricting self-referral on patient access to diagnostic imaging, the quality of care patients receive, and imaging-related expenditures.

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EXHIBIT E

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Consequences of Physicians' Ownership of Health Care Facilities — Joint Ventures in Radiation Therapy

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UNDER federal law, it is illegal for physicians to receive kickbacks for referrals of Medicare and Medicaid patients. Thirty-six states also have anti-kickback laws of various types that apply to both publicly and privately insured patients. General prohibitions of referrals to facilities in which physicians have a financial interest are uncommon, however.[1,2] Nonetheless, in recent years physicians have come to own nearly every type of health care business to which they make referrals, but at which they do not directly provide services.[3] Some critics argue that such arrangements, known as "joint ventures," have proliferated because they are lucrative investments from which the referring physicians are able to earn disguised kickbacks.[4]

Critics contend that the financial incentives for referring physicians that are created by joint ventures lead to overuse of services, increased costs to consumers, reduced access for the poor, and service of diminished quality.[5,6,7,8] Proponents claim that joint ventures may increase access to care for persons in medically underserved areas, may provide needed financing, and may allow physicians to improve the quality of the services provided to their patients.[9,10] Despite intense debate, there is little empirical evidence of the effects of joint ventures involving physicians.

This study uses recent data, principally from Florida, to examine the effects of joint ventures in radiation therapy. Previous research on the effects of physicians' financial interests has concentrated on use of services and costs.[11,12,13,14,15] We examine a broader range of effects, including those on access and (to a more limited extent) quality, in accordance with a recent study conducted by one of us.[16] The examination of data from Florida is particularly appropriate, because a large proportion of the free-standing radiation-therapy centers there are owned by referring physicians. In contrast, joint-venture centers providing radiation therapy were rare elsewhere before 1991. Thus, comparing the situation in Florida with that in other states constitutes something of a natural experiment.

METHODS

All free-standing facilities providing radiation therapy and all acute care general hospitals in Florida were sent questionnaires as part of a comprehensive study of health care facilities commissioned by the Florida legislature.[16] Twenty-three of the 32 free-standing facilities (72 percent) provided information on ownership, staffing, and revenue according to category of payer; facilities that did not respond were contacted by telephone for information about their ownership. Over 95 percent of the 238 acute care licensed hospitals returned the surveys, from which we identified 39 hospital-based departments providing radiation therapy.

The free-standing facilities were classified according to ownership status as either joint ventures or non-joint ventures. The term "joint venture" was defined to indicate any ownership or investment interest between a referring physician (or other health care professional making referrals) and a business providing radiation-therapy services. Because radiation oncologists are consultative physicians who receive and treat patients referred by other physicians, radiation-therapy centers owned solely by such specialists are not joint ventures. Joint ventures located outside Florida that provided radiation therapy were identified by tabulating data from the 1989 Group Practice Survey of the American College of Radiology.[17]

Access

We compared joint ventures with other facilities providing radiation-therapy services in Florida in order to evaluate geographic access — that is, whether any facilities were located in inner-city neighborhoods or outside urban areas. In accordance with the practice of Florida's Department of Health and Rehabilitative Services, we defined urban areas to include metropolitan statistical areas

(as designated by the U.S. Census Bureau) and counties with a population in excess of 100,000 persons.

We also evaluated economic access by comparing the percentage of revenues derived from well-paying sources with that derived from poorly paying sources. Managed care payers, Blue Cross, and commercial insurers were classified as well-paying sources, because during 1989 these payers reimbursed, on average, about 90 percent of the submitted charges. In contrast, during 1989 Medicaid reimbursements for radiation-therapy services averaged between 5 and 10 percent of the full charges, Medicare reimbursements averaged approximately 70 percent, and patients nominally paying their own bills were typically recipients of charity care. These were classified as poorly paying revenue sources.

Use of Services

Radiation therapy for cancer has become somewhat standardized as a result of the Patterns of Care study.[18] [19] [20] Hence, any variations in use associated with joint ventures are likely to result more from different numbers of patients receiving treatment than from changes in the number of services per patient treated. Radiation therapy thus offers an interesting contrast to clinical laboratory services, in which investors who are referring physicians can easily increase the use of services not only by ordering tests for more of their patients, but also by ordering more tests per patient.

We evaluated the effects of joint ventures on the use of services by taking a market-area approach.[21] , [22] Specifically, we measured the use of radiation-therapy services per Medicare beneficiary in Florida and compared these figures with corresponding data for the rest of the United States. Such ratios of use to population take into account differences both in the percentage of patients receiving treatment and in the number of services provided to each such patient.

An analysis of Medicare data is particularly appropriate in the case of radiation-therapy services because cancer, the disease that is treated by radiation therapy, is very much a disease of the elderly (persons 65 years of age or older). The source of data used to study use of services and costs was the procedure file of Part B Medicare Annual Data for 1989. This file contains data on all physicians' services provided under Medicare, including the number of services, the charges submitted, and the amounts paid according to procedure, locality and state, and place of service (i.e., hospital or nonhospital), and other variables.

Two measures of use were employed: the number of radiation-therapy services per 1000 Medicare enrollees and the number of relative-value units for radiation therapy per 1000 Medicare enrollees. To standardize the count of services, each "weekly treatment management" service (codes 77420 to 77430 of *Current Procedural Terminology*, fourth revision [CPT-4]) was counted as five services, in accordance with Medicare's definition of weekly treatment management.[23] The Medicare relative-value scale for radiation-therapy services was developed by radiation oncologists. A relative-value scale recognizes the amount of work involved in providing each individual service and thus represents a more refined measure of use than a simple count of services.[24] The use of hospital-based facilities, which may serve as a substitute for the use of free-standing centers, was measured in the same two ways.

We also compared both the incidence of cancer and mortality from cancer in the Florida elderly population in 1989 with the corresponding statistics for the entire United States, since these factors could underlie differences in service use. Data on cancer in Florida were obtained from the Florida Department of Health and Rehabilitative Services. National data were obtained from the Surveillance, Epidemiology and End Results (SEER) program of the National Cancer Institute, with the incidence data for 1984 through 1988 extrapolated to 1989,[25] and from the National Center for Health Statistics (for 1989 death rates). With respect to age and sex, the composition of the Florida elderly population was almost identical to that of the overall U.S. elderly population, so no adjustments for age or sex were made to the data on use of services or cancer rates.

Costs

We compared the Medicare Part B data on submitted charges and amounts reimbursed by Medicare (the so-called "allowed charges") for all radiation-therapy procedures rendered in free-standing facilities in Florida with the corresponding figures for the rest of the United States. Free-standing facilities charge a global fee that includes both the physician's "professional component" and the technical or facility component. Submitted charges and payments for radiation-therapy procedures performed in hospitals were not analyzed, because the Medicare Part B file contains only the physician's professional component.

Quality

We evaluated the use of time by radiation physicists, the nonphysician personnel most responsible for quality control. Specifically, we compared joint ventures and non-joint ventures with respect to physicists' hours of work per patient treated in free-standing facilities. We also compared outcomes of cancer in Florida with those in the United States as a whole. The outcome measure was an approximation of the cancer lethality rate, calculated as the number of cancer deaths in 1989 divided by the 1989 incidence rate for cancer. Since outcomes of cancer differ according to age and sex, and this measure may be sensitive to very small differences, we adjusted the U.S. nationwide data to the age- and sex-related mix of Florida's elderly population before computing the U.S. lethality

rate. The statistic we used was not a strict case fatality rate. For example, some of the 1989 cancer deaths involved patients who were first given their diagnoses in earlier years. However, since incidence and death rates change slowly, a comparison of our statistic across geographic areas provides a reasonable measure of relative outcomes.

Statistical Analysis

Percentages of revenue derived from high-paying sources and physicists' time spent per patient were compared by two-tailed t-tests. Since the sample of radiation-therapy facilities represented a large percentage of the total number, we applied the usual finite-population correction factor to adjust the standard errors of these variables. The Medicare data represented the entire population, rather than a sample. In such cases, the usual view of statisticians is that tests of significance are not required, because all differences found are real.[26]

RESULTS

During 1989, 14 of the 32 free-standing radiation-therapy facilities in Florida (44 percent) were joint ventures. Tabulations from the 1989 Group Practice Survey of the American College of Radiology show that elsewhere in the United States, 7 percent of such centers (95 percent confidence interval, 3 to 10 percent) were joint ventures.

Access

None of the joint ventures among the free-standing radiation-therapy centers in Florida were located in a rural county or an inner-city neighborhood. In contrast, 1 of the 18 free-standing centers that were not joint ventures (6 percent) was located in a rural county, and 5 of the 39 hospital-based facilities (13 percent) were situated in inner-city neighborhoods.

With respect to economic access, we found that among free-standing facilities in Florida, the joint ventures generated 39 percent of their revenues from high-paying sources. In comparison, free-standing centers that were not joint ventures derived 31 percent of their revenues from such sources ($P<0.01$).

Use of Services

At free-standing centers, the number of radiation-therapy procedures per 1000 Medicare enrollees was 58 percent higher, and the number of relative-value units for radiation therapy 53 percent higher, in Florida than the average in the rest of the United States (Table 1).

The frequency with which radiation therapy was administered in hospital-based facilities, measured by a count both of procedures and of relative-value units, was slightly higher in Florida than in the rest of the United States (Table 2). The higher volume of services performed in hospitals as compared with free-standing centers, both in Florida and nationally, does not imply that hospitals use more resources to treat patients. Instead, it probably indicates that there are more hospital-based facilities than free-standing centers. The incidence of cancer among the elderly in Florida and the mortality rate from cancer were, respectively, 8 and 6 percent below the national average (Table 3).

TABLE 1

Cost and Frequency of Radiation-Therapy Services Provided in 1989 at Free-Standing Centers, per 1000 Medicare Enrollees.

TABLE 2

Frequency of Radiation-Therapy Services Provided in 1989 at Hospitals, per 1000 Medicare Enrollees.

Costs

For every 1000 Medicare enrollees, the submitted charges for radiation therapy performed in free-standing centers in Florida exceeded the submitted charges for the rest of the United States by 42 percent ($13,290 vs. $9,572) (Table 1). A similar comparison of the amount actually paid by Medicare (the "allowed charges") shows that in Florida, Medicare payments for radiation therapy provided in free-standing centers exceeded the average payments elsewhere by almost 46 percent ($9,572 per 1000 enrollees in Florida vs. $6,556 nationally).

Quality

Among free-standing facilities, the joint ventures used radiation physicists 18 percent less than facilities that were not joint ventures. They averaged 4.78 hours of physicist time per patient treated, as compared with 5.82 hours for free-standing facilities that were not joint ventures ($P<0.05$). Approximately 54 percent of patients with cancer died of their disease in Florida, as compared with 53 percent nationally (Table 3). Adjustments for age and sex made a difference of approximately 0.1 percent in this measure of lethality.

TABLE 3

Cancer Rates among the Elderly in 1989.

DISCUSSION

Findings in Florida

Our analysis of Florida shows that free-standing radiation-therapy facilities owned by referring physicians provide less access to poorly served populations than other types of radiation-therapy facilities. Geographically, hospitals provide the most ready access for such populations, because a considerable percentage of hospitals are located in inner-city neighborhoods. Economically, joint

ventures "skim the cream," because they generate substantially more of their revenues from patients with good insurance than do free-standing centers that are not joint ventures. The disparity we measured would probably have been even greater if we had data on sources of revenue for hospital-based facilities, many of which are located in inner cities. "Cream skimming" tends to undermine the financial base of facilities that are more willing to treat poorly insured patients.

Since 44 percent of the free-standing facilities in Florida were joint ventures, as compared with 7 percent elsewhere, joint ventures must be regarded as a likely explanation for the high levels of use and costs characteristic of Florida. Moreover, we investigated the two most obvious alternative explanations: that free-standing centers substitute for hospital-based facilities and that cancer is more common in Florida than elsewhere. Our analyses show that neither of these explanations is valid. Indeed, since the use of hospital-based radiation-therapy services was slightly higher in Florida than elsewhere in the United States and the burden of cancer lower, these factors should lead to lower use and costs at free-standing centers in Florida.

A replication of the analysis of use of services with 1988 data showed that rates of use in Florida were at least as far above the U.S. average in 1988 as in 1989. Therefore, the 1989 findings were not a onetime occurrence. Since use of services and costs at free-standing facilities are about equally elevated in Florida, the increase in use is probably the principal cause of the higher costs.

Other evidence supports the contention that joint ventures are responsible for the increase in service use and costs. Several recent studies have found that when physicians gain financially from the provision of services, as is the case with joint ventures, service use and costs are substantially higher.[1,11,12,13,14,16] In one case in Florida, a radiation oncologist in an academic center reported that in an area where approximately 80 patients per day had received radiation therapy, the number increased to approximately 110 after the opening of a free-standing facility owned by some 175 referring physicians.[27] Additional case studies of this sort would help resolve the issue of causality more definitively. Currently, Florida's high rate of use of services and costs could possibly be explained by factors other than joint ventures. For example, physicians in the state may provide more services for all kinds of illnesses, with radiation therapy being only an example of this pattern. Nonetheless, joint ventures are extremely common in Florida in many types of health care services,[3] and this might well account for a generally higher use of services.

Our evidence with regard to quality is quite limited. Traditionally, quality has been conceptualized as consisting of a number of factors related to structure, process, and outcome. We measured only one structure variable (staffing with physicists) and one outcome variable (the percentage of patients with cancer who die of their disease). The structural measure suggests that quality is lower in joint ventures. Our outcome measure was probably not particularly sensitive, because many patients with cancer receive no radiation therapy, whereas others receive it only for palliative treatment, with no expected effect on mortality. Still, it is clear that mortality from cancer in Florida has not declined substantially, despite the many joint ventures in the state.

Policy Considerations

At its annual meeting in December 1991, the American Medical Association (AMA) adopted new guidelines on joint ventures, specifying that "physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility."[28] An exception was made for facilities established both because there is a demonstrated need in the community and because alternative financing is not available. The AMA emphasized that a physician's professional obligation is to the wellbeing of the patient and that the financial interest created by joint ventures results in at least the appearance of a conflict of interest.

Our findings documenting the generally negative consequences of joint ventures in radiation therapy, the similar findings of others on the effect of physicians' financial interests,[1,11,12,13,14,16] and the conflict of interest inherent in self-referral by physicians all lead us to conclude that joint ventures involving referring physicians should be made illegal. The AMA's repudiation of its strong stance in June 1992 shows that professional guidelines are a weak reed. The existing federal anti-kickback law is in itself not an adequate remedy, if only because most patients are not covered by Medicare or Medicaid, and therefore the federal law does not apply to them. Banning joint ventures should substantially mitigate the continued escalation of health care costs. Such prohibitions have been recommended by President George Bush as part of his comprehensive program of health care reform.[29] Bans on physicians' joint ventures, covering various types of services, were enacted this year in Illinois, Florida, and New York.

For such laws to be effective, they must include a requirement for the reasonably prompt divestiture or dissolution of existing joint ventures. For example, the federal ban on joint ventures involving clinical laboratories allowed two years for divestiture or dissolution.[8] Provisions that allow "grandfathering" over the long or moderately long term only perpetuate deleterious effects. Also, the laws must effectively prevent new forms of abuse. If joint ventures are clearly outlawed and actively prosecuted, we expect to see attempts to achieve the same inappropriate financial gains through legal stratagems intended to make a facility to which a physician refers patients appear to be part of the physician's own practice.

SOURCE INFORMATION

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EXHIBIT F

Study Says Fees Are Often Higher When Doctor Has Stake in Clinic

By ROBERT PEAR.
Published: August 9, 1991

TALLAHASSEE, Fla., Aug. 8— Doctors' ownership of laboratories, diagnostic imaging centers and physical therapy clinics tends to increase the use and cost of such services without improving access to care for poor people or residents of rural areas, a Florida state agency reported today.

A study done by the agency also found that more than 45 percent of the doctors practicing in Florida, 8,500 of 18,250 doctors, have invested in joint ventures to which they can refer patients.

The investments have generated intense debate in Florida and other states, with some people asserting that there is a potential conflict of interest whenever doctors refer patients to clinics in which the doctors have invested. Hard Numbers for First Time

The Florida study, eagerly awaited by health officials around the country, is the first to document how pervasive such investments are, and how they can add to health-care costs.

The Federal Department of Health and Human Services has adopted rules to limit such investments by doctors paid through Medicare and Medicaid. The results of the Florida study are likely to bolster efforts by members of Congress and officials in other states to adopt broader restrictions on investments by doctors in health-care businesses. But such investments are so widespread that a complete ban would be extremely disruptive, doctors warn.

The study here, by the Florida Health Care Cost Containment Board, adds an ingredient largely missing from the national debate: concrete data, based on a statewide survey of 2,200 clinics and other health-care businesses. The Florida study is far more comprehensive than any done by the Federal Government or other states, but its results are consistent with findings from a more limited survey by the Federal Government in 1989.

James J. Bracher, executive director of the Florida agency, said at a news conference that clinics and laboratories in which doctors had invested had higher costs than businesses offering the same services but not owned by doctors. In addition, he said, there was evidence that the doctor-owned joint ventures were used more frequently, used less-skilled workers and offered limited access to the poor.

In Florida and elsewhere, joint ventures for doctors have proliferated in the last five years. The trend is particularly strong among imaging centers, which diagnose abnormalities in the spine, knees, brain and other parts of the body with techniques like magnetic resonance imaging, CAT scans and X-rays.

Proponents say the joint ventures raise capital for expensive, sophisticated equipment, make it more convenient for people to obtain the latest medical procedures and give doctors more control over the quality of services.

But the critics say there is a conflict of interest whenever a doctor refers patients to laboratories and clinics in which the doctor has invested. More Tests at Higher Fees

The Florida study is based on 18 months of research done under contract with the board by Jean M. Mitchell, associate professor of economics at Florida State University, and Elton Scott, associate professor of finance at the university.

They reported that investments by doctors had relatively little effect on the cost or quality of services at hospitals and nursing homes, ambulatory surgery centers and agencies providing health-care services to people at home. But they said, "Results clearly indicated problems in either access, costs, charges, utilization or quality of health-care services for clinical laboratories, diagnostic imaging and physical therapy centers."

For example, Mr. Bracher said, clinical laboratories owned by doctors perform "almost twice as many diagnostic tests per patient" as similar laboratories with no physician investors. "The average charge in a full-service joint venture lab is $43 per patient, as compared with an average charge of $20 per patient" in the other labs, he said.

Likewise, the study says that physical therapy centers owned by doctors typically schedule more visits for each patient but use fewer licensed therapists, so there is more revenue derived from each patient.

"A physical therapist employed by a joint venture facility treats an average of 20 patients per day, whereas in the typical non-joint venture facility a physical therapist treats an average of 12 patients per day," the study says. It concludes that the doctor-owned centers "provide a lower quality of care," in part because workers spend less time with each patient.

Florida doctors say they would oppose a ban on investments by doctors in health-care businesses. But some doctors acknowledge that there have been cases of abuse and say they would welcome official guidelines. "There needs to be some state legislation that establishes guidelines for physician investment in joint ventures," said Donald S. Fraser Jr., a spokesman for the Florida Medical Association. Another spokesman for the group, Gerald M. Soud, said, "We don't dispute the findings, but we want to analyze the data."

Dr. Charles P. Hayes Jr., a kidney specialist in Jacksonville, Fla., said the high volume of medical tests and procedures here could be explained partly by the presence of a large elderly population and by doctors' desire to protect themselves against lawsuits alleging medical malpractice. "We may have a sicker elderly population than other parts of the country because a lot of them move down here for their health," he said.

The Florida study surveyed 160 diagnostic imaging centers and found that 92.5 percent of them were owned wholly or in part by doctors. "The study shows that profits for diagnostic imaging centers are higher than for all other types of joint ventures," Mr. Bracher said.

The study compared Florida imaging centers with those in the Baltimore area, which are less likely to be owned by doctors who refer patients for examinations. Doctors ordered about 20 magnetic resonance imaging procedures for each 1,000 Miami residents, as against 12 for each 1,000 people in the Baltimore area. Lawmakers' Interest

The study does not makes no recommendations, but the board will submit proposals to the Florida Legislature in a few months. "This is a hot topic in Florida and much of the nation," Mr. Bracher said. "Because of the amount of local and national attention this study has generated and the need to avoid widespread speculation about the findings, we thought it was best to go ahead and release these preliminary findings."

The findings indicate that laboratories owned by doctors "perform more tests per patient, have higher charges and provide a lower quality of services" than laboratories having no investments by doctors, the report says.

The study notes that proponents say joint ventures promote access to new health-care technology for people in isolated rural or urban areas. "This does not appear to be the case in Florida, however, as none of the joint venture facilities are located in medically underserved areas," the study says. Thus, it concludes, in Florida "joint ventures do not increase access to rural or underserved indigent patients."

Graph: "When Doctors Own the Clinics" Percentage of Florida clinics wholly or partly owned by doctors. Figures are for the past year and come from a survey by the Florida Health Care Cost Containment Board. Diagnostic imaging: 92.5% Radiation therapy: 78.3% Ambulatory surgical: 76.4% Clinical laboratory: 60.4% Physical therapy and rehabiliation: 38.2% Medical equipment and supplies: 20.2% Home health care: 12.4% Nursing homes: 12.0% Hospitals: 5.3% (pg. A16)

EXHIBIT G

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Acquisition Of MRI Equipment By Doctors Drives Up Imaging Use And Spending

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Abstract

Some orthopedists and neurologists acquired their own magnetic resonance imaging (MRI) equipment during the early 2000s. This paper examines changes in imaging use and in overall spending by patients of orthopedists and neurologists who began billing for MRI scans between 1999 and 2005. Results show that physicians ordered substantially more scans once they began billing for MRI. For example, after orthopedists began billing for MRI, the number of MRI procedures used within thirty days of a first visit increased by about 38 percent. Not only did MRI spending increase for their patients, but spending for other aspects of care rose as well. Attention should be paid to ensuring that advanced medical equipment acquired in physician practices is used appropriately.

Health Spending Cost of Health Care Medical technology

As the potential for using advanced medical technologies in outpatient settings has grown, physicians have acquired an increasingly wide array of technologies for their own practices. Physicians' acquisition of new equipment may sometimes improve health outcomes or produce other benefits for patients. But physicians' ownership of advanced medical technology also raises important questions. Among these is the extent to which physicians' practice patterns are influenced by financial incentives to use equipment they have acquired.[1]

As policy makers and others grapple with the implications of spreading physician-ownership of equipment, understanding the extent to which it influences diagnosis and treatment choices is important. The acquisition by nonradiologists of advanced imaging equipment—a trend that has occurred over the past decade or two—provides a useful opportunity to investigate these effects. This paper examines the association between physicians acquisition of magnetic resonance imaging (MRI) equipment, use of MRI by patients, and health care spending.

Background On Imaging

Traditionally, nonradiologists refer patients needing MRI to hospitals or other facilities that own the equipment, and radiologists typically interpret the results. In such cases, the facility performing the test and the radiologist interpreting the results bill for the services; the referring physician receives no payment for the performance of the procedure or interpretation of results.

Beginning noticeably in the mid-1990s, some nonradiologist physicians began acquiring the ability to bill payers themselves when their patients underwent MRI. Some purchased or leased the equipment for their own practices.[2–5] Reports also suggest that some physicians entered into leasing or similar arrangements with independent diagnostic facilities, sometimes referred to as "per click" leases, which allowed them to refer patients to the facility and bill payers as if they were using their own equipment.[1,6,7]

Although the share of nonradiologists with the ability to bill directly for MRI has increased over time, most physicians continue to refer for MRI using more traditional approaches. According to one report, nonradiologists accounted for about 20 percent of the in-office MRI market in 2005.[2]

It would not be surprising if acquiring the ability to bill for the imaging led to changes in MRI use. Easier access to equipment could reduce the inconvenience of making a referral and getting a procedure done. There can also be important

financial implications. Physicians who own or lease equipment can bill for the performance of the procedures done with their equipment. During the period studied here, reimbursements could greatly exceed the costs of acquiring and operating the equipment, making the services potentially quite profitable.[8] Physicians with "per click" leases could also find referrals financially beneficial[7] since they could bill payers for procedures done under the arrangement, paying a lease fee typically set below the normal reimbursement.

More imaging may benefit some patients, but these incentives have also raised serious questions about the potential for inappropriate use.[5,9]

Goals Of This Study

This study used Medicare claims data to identify physicians who began billing for MRI, and it compared their patients' MRI use before and after the physicians began billing. It adds to a body of previous work[5,10–16] that has examined self-referral for imaging, often using older data or different study designs. The analysis focused on orthopedic surgeons and neurologists—specialists who are among the most frequent nonradiologist performers of office-based MRI.[2] Results show that beginning to bill for MRI was associated with substantial increases in the likelihood of patients' receiving MRI procedures.

The study also examined variation in Medicare spending for patients of doctors who began billing for MRI. MRI is costly, so increases in use should directly drive changes in spending. Use of MRI may also influence other aspects of care. If its use improves the overall efficiency of care, the net effect may be lower costs. On the other hand, if its use leads to the use of additional services, the net effect could be higher costs beyond simply the costs of the imaging.

Results show that when physicians began to bill for MRI, total Medicare spending by their patients rose, on average, reflecting increases in both spending for MRI and spending for other procedures performed by physicians.

Study Data And Methods

Data Sources

Data are derived from 1998–2005 Medicare claims records for a 20 percent random sample of traditional, fee-for-service Medicare beneficiaries. To define an initial sample of physicians of interest, all physicians who identified themselves to Medicare as neurologists or orthopedic surgeons and who billed Medicare for at least ten evaluation and management services during 1998–2005 were identified.

From this larger group, physicians who began billing directly for MRI during the study period were identified based on patterns in the claims data. Bills for MRI have two components: the "technical component," which covers performance of the procedure, and the "professional component," which covers interpretation of results. Technical components carry much higher reimbursements than professional components. When physicians acquire MRI equipment in their practices or enter into "per click" leases, the key financial feature of the change is the ability to bill for technical components.

Accordingly, orthopedists or neurologists who submitted bills that included the technical component of an MRI procedure on more than three occasions were identified as acquiring the ability to bill for MRI. For them, the earliest date of service on such a bill was recorded.

Data on the use of MRI by outpatients seen by each acquiring physician were then collected. (The incentives at play should have different—presumably weaker—impacts on MRI use for hospital inpatients.) For each physician, claims records were searched for instances in which a patient had an outpatient visit with the physician, following a one-year period in which the patient did not have any visits to a physician in the same specialty. Each such instance is treated as an "index visit," indicating the beginning of a new outpatient episode with the physician.

The data used in the analyses presented here include episodes with index visits between January 1, 1999, and September 30, 2005, which allows sufficient time to track use before and after the episodes began. Episodes that started fewer than ninety days before the physician's initial billing date were excluded, because the precise date of acquisition may be measured with error, and these episodes may have been in progress at the time the physician began billing for MRI.[17]

For each episode, claims data were searched to find MRI procedures done for the patient and ordered by the index-visit physician. The total number of MRIs received by each patient within thirty and ninety days of the index visit was recorded. The number received on the same day as the index visit was also recorded. These measures count all MRIs received by the patients and ordered by the index-visit doctor, regardless of who performed the procedure.

To study spending, total Medicare spending for each patient in the ninety days and one year following the index visit was calculated using inpatient, outpatient, and physician claims records. These measures capture all spending associated with all physicians and procedures observed in the claims, and they exclude copayments or deductibles paid by the patients.

'Traditional' MRI Comparison Group

To provide comparative evidence about general trends in MRI use, the study also examined use among the patients of a comparison group of physicians. These physicians were orthopedists or neurologists who were never observed in the claims data to bill for an MRI technical component, to self-refer an MRI procedure, or to refer an MRI procedure to another physician in their specialty.

This group also excludes any physicians who referred for MRI to independent diagnostic and testing facilities, because some such referrals entail financial incentives that encourage MRI use but are difficult to detect. This group should exclude doctors with the vast majority of common and direct nonmedical incentives for ordering the scans. For these "traditional" MRI users, the set of index visits and other measures were derived as described above.

Methods

The analysis focused on before-and-after comparisons of MRI use by patients of physicians who began billing for MRI. To account for independent time trends, changes in use by billing physicians were compared to changes over time in use by patients of traditional MRI users.

Introductory analyses included graphical analysis of time trends in MRI use and unadjusted pre-post comparisons of mean MRI rates. The main analyses used ordinary least squares regression analyses to produce estimates of changes in MRI use or spending, adjusting for a range of possible confounding factors.

These models controlled for patient characteristics including age, sex, race, Medicaid status, prior-year health care spending, the presence of comorbidities based on the methodology described by Anne Elixhauser and colleagues,[18] and the Agency for Healthcare Research and Quality (AHRQ) Clinical Classifications Software code of the index-visit principal diagnosis. The models also controlled for physicians' characteristics, using a set of dummy variables ("fixed effects") for physicians. These will capture all characteristics of doctors that do not change over time, such as demographic characteristics, underlying preferences about care, and attributes of their geographic area.

The models also adjusted for overall time trends in MRI use, controlling for the year and the month of the index visit. Since the models incorporated episodes associated with traditional MRI physicians to account for general trends in use over time, the adjusted regression results can be interpreted as before-after differences in MRI use by physicians who began billing, relative to changes in the same time period for traditional users.

Results

Patient Characteristics

The analysis included data on 1,129,660 episodes of care with 11,844 total orthopedists. Of these, 270,755 episodes were associated with 3,535 orthopedists who began billing for MRI, and 858,905 episodes were associated with 8,309 traditional users. For neurologists, the data contain 459,231 total episodes with 5,993 physicians, encompassing 42,642 episodes associated with 706 physicians who began billing and 416,589 episodes associated with 5,287 traditional users.

Characteristics of patients were quite stable over time (see the Technical Appendix for more detail).[19] Most important, among doctors who began billing for MRI, there were no meaningful changes in patients' characteristics between the time before and after they billed directly for MRI. Even so, the main results reported below were adjusted for patient characteristics.

MRI Rates

Exhibit 1 shows trends in the number of MRI procedures used within thirty days of the index visit. Across all study years orthopedists in the sample used MRI at a rate of 61 procedures per 1,000 episodes. The rate increased over time from 46 in the first quarter of 1999 to 72 in the third quarter of 2005.

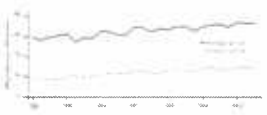

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Exhibit 1

Rates Of Magnetic Resonance Imaging (MRI) Procedure Use Per 1,000 Orthopedist And Neurologist Episodes, By Calendar Quarter, 1999–2005

SOURCE Author's analysis of Medicare claims data.

Neurologists used MRI more frequently, with an average thirty-day MRI rate of 165 procedures per 1,000 episodes across the entire study period. MRI use by neurologists grew from 148 per 1,000 episodes at the beginning of the period to 183 at the end.[20]

Changes In MRI Use Associated With Acquisition

Exhibit 2 compares average MRI use by physicians who began billing for MRI, before and after they began. Unadjusted pre-post changes are shown, as well as estimates of changes based on regressions that adjust for time trends, physicians' characteristics, and patient case-mix.

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Exhibit 2

Changes In Magnetic Resonance Imaging (MRI) Use Measures Before And After Physicians First Billed For MRI

Study physicians ordered significantly more MRI procedures after they began billing for them. For orthopedists, the number of MRI procedures used within thirty days of the index visit increased by 23 per 1,000 episodes—an increase of about 38 percent. This was driven largely by increases in the number of episodes where any MRI was used, but there was also a small increase in the average number of MRI procedures used by patients who had at least one. Neurologists used more MRI and had larger increases associated with beginning to bill.

In both specialties, there were only small changes in the use of MRI on the same day as the index visit. Most of the effect was evident by thirty days from the index visit, and there was a smaller increment between thirty and ninety days from the index visit.

These changes in use were largely driven by a discrete jump that occurred when physicians first billed for MRI. Exhibit 3 shows regression-adjusted average thirty-day MRI rates by quarter, starting six quarters before the date of the first bill for MRI and ending six quarters after. The values shown are the difference between the rate in the acquiring group and the traditional-user group.

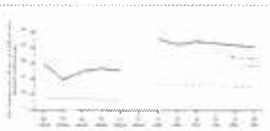

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Exhibit 3

Regression-Adjusted Quarterly Magnetic Resonance Imaging (MRI) Use Rates For Study Physicians Who Began Billing For MRI, Relative To The Date Of First Billing For MRI

SOURCE Author's analysis of Medicare claims data. NOTES Rates are measured relative to use by traditional MRI users. Episodes that began in the quarter immediately preceding the initial billing for MRI were not included, to eliminate cases in which the ensuing episode could have been in progress at the time of the first billing for MRI.

Even before they began billing for MRI, orthopedists and neurologists who later began billing had already used the technology somewhat more frequently than colleagues who ordered scans in the traditional way for the entire period. Orthopedists who began billing, for example, had used about 20 more MRI procedures per 1,000 episodes beforehand. Neurologists had averaged about 78 more.

It is important to note that the trends for both acquiring and non-acquiring doctors were very similar in the pre-billing period. There is no evidence that billing doctors were increasing their use faster than traditional users in the pre-billing period. In fact, Exhibit 3 suggests the opposite.

But at the time of acquisition of MRI, there was a distinct (and strongly statistically significant) increase. In the first quarter after they began billing, orthopedists jumped from using about 20 more MRIs per 1,000 episodes than traditional users to using about 45 more. Neurologists jumped by more, increasing their rate by about 60 to nearly 140 procedures per 1,000 episodes more than traditional users.

The higher rate of use persisted over time. For neurologists, there was some narrowing of the difference between billing and traditional physicians, but this was small relative to the initial jump. Eighteen months after they began billing, both orthopedists and neurologists who acquired continued to use MRI much more frequently than their colleagues did.

Effects On Spending

Exhibit 4 presents results from analyses of changes in total spending associated with beginning to bill for MRI. For orthopedists, after time trends, physician characteristics, and case-mix were adjusted for, beginning to bill for MRI was associated with an increase in physician and outpatient spending of about $25 per episode in the ninety days following the index visit—about a 2 percent increase in average episode spending.

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Exhibit 4

Changes In 90-Day And 365-Day Total Spending Associated With Physicians' Beginning To Bill For Magnetic Resonance Imaging (MRI)

Two components largely accounted for this: increased spending on MRI, and increased spending on physician procedures. There is no evidence that spending on other types of imaging changed, nor is there evidence that billing for MRI was associated with an increase in inpatient care. Similarly, average ninety-day physician and outpatient spending for neurologists increased by about $91 after physicians began billing for MRI—about a 6 percent increase in spending, driven by spending for MRI and physician procedures.

Going out a year past the index visit, there continued to be evidence of increased spending associated with MRI acquisition. There is no evidence that increases in spending in the first ninety days were offset by spending reductions after ninety days; in fact, the results would suggest the opposite.[21]

The reported changes in Exhibit 4 are increases in average spending across all patients, not just those patients who received an MRI. Because only some patients received MRI, the average spending increases are likely to reflect sizable spending increases for patients who came to receive MRI after their physician began billing for MRI, averaged with smaller or no spending changes for other patients who did not receive MRI.[22]

Discussion And Policy Implications

Many orthopedists and neurologists acquired the ability to bill Medicare for the performance of MRI procedures during the 1999-2005 period examined in this study. Whether physicians came to bill for MRI themselves because they bought or leased their own MRI equipment or because they entered into contracts with other facilities that own equipment, being able to bill for the procedures can create a financial incentive to order more procedures and may improve the ease with which MRI can be performed for patients. This experience provides a valuable opportunity to study the possible effects of physicians' acquiring the ability to bill

for new and high-cost medical technologies, something that appears to be taking place more and more commonly, across a growing range of services.

Orthopedists and neurologists who began billing for MRI changed their practice patterns, increasing the use of MRI for their patients. The increases occurred mainly in a distinct and easily observable jump in use that took place when they first billed Medicare and then persisted over time. The change appears primarily to reflect doctors' recommending MRI for patients for whom they would not have recommended the service before they acquired the ability to bill.

There is no strong reason to believe that these differences result fundamentally from a general trend toward higher MRI use or from changes in patient characteristics—such as a growing number of sicker patients needing more diagnostic interventions. The study results were adjusted for overall time trends as well as case-mix.

Beginning to bill for MRI was also associated with higher spending. As expected, some of the increased spending came from more use of MRI. However, an important share of the increased spending came from additional physician bills for procedures other than MRI. Analysis of the specific types of procedures affected was beyond the scope of this study, but this pattern is consistent with the view that expanded use of MRI can lead to the provision of other treatments for patients, which further increases spending. It may be that in some cases, increasing the use of MRI led to opportunities for more efficient care that were cost reducing, but these results suggest that on average cost-increasing tendencies dominated within the ninety-day and one-year time frames examined.

Reasons For Increased Use

There are at least two explanations for increases in use associated with physicians' beginning to bill for MRI. One is increased convenience that may come with equipment acquisition. Reducing the physician's burden of making a referral and sparing the patient the trouble of making another appointment and showing up at another location may have encouraged more use.

A second possibility is that financial incentives played a role. During the time period of this study, the level of Medicare payments made MRIs performed in physician offices quite profitable.[8] This analysis does not provide direct information about the relative importance of these two factors. The finding, however, that much of the observed increase in MRI use did not take place on the day of the initial visit seems to diminish the strength of the argument that convenience was the central driver. Another paper in this issue also makes the argument that this supposed "convenience" factor has not driven the change.[23]

This study did not assess health implications of expanded MRI use associated with beginning to bill. It is quite possible that additional use of MRI led to improvements in health outcomes. It may also have improved patient satisfaction, perhaps by providing information valued by patients, even if their health did not measurably improve.

At the same time, it is worth noting that physicians who began billing for MRI could and did refer patients for MRI before they began billing, and the characteristics of their patients did not change substantially after they began to bill. This raises the possibility that the additional patients who came to receive MRI after their physicians began billing were those for whom use of MRI was less clearly indicated and for whom the possible benefits were smaller.

Further investigation of health outcomes would be required to derive direct evidence about whether there are any health benefits that were associated with the incremental use of MRI.

There may have been some convenience benefits, but they do not seem large. Consistent with other studies, results here do show small increases in MRI on the day the patient first saw the physician. This, however, accounted for only a small part of the total rise in MRI use associated with billing for MRI.[24] Most of the incremental MRI use required an extra visit for patients.

Other Market Forces

Physicians' acquisition of MRI has an important impact on use, but it is only one of many forces driving the use of MRI. Within the set of episodes studied here, thirty-day MRI use among orthopedists' patients rose from about 45 per 1,000

episodes in 1999 to about 70 in 2005. For neurologists, the increase was from about 150 to about 185.

The portion of these increases that can be attributed to physicians' acquisition of equipment is limited. A back-of-the-envelope calculation suggests that if no physicians had begun to bill, the 2005 rates might have instead been about 67 for orthopedists and 180 for neurologists, about 2 percent lower for neurologists and 6 percent lower for orthopedists. This study also considered two specialties where physician acquisition was more noticeable and thus probably had larger effects than in other specialties. Although acquisition of MRI can have a strong impact on use, efforts to promote efficiency in use of imaging will also need to consider other drivers such as more widespread availability of equipment in many settings, expanding indications for use, and patients' interest.

One of the important features of the time period over which this study took place was the generous reimbursement for in-office imaging built into the Medicare fee schedule. This, along with generous reimbursement by private payers, was probably an important factor driving physicians' acquisition of the technology. Over the past few years, Medicare has lowered reimbursement rates for in-office imaging, which may have changed the dynamics associated with physicians' acquisition of MRI equipment and with in-office imaging use more generally. The precise results obtained here might not provide direct information about patterns of imaging going forward, as payments for imaging change.

Regardless of evolution in the specific payment environment for in-office imaging, the results here should be a powerful reminder of the potent forces at work when physicians acquire new and advanced equipment and gain the ability to bill directly for its use.

Policy Responses

The spread of technologies from hospitals to physicians' offices has been rapid. It has encompassed a wide range of services such as MRI; advanced computed tomography (CT); positron emission tomography (PET); endoscopy; cardiac catheterization; and other laboratory, testing, and therapeutic procedures. Every situation need not be the same as the one examined here, but health policies must recognize the potential for important impacts on use and spending and respond appropriately. These incentives may be important in both private and public settings. This study examined a Medicare population, but it is not difficult to imagine that the same patterns could also be important in private insurance.

Appropriate responses to these challenges could come in a variety of forms, although completely effective management may be difficult to achieve.[24-26] Federal law provides a regulatory framework for managing physicians' ownership of equipment, and attention to maintaining or adapting this framework to evolving situations could be valuable. Developing ways to understand the value of new technologies, such as with expanded efforts in technology evaluation, cost-effectiveness, and comparative effectiveness, would help target efforts to areas where the greatest concerns about efficiency are apparent.

Finally, managing financial incentives seems crucial. If administered fee-for-service pricing systems do not effectively evolve with the costs and many uses of new technologies, they run the risk of increasing inefficiencies by promoting the overuse of new services. Policy processes must devote attention to the management of these systems or to the development of systems such as bundled payments that could better adapt to new technologies.

Acknowledgments

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21. Analyses of ninety-day spending used the same sample as previous analyses. Analyses of 365-day spending excluded episodes that started after January 1, 2005, and that thus could not be followed for an entire year after the index visit.

22. The estimate changes in MRI spending are generally consistent with the changes in MRI use reported above. For orthopedists, for example, an increase in 90-day MRI spending of $17 per episode, or $17,000 per 1,000 episodes, is comparable to an increase of 33 MRI procedures per 1,000 episodes over 90 days since Medicare paid $500–$600 per procedure for office-based imaging during this period. For neurologists, the increase in MRI spending is somewhat larger than can be explained by the change in MRI use reported above. It likely implies additional MRI procedures done by

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EXHIBIT H

ANNALS OF MEDICINE | **JUNE 1, 2009 ISSUE**

THE COST CONUNDRUM

What a Texas town can teach us about health care.

BY ATUL GAWANDE

Costlier care is often worse care.

PHOTOGRAPH BY PHILLIP TOLEDANO

It is spring in McAllen, Texas. The morning sun is warm. The streets are lined with palm trees and pickup trucks. McAllen is in Hidalgo County, which has the lowest household income in the country, but it's a border town, and a thriving foreign-trade zone has kept the unemployment rate below ten per cent. McAllen calls itself the Square Dance Capital of the World. "Lonesome Dove" was set around here.

McAllen has another distinction, too: it is one of the most expensive health-care markets in the country. Only Miami—which has much higher labor and living costs—spends more per person on health care. In 2006, Medicare spent fifteen thousand dollars per enrollee here, almost twice the national average. The income per capita is twelve thousand dollars. In other words, Medicare spends three thousand dollars more per person here than the average person earns.

The explosive trend in American medical costs seems to have occurred here in an especially intense form. Our country's health care is by far the most expensive in the world. In Washington, the aim of health-care reform is not just to extend medical coverage to everybody but also to bring costs under control. Spending on doctors, hospitals, drugs, and the like now consumes more than one of every six dollars we earn. The financial burden has damaged the global competitiveness of American businesses and bankrupted millions of families, even those with insurance. It's also devouring our government. "The greatest threat to America's fiscal health is not Social Security," President Barack Obama said in a March speech at the White House. "It's not the investments that we've made to rescue

our economy during this crisis. By a wide margin, the biggest threat to our nation's balance sheet is the skyrocketing cost of health care. It's not even close."

The question we're now frantically grappling with is how this came to be, and what can be done about it. McAllen, Texas, the most expensive town in the most expensive country for health care in the world, seemed a good place to look for some answers.

From the moment I arrived, I asked almost everyone I encountered about McAllen's health costs—a businessman I met at the five-gate McAllen-Miller International Airport, the desk clerks at the Embassy Suites Hotel, a police-academy cadet at McDonald's. Most weren't surprised to hear that McAllen was an outlier. "Just look around," the cadet said. "People are not healthy here." McAllen, with its high poverty rate, has an incidence of heavy drinking sixty per cent higher than the national average. And the Tex-Mex diet has contributed to a thirty-eight-per-cent obesity rate.

One day, I went on rounds with Lester Dyke, a weather-beaten, ranch-owning fifty-three-year-old cardiac surgeon who grew up in Austin, did his surgical training with the Army all over the country, and settled into practice in Hidalgo County. He has not lacked for business: in the past twenty years, he has done some eight thousand heart operations, which exhausts me just thinking about it. I walked around with him as he checked in on ten or so of his patients who were recuperating at the three hospitals where he operates. It was easy to see what had landed them under his knife. They were nearly all obese or diabetic or both. Many had a family history of heart disease. Few were taking preventive measures, such as cholesterol-lowering drugs, which, studies indicate, would have obviated surgery for up to half of them.

Yet public-health statistics show that cardiovascular-disease rates in the county are actually lower than average, probably because its smoking rates are quite low. Rates of asthma, H.I.V., infant mortality, cancer, and injury are lower, too. El Paso County, eight hundred miles up the border, has essentially the same demographics. Both counties have a population of roughly seven hundred thousand, similar public-health statistics, and similar percentages of non-

English speakers, illegal immigrants, and the unemployed. Yet in 2006 Medicare expenditures (our best approximation of over-all spending patterns) in El Paso were $7,504 per enrollee—half as much as in McAllen. An unhealthy population couldn't possibly be the reason that McAllen's health-care costs are so high. (Or the reason that America's are. We may be more obese than any other industrialized nation, but we have among the lowest rates of smoking and alcoholism, and we are in the middle of the range for cardiovascular disease and diabetes.)

Was the explanation, then, that McAllen was providing unusually good health care? I took a walk through Doctors Hospital at Renaissance, in Edinburg, one of the towns in the McAllen metropolitan area, with Robert Alleyn, a Houston-trained general surgeon who had grown up here and returned home to practice. The hospital campus sprawled across two city blocks, with a series of three- and four-story stucco buildings separated by golfing-green lawns and black asphalt parking lots. He pointed out the sights—the cancer center is over here, the heart center is over there, now we're coming to the imaging center. We went inside the surgery building. It was sleek and modern, with recessed lighting, classical music piped into the waiting areas, and nurses moving from patient to patient behind rolling black computer pods. We changed into scrubs and Alleyn took me through the sixteen operating rooms to show me the laparoscopy suite, with its flat-screen video monitors, the hybrid operating room with built-in imaging equipment, the surgical robot for minimally invasive robotic surgery.

I was impressed. The place had virtually all the technology that you'd find at Harvard and Stanford and the Mayo Clinic, and, as I walked through that hospital on a dusty road in South Texas, this struck me as a remarkable thing. Rich towns get the new school buildings, fire trucks, and roads, not to mention the better teachers and police officers and civil engineers. Poor towns don't. But that rule doesn't hold for health care.

At McAllen Medical Center, I saw an orthopedic surgeon work under an operating microscope to remove a tumor that had wrapped around the spinal cord of a fourteen-year-old. At a home-health agency, I spoke to a nurse who could provide intravenous-drug therapy for patients with congestive heart failure. At McAllen Heart Hospital, I

watched Dyke and a team of six do a coronary-artery bypass using technologies that didn't exist a few years ago. At Renaissance, I talked with a neonatologist who trained at my hospital, in Boston, and brought McAllen new skills and technologies for premature babies. "I've had nurses come up to me and say, 'I never knew these babies could survive,' " he said.

And yet there's no evidence that the treatments and technologies available at McAllen are better than those found elsewhere in the country. The annual reports that hospitals file with Medicare show that those in McAllen and El Paso offer comparable technologies—neonatal intensive-care units, advanced cardiac services, PET scans, and so on. Public statistics show no difference in the supply of doctors. Hidalgo County actually has fewer specialists than the national average.

Nor does the care given in McAllen stand out for its quality. Medicare ranks hospitals on twenty-five metrics of care. On all but two of these, McAllen's five largest hospitals performed worse, on average, than El Paso's. McAllen costs Medicare seven thousand dollars more per person each year than does the average city in America. But not, so far as one can tell, because it's delivering better health care.

One night, I went to dinner with six McAllen doctors. All were what you would call bread-and-butter physicians: busy, full-time, private-practice doctors who work from seven in the morning to seven at night and sometimes later, their waiting rooms teeming and their desks stacked with medical charts to review.

Some were dubious when I told them that McAllen was the country's most expensive place for health care. I gave them the spending data from Medicare. In 1992, in the McAllen market, the average cost per Medicare enrollee was $4,891, almost exactly the national average. But since then, year after year, McAllen's health costs have grown faster than any other market in the country, ultimately soaring by more than ten thousand dollars per person.

"Maybe the service is better here," the cardiologist suggested. People can be seen faster and get their tests more readily, he said.

Others were skeptical. "I don't think that explains the costs he's talking about," the general surgeon said.

"It's malpractice," a family physician who had practiced here for thirty-three years said.

"McAllen is legal hell," the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere.

That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. Didn't lawsuits go down?

"Practically to zero," the cardiologist admitted.

"Come on," the general surgeon finally said. "We all know these arguments are bullshit. There is overutilization here, pure and simple." Doctors, he said, were racking up charges with extra tests, services, and procedures.

The surgeon came to McAllen in the mid-nineties, and since then, he said, "the way to practice medicine has changed completely. Before, it was about how to do a good job. Now it is about 'How much will you benefit?' "

Everyone agreed that something fundamental had changed since the days when health-care costs in McAllen were the same as those in El Paso and elsewhere. Yes, they had more technology. "But young doctors don't think anymore," the family physician said.

The surgeon gave me an example. General surgeons are often asked to see patients with pain from gallstones. If there aren't any complications—and there usually aren't—the pain goes away on its own or with pain medication. With instruction on eating a lower-fat diet, most patients experience no further difficulties. But some have recurrent episodes, and need surgery to remove their gallbladder.

Seeing a patient who has had uncomplicated, first-time gallstone pain requires some judgment. A surgeon has to provide reassurance (people are often scared and want to go straight to surgery), some education about gallstone disease and diet, perhaps a prescription for pain; in a

few weeks, the surgeon might follow up. But increasingly, I was told, McAllen surgeons simply operate. The patient wasn't going to moderate her diet, they tell themselves. The pain was just going to come back. And by operating they happen to make an extra seven hundred dollars.

I gave the doctors around the table a scenario. A forty-year-old woman comes in with chest pain after a fight with her husband. An EKG is normal. The chest pain goes away. She has no family history of heart disease. What did McAllen doctors do fifteen years ago?

Send her home, they said. Maybe get a stress test to confirm that there's no issue, but even that might be overkill.

And today? Today, the cardiologist said, she would get a stress test, an echocardiogram, a mobile Holter monitor, and maybe even a cardiac catheterization.

"Oh, she's *definitely* getting a cath," the internist said, laughing grimly.

"When you head off to camp, your parents will want to see some separation anxiety."

To determine whether overuse of medical care was really the problem in McAllen, I turned to Jonathan Skinner, an economist at Dartmouth's Institute for Health Policy and Clinical Practice, which has three decades of expertise in examining regional patterns in Medicare payment data. I also turned to two private firms—D2Hawkeye, an independent company, and Ingenix, UnitedHealthcare's data-analysis company—to analyze commercial insurance data for McAllen. The answer was yes. Compared with patients in El Paso and nationwide, patients in McAllen got more of pretty much everything—more diagnostic testing, more hospital treatment, more surgery, more home care.

The Medicare payment data provided the most detail. Between 2001 and 2005, critically ill Medicare patients received almost fifty per cent more specialist visits in McAllen than in El Paso, and were two-thirds more likely to see ten or more specialists in a six-month period. In 2005 and 2006, patients in McAllen received twenty per cent more abdominal ultrasounds, thirty per cent more bone-density studies,

sixty per cent more stress tests with echocardiography, two hundred per cent more nerve-conduction studies to diagnose carpal-tunnel syndrome, and five hundred and fifty per cent more urine-flow studies to diagnose prostate troubles. They received one-fifth to two-thirds more gallbladder operations, knee replacements, breast biopsies, and bladder scopes. They also received two to three times as many pacemakers, implantable defibrillators, cardiac-bypass operations, carotid endarterectomies, and coronary-artery stents. And Medicare paid for five times as many home-nurse visits. The primary cause of McAllen's extreme costs was, very simply, the across-the-board overuse of medicine.

This is a disturbing and perhaps surprising diagnosis. Americans like to believe that, with most things, more is better. But research suggests that where medicine is concerned it may actually be worse. For example, Rochester, Minnesota, where the Mayo Clinic dominates the scene, has fantastically high levels of technological capability and quality, but its Medicare spending is in the lowest fifteen per cent of the country—$6,688 per enrollee in 2006, which is eight thousand dollars less than the figure for McAllen. Two economists working at Dartmouth, Katherine Baicker and Amitabh Chandra, found that the more money Medicare spent per person in a given state the lower that state's quality ranking tended to be. In fact, the four states with the highest levels of spending—Louisiana, Texas, California, and Florida—were near the bottom of the national rankings on the quality of patient care.

In a 2003 study, another Dartmouth team, led by the internist Elliott Fisher, examined the treatment received by a million elderly Americans diagnosed with colon or rectal cancer, a hip fracture, or a heart attack. They found that patients in higher-spending regions received sixty per cent more care than elsewhere. They got more frequent tests and procedures, more visits with specialists, and more frequent admission to hospitals. Yet they did no better than other patients, whether this was measured in terms of survival, their ability to function, or satisfaction with the care they received. If anything, they seemed to do worse.

That's because nothing in medicine is without risks. Complications can arise from hospital stays, medications, procedures, and tests, and when these things are of marginal value the harm can be greater than the benefits. In recent years, we doctors have markedly increased the number of operations we do, for instance. In 2006, doctors performed at least sixty million surgical procedures, one for every five Americans. No other country does anything like as many operations on its citizens. Are we better off for it? No one knows for sure, but it seems highly unlikely. After all, some hundred thousand people die each year from complications of surgery—far more than die in car crashes.

To make matters worse, Fisher found that patients in high-cost areas were actually less likely to receive low-cost preventive services, such as flu and pneumonia vaccines, faced longer waits at doctor and emergency-room visits, and were less likely to have a primary-care physician. They got more of the stuff that cost more, but not more of what they needed.

In an odd way, this news is reassuring. Universal coverage won't be feasible unless we can control costs. Policymakers have worried that doing so would require rationing, which the public would never go along with. So the idea that there's plenty of fat in the system is proving deeply attractive. "Nearly thirty per cent of Medicare's costs could be saved without negatively affecting health outcomes if spending in high- and medium-cost areas could be reduced to the level in low-cost areas," Peter Orszag, the President's budget director, has stated.

Most Americans would be delighted to have the quality of care found in places like Rochester, Minnesota, or Seattle, Washington, or Durham, North Carolina—all of which have world-class hospitals and costs that fall below the national average. If we brought the cost curve in the expensive places down to their level, Medicare's problems (indeed, almost all the federal government's budget problems for the next fifty years) would be solved. The difficulty is how to go about it. Physicians in places like McAllen behave differently from others. The $2.4-trillion question is why. Unless we figure it out, health reform will fail.

I had what I considered to be a reasonable plan for finding out what was going on in McAllen. I would call on the heads of its hospitals, in their swanky, decorator-designed, *churrigueresco* offices, and I'd ask them.

The first hospital I visited, McAllen Heart Hospital, is owned by Universal Health Services, a for-profit hospital chain with headquarters in King of Prussia, Pennsylvania, and revenues of five billion dollars last year. I went to see the hospital's chief operating officer, Gilda Romero. Truth be told, her office seemed less *churrigueresco* than Office Depot. She had straight brown hair, sympathetic eyes, and looked more like a young school teacher than like a corporate officer with nineteen years of experience. And when I inquired, "What is going on in this place?" she looked surprised.

Is McAllen really that expensive? she asked.

I described the data, including the numbers indicating that heart operations and catheter procedures and pacemakers were being performed in McAllen at double the usual rate.

"That is *interesting*," she said, by which she did not mean, "Uh-oh, you've caught us" but, rather, "That is actually interesting." The problem of McAllen's outlandish costs was new to her. She puzzled over the numbers. She was certain that her doctors performed surgery only when it was necessary. It had to be one of the other hospitals. And she had one in mind—Doctors Hospital at Renaissance, the hospital in Edinburg that I had toured.

She wasn't the only person to mention Renaissance. It is the newest hospital in the area. It is physician-owned. And it has a reputation (which it disclaims) for aggressively recruiting high-volume physicians to become investors and send patients there. Physicians who do so receive not only their fee for whatever service they provide but also a percentage of the hospital's profits from the tests, surgery, or other care patients are given. (In 2007, its profits totalled thirty-four million dollars.) Romero and others argued that this gives physicians an unholy temptation to overorder.

Such an arrangement can make physician investors rich. But it can't be the whole explanation. The hospital gets barely a sixth of the patients in the region; its margins are no bigger than the other

hospitals'—whether for profit or not for profit—and it didn't have much of a presence until 2004 at the earliest, a full decade after the cost explosion in McAllen began.

"Those are good points," Romero said. She couldn't explain what was going on.

The following afternoon, I visited the top managers of Doctors Hospital at Renaissance. We sat in their boardroom around one end of a yacht-length table. The chairman of the board offered me a soda. The chief of staff smiled at me. The chief financial officer shook my hand as if I were an old friend. The C.E.O., however, was having a hard time pretending that he was happy to see me. Lawrence Gelman was a fifty-seven-year-old anesthesiologist with a Bill Clinton shock of white hair and a weekly local radio show tag-lined "Opinions from an Unrelenting Conservative Spirit." He had helped found the hospital. He barely greeted me, and while the others were trying for a how-can-I-help-you-today attitude, his body language was more let's-get-this-over-with.

So I asked him why McAllen's health-care costs were so high. What he gave me was a disquisition on the theory and history of American health-care financing going back to Lyndon Johnson and the creation of Medicare, the upshot of which was: (1) Government is the problem in health care. "The people in charge of the purse strings don't know what they're doing." (2) If anything, government insurance programs like Medicare don't pay enough. "I, as an anesthesiologist, know that they pay me ten per cent of what a private insurer pays." (3) Government programs are full of waste. "Every person in this room could easily go through the expenditures of Medicare and Medicaid and see all kinds of waste." (4) But not in McAllen. The clinicians here, at least at Doctors Hospital at Renaissance, "are providing necessary, essential health care," Gelman said. "We don't invent patients."

Then why do hospitals in McAllen order so much more surgery and scans and tests than hospitals in El Paso and elsewhere?

In the end, the only explanation he and his colleagues could offer was this: The other doctors and hospitals in McAllen may be overspending, but, to the extent that his hospital provides costlier treatment than other places in the country, it is making people better in ways that data on quality and outcomes do not measure.

"Do we provide better health care than El Paso?" Gelman asked. "I would bet you two to one that we do."

It was a depressing conversation—not because I thought the executives were being evasive but because they weren't being evasive. The data on McAllen's costs were clearly new to them. They were defending McAllen reflexively. But they really didn't know the big picture of what was happening.

And, I realized, few people in their position do. Local executives for hospitals and clinics and home-health agencies understand their growth rate and their market share; they know whether they are losing money or making money. They know that if their doctors bring in enough business—surgery, imaging, home-nursing referrals—they make money; and if they get the doctors to bring in more, they make more. But they have only the vaguest notion of whether the doctors are making their communities as healthy as they can, or whether they are more or less efficient than their counterparts elsewhere. A doctor sees a patient in clinic, and has her check into a McAllen hospital for a CT scan, an ultrasound, three rounds of blood tests, another ultrasound, and then surgery to have her gallbladder removed. How is Lawrence Gelman or Gilda Romero to know whether all that is essential, let alone the best possible treatment for the patient? It isn't what they are responsible or accountable for.

Health-care costs ultimately arise from the accumulation of individual decisions doctors make about which services and treatments to write an order for. The most expensive piece of medical equipment, as the saying goes, is a doctor's pen. And, as a rule, hospital executives don't own the pen caps. Doctors do.

"Hey, Sisyphus, when you've got a minute I'd like to discuss this progress report with you."

If doctors wield the pen, why do they do it so differently from one place to another? Brenda Sirovich, another Dartmouth

researcher, published a study last year that provided an important clue. She and her team surveyed some eight hundred primary-care physicians from high-cost cities (such as Las Vegas and New York), low-cost cities (such as Sacramento and Boise), and others in between. The researchers asked the physicians specifically how they would handle a variety of patient cases. It turned out that differences in decision-making emerged in only some kinds of cases. In situations in which the right thing to do was well established—for example, whether to recommend a mammogram for a fifty-year-old woman (the answer is yes)—physicians in high- and low-cost cities made the same decisions. But, in cases in which the science was unclear, some physicians pursued the maximum possible amount of testing and procedures; some pursued the minimum. And which kind of doctor they were depended on where they came from.

Sirovich asked doctors how they would treat a seventy-five-year-old woman with typical heartburn symptoms and "adequate health insurance to cover tests and medications." Physicians in high- and low-cost cities were equally likely to prescribe antacid therapy and to check for H. pylori, an ulcer-causing bacterium—steps strongly recommended by national guidelines. But when it came to measures of less certain value—and higher cost—the differences were considerable. More than seventy per cent of physicians in high-cost cities referred the patient to a gastroenterologist, ordered an upper endoscopy, or both, while half as many in low-cost cities did. Physicians from high-cost cities typically recommended that patients with well-controlled hypertension see them in the office every one to three months, while those from low-cost cities recommended visits twice yearly. In case after uncertain case, more was not necessarily better. But physicians from the most expensive cities did the most expensive things.

Why? Some of it could reflect differences in training. I remember when my wife brought our infant son Walker to visit his grandparents in Virginia, and he took a terrifying fall down a set of stairs. They drove him to the local community hospital in Alexandria. A CT scan showed that he had a tiny subdural hematoma—a small area of bleeding in the brain. During ten hours of observation, though, he was fine—eating, drinking, completely alert. I was a surgery resident then and had seen many cases like his. We observed each child in intensive care for at least twenty-four hours and got a repeat CT scan.

That was how I'd been trained. But the doctor in Alexandria was going to send Walker home. That was how he'd been trained. Suppose things change for the worse? I asked him. It's extremely unlikely, he said, and if anything changed Walker could always be brought back. I bullied the doctor into admitting him anyway. The next day, the scan and the patient were fine. And, looking in the textbooks, I learned that the doctor was right. Walker could have been managed safely either way.

There was no sign, however, that McAllen's doctors as a group were trained any differently from El Paso's. One morning, I met with a hospital administrator who had extensive experience managing for-profit hospitals along the border. He offered a different possible explanation: the culture of money.

"In El Paso, if you took a random doctor and looked at his tax returns eighty-five per cent of his income would come from the usual practice of medicine," he said. But in McAllen, the administrator thought, that percentage would be a lot less.

He knew of doctors who owned strip malls, orange groves, apartment complexes—or imaging centers, surgery centers, or another part of the hospital they directed patients to. They had "entrepreneurial spirit," he said. They were innovative and aggressive in finding ways to increase revenues from patient care. "There's no lack of work ethic," he said. But he had often seen financial considerations drive the decisions doctors made for patients—the tests they ordered, the doctors and hospitals they recommended—and it bothered him. Several doctors who were unhappy about the direction medicine had taken in McAllen told me the same thing. "It's a machine, my friend," one surgeon explained.

No one teaches you how to think about money in medical school or residency. Yet, from the moment you start practicing, you must think about it. You must consider what is covered for a patient and what is not. You must pay attention to insurance rejections and government-reimbursement rules. You must think about having enough money for the secretary and the nurse and the rent and the malpractice insurance.

Beyond the basics, however, many physicians are remarkably oblivious to the financial implications of their decisions. They see their patients. They make their recommendations. They send out the bills. And, as long as the numbers come out all right at the end of each month, they put the money out of their minds.

Others think of the money as a means of improving what they do. They think about how to use the insurance money to maybe install electronic health records with colleagues, or provide easier phone and e-mail access, or offer expanded hours. They hire an extra nurse to monitor diabetic patients more closely, and to make sure that patients don't miss their mammograms and pap smears and colonoscopies.

Then there are the physicians who see their practice primarily as a revenue stream. They instruct their secretary to have patients who call with follow-up questions schedule an appointment, because insurers don't pay for phone calls, only office visits. They consider providing Botox injections for cash. They take a Doppler ultrasound course, buy a machine, and start doing their patients' scans themselves, so that the insurance payments go to them rather than to the hospital. They figure out ways to increase their high-margin work and decrease their low-margin work. This is a business, after all.

In every community, you'll find a mixture of these views among physicians, but one or another tends to predominate. McAllen seems simply to be the community at one extreme.

In a few cases, the hospital executive told me, he'd seen the behavior cross over into what seemed like outright fraud. "I've had doctors here come up to me and say, 'You want me to admit patients to your hospital, you're going to have to pay me.' "

"How much?" I asked.

"The amounts—all of them were over a hundred thousand dollars per year," he said. The doctors were specific. The most he was asked for was five hundred thousand dollars per year.

He didn't pay any of them, he said: "I mean, I gotta sleep at night." And he emphasized that these were just a handful of doctors. But he had never been asked for a kickback before coming to McAllen.

Woody Powell is a Stanford sociologist who studies the economic culture of cities. Recently, he and his research team studied why certain regions—Boston, San Francisco, San Diego—became leaders in biotechnology while others with a similar concentration of scientific and corporate talent—Los Angeles, Philadelphia, New York—did not. The answer they found was what Powell describes as the anchor-tenant theory of economic development. Just as an anchor store will define the character of a mall, anchor tenants in biotechnology, whether it's a company like Genentech, in South San Francisco, or a university like M.I.T., in Cambridge, define the character of an economic community. They set the norms. The anchor tenants that set norms encouraging the free flow of ideas and collaboration, even with competitors, produced enduringly successful communities, while those that mainly sought to dominate did not.

Powell suspects that anchor tenants play a similarly powerful community role in other areas of economics, too, and health care may be no exception. I spoke to a marketing rep for a McAllen home-health agency who told me of a process uncannily similar to what Powell found in biotech. Her job is to persuade doctors to use her agency rather than others. The competition is fierce. I opened the phone book and found seventeen pages of listings for home-health agencies—two hundred and sixty in all. A patient typically brings in between twelve hundred and fifteen hundred dollars, and double that amount for specialized care. She described how, a decade or so ago, a few early agencies began rewarding doctors who ordered home visits with more than trinkets: they provided tickets to professional sporting events, jewelry, and other gifts. That set the tone. Other agencies jumped in. Some began paying doctors a supplemental salary, as "medical directors," for steering business in their direction. Doctors came to expect a share of the revenue stream.

Agencies that want to compete on quality struggle to remain in business, the rep said. Doctors have asked her for a medical-director salary of four or five thousand dollars a month in return for sending her business. One asked a colleague of hers for private-school tuition for his child; another wanted sex.

"I explained the rules and regulations and the anti-kickback law, and told them no," she said of her dealings with such doctors. "Does it hurt my business?" She paused. "I'm O.K. working only with ethical physicians," she finally said.

About fifteen years ago, it seems, something began to change in McAllen. A few leaders of local institutions took profit growth to be a legitimate ethic in the practice of medicine. Not all the doctors accepted this. But they failed to discourage those who did. So here, along the banks of the Rio Grande, in the Square Dance Capital of the World, a medical community came to treat patients the way subprime-mortgage lenders treated home buyers: as profit centers.

The real puzzle of American health care, I realized on the airplane home, is not why McAllen is different from El Paso. It's why El Paso isn't like McAllen. Every incentive in the system is an invitation to go the way McAllen has gone. Yet, across the country, large numbers of communities have managed to control their health costs rather than ratchet them up.

I talked to Denis Cortese, the C.E.O. of the Mayo Clinic, which is among the highest-quality, lowest-cost health-care systems in the country. A couple of years ago, I spent several days there as a visiting surgeon. Among the things that stand out from that visit was how much time the doctors spent with patients. There was no churn—no shuttling patients in and out of rooms while the doctor bounces from one to the other. I accompanied a colleague while he saw patients. Most of the patients, like those in my clinic, required about twenty minutes. But one patient had colon cancer and a number of other complex issues, including heart disease. The physician spent an hour with her, sorting things out. He phoned a cardiologist with a question.

"I'll be there," the cardiologist said.

Fifteen minutes later, he was. They mulled over everything together. The cardiologist adjusted a medication, and said that no further testing was needed. He cleared the patient for surgery, and the operating room gave her a slot the next day.

The whole interaction was astonishing to me. Just having the cardiologist pop down to see the patient with the surgeon would be unimaginable at my hospital. The time required wouldn't pay. The time required just to organize the system wouldn't pay.

The core tenet of the Mayo Clinic is "The needs of the patient come first"—not the convenience of the doctors, not their revenues. The doctors and nurses, and even the janitors, sat in meetings almost weekly, working on ideas to make the service and the care better, not to get more money out of patients. I asked Cortese how the Mayo Clinic made this possible.

"It's not easy," he said. But decades ago Mayo recognized that the first thing it needed to do was eliminate the financial barriers. It pooled all the money the doctors and the hospital system received and began paying everyone a salary, so that the doctors' goal in patient care couldn't be increasing their income. Mayo promoted leaders who focussed first on what was best for patients, and then on how to make this financially possible.

No one there actually intends to do fewer expensive scans and procedures than is done elsewhere in the country. The aim is to raise quality and to help doctors and other staff members work as a team. But, almost by happenstance, the result has been lower costs.

"When doctors put their heads together in a room, when they share expertise, you get more thinking and less testing," Cortese told me.

Skeptics saw the Mayo model as a local phenomenon that wouldn't carry beyond the hay fields of northern Minnesota. But in 1986 the Mayo Clinic opened a campus in Florida, one of our most expensive states for health care, and, in 1987, another one in Arizona. It was difficult to recruit staff members who would accept a salary and the Mayo's collaborative way of practicing. Leaders were working against the dominant medical culture and incentives. The expansion sites took at least a decade to get properly established. But eventually they achieved the same high-quality, low-cost results as Rochester. Indeed, Cortese says that the Florida site has become, in some respects, the most efficient one in the system.

The Mayo Clinic is not an aberration. One of the lowest-cost markets in the country is Grand Junction, Colorado, a community of a hundred and twenty thousand that nonetheless has achieved some of Medicare's highest quality-of-care scores. Michael Pramenko is a family physician and a local medical leader there. Unlike doctors at the Mayo Clinic, he told me, those in Grand Junction get piecework fees from insurers. But years ago the doctors agreed among themselves to a system that paid them a similar fee whether they saw Medicare, Medicaid, or private-insurance patients, so that there would be little incentive to cherry-pick patients. They also agreed, at the behest of the main health plan in town, an H.M.O., to meet regularly on small peer-review committees to go over their patient charts together. They focussed on rooting out problems like poor prevention practices, unnecessary back operations, and unusual hospital-complication rates. Problems went down. Quality went up. Then, in 2004, the doctors' group and the local H.M.O. jointly created a regional information network—a community-wide electronic-record system that shared office notes, test results, and hospital data for patients across the area. Again, problems went down. Quality went up. And costs ended up lower than just about anywhere else in the United States.

Grand Junction's medical community was not following anyone else's recipe. But, like Mayo, it created what Elliott Fisher, of Dartmouth, calls an accountable-care organization. The leading doctors and the hospital system adopted measures to blunt harmful financial incentives, and they took collective responsibility for improving the sum total of patient care.

This approach has been adopted in other places, too: the Geisinger Health System, in Danville, Pennsylvania; the Marshfield Clinic, in Marshfield, Wisconsin; Intermountain Healthcare, in Salt Lake City; Kaiser Permanente, in Northern California. All of them function on similar principles. All are not-for-profit institutions. And all have produced enviably higher quality and lower costs than the average American town enjoys.

When you look across the spectrum from Grand Junction to McAllen—and the almost threefold difference in the costs of care—you come to realize that we are witnessing a battle for the soul of American medicine. Somewhere in the United States at this moment, a patient with chest

pain, or a tumor, or a cough is seeing a doctor. And the damning question we have to ask is whether the doctor is set up to meet the needs of the patient, first and foremost, or to maximize revenue.

There is no insurance system that will make the two aims match perfectly. But having a system that does so much to misalign them has proved disastrous. As economists have often pointed out, we pay doctors for quantity, not quality. As they point out less often, we also pay them as individuals, rather than as members of a team working together for their patients. Both practices have made for serious problems.

Providing health care is like building a house. The task requires experts, expensive equipment and materials, and a huge amount of coördination. Imagine that, instead of paying a contractor to pull a team together and keep them on track, you paid an electrician for every outlet he recommends, a plumber for every faucet, and a carpenter for every cabinet. Would you be surprised if you got a house with a thousand outlets, faucets, and cabinets, at three times the cost you expected, and the whole thing fell apart a couple of years later? Getting the country's best electrician on the job (he trained at Harvard, somebody tells you) isn't going to solve this problem. Nor will changing the person who writes him the check.

This last point is vital. Activists and policymakers spend an inordinate amount of time arguing about whether the solution to high medical costs is to have government or private insurance companies write the checks. Here's how this whole debate goes. Advocates of a public option say government financing would save the most money by having leaner administrative costs and forcing doctors and hospitals to take lower payments than they get from private insurance. Opponents say doctors would skimp, quit, or game the system, and make us wait in line for our care; they maintain that private insurers are better at policing doctors. No, the skeptics say: all insurance companies do is reject applicants who need health care and stall on paying their bills. Then we have the economists who say that the people who should pay the doctors are the ones who use them. Have consumers pay with their own dollars, make sure that they have some "skin in the game," and then they'll get the care they deserve. These arguments miss the main issue. When it comes to making care better and cheaper, changing who pays the doctor will make no more difference than

changing who pays the electrician. The lesson of the high-quality, low-cost communities is that someone has to be accountable for the totality of care. Otherwise, you get a system that has no brakes. You get McAllen.

One afternoon in McAllen, I rode down McColl Road with Lester Dyke, the cardiac surgeon, and we passed a series of office plazas that seemed to be nothing but home-health agencies, imaging centers, and medical-equipment stores.

"Medicine has become a pig trough here," he muttered.

Dyke is among the few vocal critics of what's happened in McAllen. "We took a wrong turn when doctors stopped being doctors and became businessmen," he said.

We began talking about the various proposals being touted in Washington to fix the cost problem. I asked him whether expanding public-insurance programs like Medicare and shrinking the role of insurance companies would do the trick in McAllen.

"I don't have a problem with it," he said. "But it won't make a difference." In McAllen, government payers already predominate—not many people have jobs with private insurance.

How about doing the opposite and increasing the role of big insurance companies?

"What good would that do?" Dyke asked.

The third class of health-cost proposals, I explained, would push people to use medical savings accounts and hold high-deductible insurance policies: "They'd have more of their own money on the line, and that'd drive them to bargain with you and other surgeons, right?"

He gave me a quizzical look. We tried to imagine the scenario. A cardiologist tells an elderly woman that she needs bypass surgery and has Dr. Dyke see her. They discuss the blockages in her heart, the operation, the risks. And now they're supposed to haggle over the price as if he were selling a rug in a souk? "I'll do three vessels for thirty thousand, but if you take four I'll throw in an extra night in the

I.C.U."—that sort of thing? Dyke shook his head. "Who comes up with this stuff?" he asked. "Any plan that relies on the sheep to negotiate with the wolves is doomed to failure."

Instead, McAllen and other cities like it have to be weaned away from their untenably fragmented, quantity-driven systems of health care, step by step. And that will mean rewarding doctors and hospitals if they band together to form Grand Junction-like accountable-care organizations, in which doctors collaborate to increase prevention and the quality of care, while discouraging overtreatment, undertreatment, and sheer profiteering. Under one approach, insurers—whether public or private—would allow clinicians who formed such organizations and met quality goals to keep half the savings they generate. Government could also shift regulatory burdens, and even malpractice liability, from the doctors to the organization. Other, sterner, approaches would penalize those who don't form these organizations.

This will by necessity be an experiment. We will need to do in-depth research on what makes the best systems successful—the peer-review committees? recruiting more primary-care doctors and nurses? putting doctors on salary?—and disseminate what we learn. Congress has provided vital funding for research that compares the effectiveness of different treatments, and this should help reduce uncertainty about which treatments are best. But we also need to fund research that compares the effectiveness of different systems of care—to reduce our uncertainty about which systems work best for communities. These are empirical, not ideological, questions. And we would do well to form a national institute for health-care delivery, bringing together clinicians, hospitals, insurers, employers, and citizens to assess, regularly, the quality and the cost of our care, review the strategies that produce good results, and make clear recommendations for local systems.

Dramatic improvements and savings will take at least a decade. But a choice must be made. Whom do we want in charge of managing the full complexity of medical care? We can turn to insurers (whether public or private), which have proved repeatedly that they can't do it. Or we can turn to the local medical communities, which have proved that they can. But we have to choose someone—because, in much of the country, no one is in charge. And the result is the most wasteful and the least sustainable health-care system in the world.

Something even more worrisome is going on as well. In the war over the culture of medicine—the war over whether our country's anchor model will be Mayo or McAllen—the Mayo model is losing. In the sharpest economic downturn that our health system has faced in half a century, many people in medicine don't see why they should do the hard work of organizing themselves in ways that reduce waste and improve quality if it means sacrificing revenue.

In El Paso, the for-profit health-care executive told me, a few leading physicians recently followed McAllen's lead and opened their own centers for surgery and imaging. When I was in Tulsa a few months ago, a fellow-surgeon explained how he had made up for lost revenue by shifting his operations for well-insured patients to a specialty hospital that he partially owned while keeping his poor and uninsured patients at a nonprofit hospital in town. Even in Grand Junction, Michael Pramenko told me, "some of the doctors are beginning to complain about 'leaving money on the table.' "

As America struggles to extend health-care coverage while curbing health-care costs, we face a decision that is more important than whether we have a public-insurance option, more important than whether we will have a single-payer system in the long run or a mixture of public and private insurance, as we do now. The decision is whether we are going to reward the leaders who are trying to build a new generation of Mayos and Grand Junctions. If we don't, McAllen won't be an outlier. It will be our future. ♦

Atul Gawande, a surgeon and public-health researcher, became a *New Yorker* staff writer in 1998.

EXHIBIT I

Statute Text

Article - Health Occupations

§1–301.

(a) In this subtitle the following words have the meanings indicated.

(b) (1) "Beneficial interest" means ownership, through equity, debt, or other means, of any financial interest.

(2) "Beneficial interest" does not include ownership, through equity, debt, or other means, of securities, including shares or bonds, debentures, or other debt instruments:

(i) In a corporation that is traded on a national exchange or over the counter on the national market system;

(ii) That at the time of acquisition, were purchased at the same price and on the same terms generally available to the public;

(iii) That are available to individuals who are not in a position to refer patients to the health care entity on the same terms that are offered to health care practitioners who may refer patients to the health care entity;

(iv) That are unrelated to the past or expected volume of referrals from the health care practitioner to the health care entity; and

(v) That are not marketed differently to health care practitioners that may make referrals than they are marketed to other individuals.

(c) (1) "Compensation arrangement" means any agreement or system involving any remuneration between a health care practitioner or the immediate family member of the health care practitioner and a health care entity.

(2) "Compensation arrangement" does not include:

(i) Compensation or shares under a faculty practice plan or a professional corporation affiliated with a teaching hospital and comprised of health care practitioners who are members of the faculty of a university;

(ii) Amounts paid under a bona fide employment agreement between a health care entity and a health care practitioner or an immediate family member of the health care practitioner;

(iii) An arrangement between a health care entity and a health care practitioner or the immediate family member of a health care practitioner for the provision of any services, as an independent contractor, if:

1. The arrangement is for identifiable services;

2. The amount of the remuneration under the arrangement is consistent with the fair market value of the service and is not determined in a manner that takes into account, directly or indirectly, the volume or value of any referrals by the referring health care practitioner; and

3. The compensation is provided in accordance with an agreement that would be commercially reasonable even if no referrals were made to the health care provider;

(iv) Compensation for health care services pursuant to a referral from a health care practitioner and rendered by a health care entity, that employs or contracts with an immediate family member of the health care practitioner, in which the immediate family member's compensation is not based on the referral;

(v) An arrangement for compensation which is provided by a health care entity to a health care practitioner or the immediate family member of the health care practitioner to induce the health care practitioner or the immediate family member of the health care practitioner to relocate to the geographic area served by the health care entity in order to be a member of the medical staff of a hospital, if:

1. The health care practitioner or the immediate family member of the health care practitioner is not required to refer patients to the health care entity;

2. The amount of the compensation under the arrangement is not determined in a manner that takes into account, directly or indirectly, the volume or value of any referrals by the referring health care practitioner; and

3. The health care entity needs the services of the practitioner to meet community health care needs and has had difficulty in recruiting a practitioner;

(vi) Payments made for the rental or lease of office space if the payments are:

1. At fair market value; and

2. In accordance with an arm's length transaction;

(vii) Payments made for the rental or lease of equipment if the payments are:

1. At fair market value; and

2. In accordance with an arm's length transaction; or

(viii) Payments made for the sale of property or a health care practice if the payments are:

1. At fair market value;

2. In accordance with an arm's length transaction; and

3. The remuneration is provided in accordance with an agreement that would be commercially reasonable even if no referrals were made.

(d) "Direct supervision" means a health care practitioner is present on the premises where the health care services or tests are provided and is available for consultation within the treatment area.

(e) "Faculty practice plan" means a tax–exempt organization established under Maryland law by or at the direction of a university to accommodate the professional practice of members of the faculty who are health care practitioners.

(f) "Group practice" means a group of two or more health care practitioners legally organized as a partnership, professional corporation, foundation, not–for–profit corporation, faculty practice plan, or similar association:

(1) In which each health care practitioner who is a member of the group provides substantially the full range of services which the practitioner routinely provides through the joint use of shared office space, facilities, equipment, and personnel;

(2) For which substantially all of the services of the health care practitioners who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; and

(3) In which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined on an annual basis by members of the group.

(g) "Health care entity" means a business entity that provides health care services for the:

(1) Testing, diagnosis, or treatment of human disease or dysfunction; or

(2) Dispensing of drugs, medical devices, medical appliances, or medical goods for the treatment of human disease or dysfunction.

(h) "Health care practitioner" means a person who is licensed, certified, or otherwise authorized under this article to provide health care services in the ordinary course of business or practice of a profession.

(i) "Health care service" means medical procedures, tests and services provided to a patient by or through a health care entity.

(j) "Immediate family member" means a health care practitioner's:

(1) Spouse;

(2) Child;

(3) Child's spouse;

(4) Parent;

(5) Spouse's parent;

(6) Sibling; or

(7) Sibling's spouse.

(k) (1) "In–office ancillary services" means those basic health care services and tests routinely performed in the office of one or more health care practitioners.

(2) Except for a radiologist group practice or an office consisting solely of one or more radiologists, "in–office ancillary services" does not include:

(i) Magnetic resonance imaging services;

(ii) Radiation therapy services; or

(iii) Computer tomography scan services.

(l) (1) "Referral" means any referral of a patient for health care services.

(2) "Referral" includes:

(i) The forwarding of a patient by one health care practitioner to another health care practitioner or to a health care entity outside the health care practitioner's office or group practice; or

(ii) The request or establishment by a health care practitioner of a plan of care for the provision of health care services outside the health care practitioner's office or group practice.

EXHIBIT J

National Business Group on Health

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www.businessgrouphealth.org

Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

July 8, 2009

The Honorable Jackie Speier
U.S. House of Representatives
211 Cannon House Office Building
Washington, DC 20515

Dear Representative Speier:

The National Business Group on Health wholeheartedly supports the objective of H.R. 2962, the Integrity in Medicare Advanced Diagnostic Imaging Act of 2009, to reduce overutilization of unnecessary and potentially harmful imaging services. We applaud your leadership on this issue.

The National Business Group on Health represents approximately 300, primarily large, employers who voluntarily provide health benefits and other health programs to over 55 million American employees, retirees, and their families.

H.R. 2962 would amend the current Stark law to prohibit Medicare physician self-referrals for magnetic resonance imaging (MRI), computed tomography (CT) and positron emission tomography (PET), which are the medical scans most prone to overutilization. H.R. 2962 would still allow physician self-referral for x-rays, ultrasounds and fluoroscopies or imaging services performed for the purposes of radiation therapy treatment planning or in conjunction with an interventional radiological procedure or nuclear medicine other than PET.

The current Stark exception allows Medicare physicians to self-refer patients to imaging studies conducted in their office, in which they could have a financial interest. Studies have shown that physicians who own imaging equipment are two to seven times more likely to order imaging tests and that physician self-referrals are driving up imaging utilization.[1]

Undoubtedly, advances in radiology aid in the diagnosis and treatment of illness, with some studies pointing to less invasive testing and lower total costs. Like everything else in medicine, balance is extremely important and imaging services are clearly out of balance in some locations and under some circumstances. Imaging use varies widely across geographic areas giving rise to speculation that these increases may be related to other factors such as imaging equipment availability that do not necessarily correlate with

[1] America's Health Insurance Plans. Ensuring Quality through Appropriate Use of Diagnostic Imaging. July 2008. Available at http://www.ahip.org/content/default.aspx?docid=24057

better quality or superior outcomes. For example, a recent Government Accountability Office (GAO) report found that in-office imaging spending per beneficiary varied almost eight-fold across the states—from $62 in Vermont to $472 in Florida. [2]

The increased use of certain imaging (CT and PET scans) has also raised concerns about unnecessary exposure to radiation due to inappropriate imaging. For example, one study estimates that as many as 1.5 to 2 percent of all cancers in the U.S. may be attributable to radiation from CT scans, a concern that is magnified for children and pregnant women.[3]

The GAO recently reported that medical imaging has approximately doubled from 2001-2006 to $14.11 billion under Medicare (Part B).[4] We believe it is necessary for the financial future of Medicare as well as the quality and safety of care received by beneficiaries that strategies that promote the appropriate use of imaging services be pursued to avoid duplicate tests and unnecessary radiation exposure.

The National Business Group on Health strongly supports your leadership on this issue which will increase patient safety, reduce overutilization of imaging services, and ensure that Medicare beneficiaries will be able to continue to access the medical imaging technology they need to detect and fight serious illnesses. We thank you for your efforts and look forward to working with you to assist in the passage or inclusion of this important bill into this year's health care reform legislation.

Sincerely,

Helen Darling
President

[2] Demmerle, Cara and Jon Glaudemans. Diagnostic Imaging: Spending Trends and the Increasing Use of Appropriateness Criteria and Accreditation. Avalere Health. July 2008.
[3] Brenner D, Hall E. Computed tomography – an increasing source of radiation exposure. New England Journal of Medicine. 2007. 357, 2277-2284.
[4] Government Accountability Office (GAO). Medicare Part B Imaging Services. Rapid Spending Growth and Shift to Physicians Offices Indicate Need for CMS to Consider Additional Management Practices. June 2008.

National Business Group on Health

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

March 4, 2010

The Honorable Charles E. Schumer
U.S. Senate
313 Hart Senate Office Building
Washington, DC 20515

Dear Senator Schumer:

The National Business Group on Health wholeheartedly supports your recent statement at the President's February 25th "Health Summit" to eliminate the abuse and overutilization of unnecessary and potentially harmful imaging services.

The National Business Group on Health represents approximately 300, primarily large, employers who voluntarily provide health benefits and other health programs to over 55 million American employees, retirees, and their families.

As you know, legislation has been introduced in the House that would amend the current Stark law to prohibit Medicare physician self-referrals for magnetic resonance imaging (MRI), computed tomography (CT) and positron emission tomography (PET), which are the medical scans most prone to overutilization.

The current Stark exception allows Medicare physicians to self-refer patients for imaging studies conducted in their office, in which they have a financial interest. Studies have shown that physicians who own imaging equipment are two to seven times more likely to order imaging tests and that physician self-referrals are driving up imaging utilization.[1] The Government Accountability Office (GAO) recently reported that spending for medical imaging has approximately doubled from 2001-2006 to $14.11 billion under Medicare (Part B).[2] In response to concerns about overutilization of imaging in Medicare, the Medicare Payment Advisory Commission (MedPAC) recently recommended excluding certain services from the exception, reducing payments for rates for tests performed by self-referring physicians and requiring prior authorization for physicians who self-refer for advanced imaging.[3]

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[1] America's Health Insurance Plans. Ensuring Quality through Appropriate Use of Diagnostic Imaging. July 2008. Available at http://www.ahip.org/content/default.aspx?docid=24057

[2] Government Accountability Office (GAO). Medicare Part B Imaging Services. Rapid Spending Growth and Shift to Physicians Offices Indicate Need for CMS to Consider Additional Management Practices. June 2008.

[3] Winter, Ariel. Services provided under the in-office ancillary exception to the physician self-referral law. January 15, 2010. Available at: http://www.medpac.gov/transcripts/In-office%20services_Jan%202010_public.pdf

Undoubtedly, advances in radiology aid in the diagnosis and treatment of illness, with some studies pointing to less invasive testing and lower total costs. As you stated during the summit we need to "wring that waste out, that fraud, abuse, duplication, without interfering with the good care that we want every person on Medicare, Medicaid and private insurance to get." Like everything else in medicine, balance is extremely important and imaging services are clearly out of balance in some locations and under some circumstances. Imaging use varies widely across geographic areas giving rise to speculation that these increases may be related to other factors such as imaging equipment availability that do not necessarily correlate with better quality or superior outcomes. For example, a recent Government Accountability Office (GAO) report found that in-office imaging spending per beneficiary varied almost eight-fold across the states—from $62 in Vermont to $472 in Florida. [4]

The increased use of certain imaging (primarily CT scans) has also raised concerns about unnecessary exposure to radiation, particularly among children. One study estimates that as many as 2 percent of all cancers in the U.S. may be attributable to radiation from CT scans, a concern that is magnified for children and pregnant women.[5] The Food and Drug Administration (FDA) also recently reported that the average American's total radiation exposure has nearly doubled in the last three decades, largely due to next-generation imaging tests.

The FDA is considering new safeguards for CT scanners, nuclear medicine studies and fluoroscopy to prevent unnecessary radiation exposure[6] and is investigating last year's incident where three California hospitals reported hundreds of acute radiation overdoses from CT scanners, with many patients reporting lost hair and skin redness. Despite these measures and heightened scrutiny, the current Stark exception and financial incentives to perform these tests will still promote unnecessary imaging.

We believe it is necessary for the quality and safety of care received by beneficiaries, the financial future of Medicare, and the wellbeing of the American people that strategies to promote the appropriate use of imaging services be pursued to avoid duplicate tests and unnecessary radiation exposure. Accordingly, we urge you to:

1) Add into any reconciliation, Medicare-related or other health care bill a prohibition on Medicare physician self-referrals for the medical scans most prone to overutilization;
2) Follow MedPAC's recent recommendations to exclude certain imaging services from the exception, reduce payments for rates for tests performed by self-referring physicians and require prior authorization for physicians who self-refer for advanced imaging; and

[4] Demmerle, Cara and Jon Glaudemans. Diagnostic Imaging: Spending Trends and the Increasing Use of Appropriateness Criteria and Accreditation. Avalere Health. July 2008.
[5] Brenner D., Hall E. Computed tomography – an increasing source of radiation exposure. New England Journal of Medicine. 2007. 357, 2277-2284.
[6] Food and Drug Administration. FDA Unveils Initiative to Reduce Unnecessary Radiation Exposure from Medical Imaging. February 9, 2010. Available at: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm200085.htm

3) Support the FDA's initiative to reduce unnecessary radiation exposure from medical imaging.

The National Business Group on Health strongly supports your leadership on these issues which will increase patient safety, reduce overutilization of imaging services, and ensure that Medicare beneficiaries will be able to continue to access the medical imaging technology they need to detect and fight serious illnesses.

We thank you for your efforts and we look forward to working with you on this important issue. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 585-1812, if you would like to discuss our comments in more detail.

Sincerely,

Helen Darling
President

cc:
The Honorable Harry Reid, Majority Leader, U.S. Senate
The Honorable Nancy Pelosi, Speaker, U.S. House of Representatives
The Honorable Jackie Speier, U.S. House of Representatives
The Honorable Anthony Weiner, U.S. House of Representatives
The Honorable Bruce Braley, U.S .House of Representatives

EXHIBIT K

CALL TO ACTION
HEALTH REFORM 2009
SENATE FINANCE COMMITTEE CHAIRMAN MAX BAUCUS (D-MONT.)

CALL TO ACTION

HEALTH REFORM 2009

November 12, 2008

U.S. Senator Max Baucus (D-Mont.)
Chairman, Senate Finance Committee

www.finance.senate.gov • Tel: 202-224-4515

percent) received payments for consulting, giving lectures, or enrolling patients in trials."[17] In 2005, pharmaceutical companies spent $7 billion on sales representative visits to physicians and provided $18 billion worth of free samples.[18]

To dissuade inappropriate relationships, both the American Medical Association (AMA) and the Pharmaceutical Research and Manufacturers of America (PhRMA) adopted or revised their codes of conduct involving industry relationships. The AMA "allows physicians to accept gifts as long as the gifts primarily benefit patients and are not of substantial value."[19] The PhRMA code states such relationships "are intended to benefit patients and to enhance the practice of medicine," and should be used, "solely on each patient's medical needs."[20] Though these updated guidelines are a step in the right direction, "there is also evidence that interactions prohibited by voluntary codes continue to occur."[21]

Four states (Minnesota, Vermont, Maine, and West Virginia) and the District of Columbia have enacted laws that require drug manufacturers to report any cash and in-kind payments made to physicians.[22] Many advocate more detailed reporting of gifts between industry and physicians on a national level. National legislation has been introduced that would require drug and device companies to disclose all gifts of $25 or more to physicians and other medical providers.[23]

A recent MedPAC report to Congress outlined several advantages of such a requirement. It may discourage inappropriate arrangements between physician and industry, allow the media to explore potential conflicts of interest, enable payers to examine physician practices that may be influenced by particular relationships, and highlight those physicians who have decided not to take part in inappropriate relationships.[24]

Unfortunately, data collection alone may not prevent inappropriate relationships. However, once national, system-wide data is available, the extent of industry influence and the wasteful spending that it leads to can be better determined. With this information, stronger enforcement can be put into place, so that regardless of provider relationships, we can be sure physicians are recommending and performing medical care based on sound medical science rather than heavy-handed industry influence.

For these reasons, the Baucus plan would require disclosure of gifts and other transfers of value made by drug and device companies to physicians and other health care professionals. Only with this information can potential bias be known. And the requirement to disclose may deter inappropriate behavior. Disclosure is the only way to know if there are inappropriate influences on the delivery of care and use of taxpayer dollars.

Physician Self-Referral. Physicians, like most professionals, expect to get paid for the work that they perform. Some physicians, however, have found a way to game the system so that, in addition to getting paid, they reap additional financial benefits from the provision of certain health care services. Physicians can accomplish this by having ownership or other financial interests in equipment or facilities — such as an MRI machine

or a hospital — that provide health services. When those physicians refer their patients for services from which the physician reaps the additional financial benefits — a practice known as self-referral — there is reason to be concerned about the physician's motives.

Physician self-referral is generally prohibited by Federal law when the patient is covered by Medicare or Medicaid.[25] Self-referral creates conflicting incentives for physicians, because the financial incentive to increase utilization of the financially-rewarding services may conflict with otherwise sound medical and professional judgment. Ultimately, this practice often results in an "increased use of services and higher payments from third party payers."[26]

Congress has enacted several laws to confront this problem. In 1972, Congress enacted the Anti-Kickback Statute, which "broadly prohibits the purposeful offer, payment, or receipt of anything of value to induce the referral of patients from services reimbursable by a federal health care program."[27] Few prosecutions occurred, however, and referrals to imaging facilities or medical laboratories were not deterred.[28]

In 1989, Congress enacted the Ethics in Patient Referrals Act (known as Stark I), which prohibits physicians from "referring Medicare or Medicaid patients for clinical laboratory services to labs with which the physician has a financial relationship…unless the relationship fits within a specified exception."[29] In 1993, Congress enacted amendments (known as Stark II) expanding the prohibited services to "physical and laboratory therapy, radiology, radiation, home health care, hospital, outpatient prescription drugs, and many types of medical equipment and supplies."[30]

The Baucus plan would scrutinize physician self-referral to ensure that physicians are not engaged in financial arrangements that place financial interests ahead of the needs of patients and the American taxpayer. Physicians deserve fair pay for providing services, but they should not be able to game the system unfairly. Increased transparency to both patients and payers in the form of disclosure of physicians' financial interests is first step.

One example is physician ownership of hospitals. There is concern that physician ownership of hospitals leads to cherry-picking the patients who are healthiest and most able to pay, while leaving the patients who are sickest and least able to pay for community hospitals to treat, often without much compensation, if any. This cherry-picking only exacerbates the cost shifting to those Americans with insurance. This concern is heightened by the fact that the patient often is unaware of a physician's financial interest in providing services at a hospital in which he or she has an ownership interest.

Physician-owned hospitals are often smaller and more specialized than community hospitals. They tend to focus on lucrative lines of service. Community hospitals, on the other hand, tend to provide all service lines, including emergency departments. Community hospitals find it difficult to compete with their more cash-rich physician-owned counterparts. Over time, the trend of increasing physician ownership of hospitals jeopardizes the continued viability of community hospitals.

The issue of self-referral must be reviewed in light of how health care is and will be delivered. No serious effort at reform can ignore the potential gaming that financial conflicts may create.

Cost and Quality Transparency. Rising health care costs have fueled an interest in greater public availability of price and quality information. Public reporting and transparency can aid patients in making more informed decisions about their treatment options. Such information could also spur providers to make improvements by benchmarking their performance against their peers. And health care price and quality information can be used by private health plans and public programs to reward quality and efficiency.

The demand for more transparent price and quality information has been driven primarily by employers and health plans.[31] But consumers believe they have much to gain from greater transparency, too. A recent survey, for example, found that 84 percent of Americans want hospitals, physicians, and pharmacies to publish their prices.[32] Additionally, 90 percent of health care consumers want to partner with their physician in making health care decisions, and more than 60 percent claim to have searched for information to help make health care decisions.[33]

Public programs have also embraced greater transparency. An August 2006 Executive Order directed Federal health programs — including the Federal Employees Health Benefit Program, Medicare, programs operated by the Indian Health Service, and TRICARE — to make quality and pricing information available to beneficiaries and enrollees by January 1, 2007.[34]

Pursuant to this order, and building on existing programs, Medicare currently posts hospital quality measures online at the Hospital Compare website. Hospital-specific process measures include those related to heart failure and heart attack care, pneumonia care, and surgical care improvement. Information is also available for risk-adjusted mortality rates and patient satisfaction. The Centers for Medicare and Medicaid Services (CMS) has also started making available comparative price information for common outpatient procedures, such as wrist fracture pinning, colonoscopy, and hernia repair.

While public availability of Medicare price information is novel and has been hailed as a first step, the information is based on an average, and it is not current or hospital-specific. In addition, the price and quality information is not linked, which undermines the value of any comparison by patients and beneficiaries.

At the state level, recent legislation has required public reporting of hospital retail charges. Most experts agree, however, that this information is too detailed and not meaningful, because it contains unit prices rather than episodes of care.[35] Trying to estimate a hospital stay based on charge data is "like shopping for a car by adding up the prices suppliers charge for all the nuts and bolts that go into one."[36]

The value and usefulness of cost and quality information may be limited by practical factors. Decisions about health care are often involuntary — made under emergency

EXHIBIT L

September 2012

GAO
Accountability * Integrity * Reliability

Highlights

Highlights of GAO-12-966, a report to congressional requesters

MEDICARE

Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions

Why GAO Did This Study

Medicare Part B expenditures—which include payment for advanced imaging services—are expected to continue growing at an unsustainable rate. Questions have been raised about self-referral's role in this growth. Self-referral occurs when a provider refers patients to entities in which the provider or the provider's family members have a financial interest. GAO was asked to examine the prevalence of advanced imaging self-referral and its effect on Medicare spending. This report examines (1) trends in the number of and expenditures for self-referred and non-self-referred advanced imaging services, (2) how provision of these services differs among providers on the basis of whether they self-refer, and (3) implications of self-referral for Medicare spending. GAO analyzed Medicare Part B claims data from 2004 through 2010 and interviewed officials from the Centers for Medicare & Medicaid Services (CMS) and other stakeholders. Because Medicare claims lack an indicator identifying self-referred services, GAO developed a claims-based methodology to identify self-referred services and expenditures and to characterize providers as self-referring or not.

What GAO Recommends

GAO recommends that CMS improve its ability to identify self-referral of advanced imaging services and address increases in these services. The Department of Health and Human Services, which oversees CMS, stated it would consider one recommendation, but did not concur with the others. GAO maintains CMS should monitor these self-referred services and ensure they are appropriate.

View GAO-12-966. For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

From 2004 through 2010, the number of self-referred and non-self-referred advanced imaging services—magnetic resonance imaging (MRI) and computed tomography (CT) services—both increased, with the larger increase among self-referred services. For example, the number of self-referred MRI services increased over this period by more than 80 percent, compared with an increase of 12 percent for non-self-referred MRI services. Likewise, the growth rate of expenditures for self-referred MRI and CT services was also higher than for non-self-referred MRI and CT services.

GAO's analysis showed that providers' referrals of MRI and CT services substantially increased the year after they began to self-refer—that is, they purchased or leased imaging equipment, or joined a group practice that already self-referred. Providers that began self-referring in 2009—referred to as switchers—increased MRI and CT referrals on average by about 67 percent in 2010 compared to 2008. In the case of MRIs, the average number of referrals switchers made increased from 25.1 in 2008 to 42.0 in 2010. In contrast, the average number of referrals made by providers who remained self-referrers or non-self-referrers declined during this period. This comparison suggests that the increase in the average number of referrals for switchers was not due to a general increase in the use of imaging services among all providers. GAO's examination of all providers that referred an MRI or CT service in 2010 showed that self-referring providers referred about two times as many of these services as providers who did not self-refer. Differences persisted after accounting for practice size, specialty, geography, or patient characteristics. These two analyses suggest that financial incentives for self-referring providers were likely a major factor driving the increase in referrals.

Change in Average Number of MRI Services Referred, 2008 and 2010

	Average 2008 referred MRI services	Average 2010 referred MRI services	Percentage change
Switchers	25.1	42.0	67.3
Non-self-referrers	20.6	19.2	-6.8
Self-referrers	47.0	45.4	-3.4

Source: GAO analysis of Medicare data.

Note: Pattern observed for MRI services was similar for CT services. GAO defines switchers as those providers that did not self-refer in 2007 or 2008, but did self-refer in 2009 and 2010.

GAO estimates that in 2010, providers who self-referred likely made 400,000 more referrals for advanced imaging services than they would have if they were not self-referring. These additional referrals cost Medicare about $109 million. To the extent that these additional referrals were unnecessary, they pose unacceptable risks for beneficiaries, particularly in the case of CT services, which involve the use of ionizing radiation that has been linked to an increased risk of developing cancer.

EXHIBIT M

HHS.gov U.S. Department of Health & Human Services

HHS FY 2017 Budget in Brief - CMS - Medicare

Centers for Medicare & Medicaid Services (CMS): Medicare

The Centers for Medicare & Medicaid Services ensures availability of effective, up-to-date health care coverage and promotes quality care for beneficiaries.

CMS Medicare Budget Overview

(Dollars in millions)

Current Law Outlays and Offsetting Receipts	2015	2016	2017	2017 +/- 2016
Benefits Spending (gross) /1	627,710	684,282	709,386	+25,105
Less: Premiums Paid Directly to Part D Plans /2	-8,520	-9,282	-11,132	-1,850
Subtotal, Benefits Net of Direct Part D Premium Payments	**619,190**	**675,000**	**698,255**	**+23,254**
Related Benefit Expenses /3	12,662	13,031	13,140	+109
Administration /4	8,593	8,940	9,346	+406
Total Outlays, Current Law	**640,445**	**696,971**	**720,741**	**+23,769**
Premiums and Offsetting Receipts	-94,218	-101,655	-111,199	-9,545
Current Law Outlays, Net of Offsetting Receipts	**546,228**	**595,317**	**609,541**	**+14,225**

For most institutional provider types, Medicare currently reimburses 65 percent of bad debts resulting from beneficiaries' non-payment of deductibles and coinsurance after providers have made reasonable efforts to collect the unpaid amounts. Starting in 2017, this proposal would reduce bad debt payments to 25 percent over 3 years for all providers who receive bad debt payments. This proposal will more closely align Medicare policy with private payers, who do not typically reimburse for bad debt. [$32.9 billion in savings over 10 years]

Encourage Workforce Development Through Targeted and More Accurate Indirect Medical Education Payment

The Medicare Payment Advisory Commission has found that existing Medicare add-on payments to teaching hospitals for the indirect costs of medical education significantly exceed the actual added patient care costs these hospitals incur. This proposal will partially correct this imbalance by reducing these payments by 10 percent, beginning in 2017. In addition, the Secretary will be granted the authority to set standards for teaching hospitals receiving Graduate Medical Education payments to encourage resident training in areas of emerging need, such as primary care and medication-assisted treatment of substance use disorders, and emphasize skills that promote high-quality, high-value health care. [$17.8 billion in savings over 10 years]

Reform Medicare Hospice Payments

CMS has taken steps to improve the accuracy of hospice benefit payments, but there are additional opportunities for improvement. This proposal reduces market basket updates for hospice providers by 1.7 percent in 2018, 2019, and 2020 as a first step toward aligning payment with costs of care. Payment updates for providers would not drop below zero as a result of this proposal. This proposal also permits the Secretary to implement a hospice-specific market basket by 2021. Currently, the hospice market basket is based on the hospital market basket, despite differences in the type of service provided (palliative vs. curative), the care setting (at home vs. inpatient), and the labor force utilized. Finally, this proposal permits the Secretary to make further budget neutral reforms to the hospice payment system. [$9.3 billion in savings over 10 years]

Exclude Certain Services from the In-Office Ancillary Services Exception

The in-office ancillary services exception to the physician self-referral law was intended to allow physicians to self-refer for certain services to be furnished by their group practices for patient convenience. While there are many appropriate uses for this exception, certain services, such as advanced imaging and outpatient therapy, are rarely furnished on the same day as the related physician office visit. Additionally, there is evidence that suggests that this exception may have resulted in overutilization and rapid growth of certain services. Effective calendar year 2018, this proposal seeks to encourage more appropriate use of ancillary services by amending the in-office ancillary services

exception to prohibit certain referrals for radiation therapy, therapy services, advanced imaging, and anatomic pathology services except in cases where a practice is clinically integrated and required to demonstrate cost containment, as defined by the Secretary. [$5.0 billion in savings over 10 years]

Provide Authority to Expand Competitive Bidding for Certain Durable Medical Equipment

Since implementation, the Competitive Bidding Program for durable medical equipment, prosthetics, and supplies has saved the Medicare program and beneficiaries billions of dollars by aligning payment amounts with market-based prices. Currently this program is restricted to certain categories of equipment, supplies and services. This proposal expands the competitive bidding program to additional categories, including: inhalation drugs, all prosthetics and orthotics, and ostomy, tracheostomy, and urological supplies. [$3.8 billion in savings over 10 years]

Encourage Appropriate Use of Inpatient Rehabilitation Facilities

This proposal adjusts the standard for classifying a facility as an Inpatient Rehabilitation Facility. Under current law, at least 60 percent of patient cases admitted to an Inpatient Rehabilitation Facility must meet 1 or more of 13 designated severity conditions. This standard was changed to 60 percent from 75 percent in the Medicare, Medicaid, and SCHIP Extension Act of 2007. Beginning in 2017, this proposal reinstitutes the 75 percent standard to ensure that health facilities are classified appropriately based on the patients they serve. [$2.2 billion in savings over 10 years]

Reduce Critical Access Hospital Reimbursements from 101 Percent of Reasonable Costs to 100 Percent of Reasonable Costs

Critical Access Hospitals are generally small, rural hospitals that provide their communities with access to basic emergency and inpatient care. Critical Access Hospitals receive enhanced cost-based Medicare payments (rather than the fixed-fee payments most hospitals receive). Medicare currently pays Critical Access Hospitals 101 percent of reasonable costs. This proposal reduces this rate to 100 percent beginning in 2017. [$1.7 billion in savings over 10 years]

Prohibit Critical Access Hospital Designation for Facilities that are Less Than 10 Miles from the Nearest Hospital

Beginning in 2017, this proposal prevents facilities that are within 10 miles of another hospital from maintaining designation as a critical access hospital and receiving the enhanced rate. These facilities will instead be paid under the applicable prospective payment system. [$880 million in savings over 10 years]

Allow the Secretary to Determine Hospital Acquired Condition Reduction Program Penalty Amounts and Distribution

Greer, Leslie

From: Fernandes, David
Sent: Tuesday, September 20, 2016 2:13 PM
To: Karen Wackerman (kwackerman@Jeffers-Law.com); Michele Volpe (mmv@bvmlaw.com); Kathleen Gedney (kgg@bvmlaw.com); Patrick J. Monahan II (pmonahan@pppclaw.com); Jennifer Groves Fusco (jfusco@uks.com)
Cc: Riggott, Kaila; Veyberman, Alla; Lazarus, Steven; Greer, Leslie; User, OHCA
Subject: 16-32063 and 16-32093 Close of Combined Hearing
Attachments: 16-32093 Close of Public Hearing.pdf; 16-32063 Close of Public Hearing.pdf

Good Afternoon,

Attached please find official notice of the closure of the public hearing held on August 30, 2016.

If you have any questions, please do not hesitate to contact me.

Have a great day.

David Fernandes
Planning Analyst (CCT)
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

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

September 20, 2016

VIA EMAIL ONLY

Michele M. Volpe, Esq.
Bershtein, Volpe & McKeon, P.C.
105 Court Street
New Haven, CT 06511

RE: Certificate of Need Application Docket Number: 16-32063-CON
Orthopaedic & Neurosurgery Specialists, P. C.
Acquisition of Magnetic Resonance Imaging Scanner
Closure of Public Hearing

Dear Attorney Volpe:

Please be advised, by way of this letter, the public hearing held on August 30, 2016, in the above referenced matter is hereby closed as of September 20, 2016. OHCA will receive no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact Alla Veyberman at (860) 418-7007 or Steven W. Lazarus at (860) 418-7012.

Sincerely,

Kevin T. Hansted
Hearing Officer

KTH: swl, df, av

Connecticut Department of Public Health

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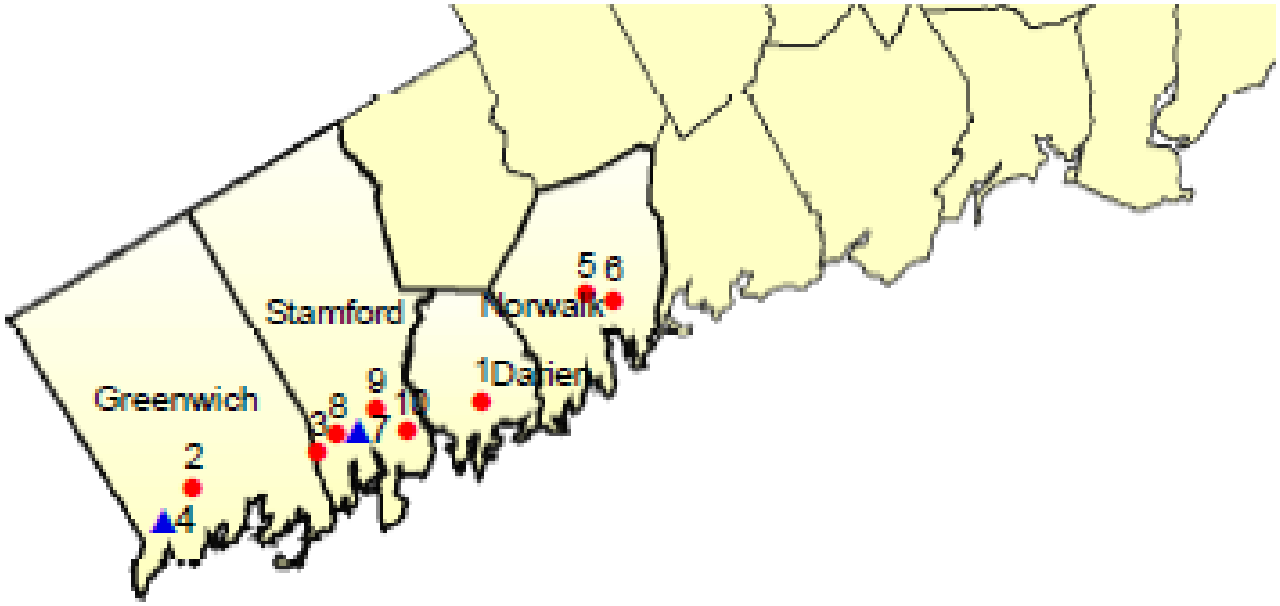
Affirmative Action/Equal Opportunity Employer

OHCA Exhibit

ID	MRI FACILITY	MRI TYPE	TOTAL SCANS FY 14	Distance from Stamford Advance Radiology Center	Distance from Greenwich ONS Practice
1	Darien Imaging Center	1.5 tesla	1,827	5.0 miles	10.8 miles
2	Greenwich Hospital	1.5 tesla 3.0 tesla	4,693 3,128	7.5 miles	1.6 miles
3	Greenwich Hospital Diagnostic Center	1.5 tesla	1,991	1.9 miles	5.9 miles
4	**Orthopedic Neurosurgical Specialist**	**1.5 tesla**	**4,800**	**7.7 miles**	**-------**
5	Norwalk Hospital	1.5 tesla	3,174	9.2 miles	15.1 miles
6	Norwalk Hospital Radiology & Mammography Center	1.5 tesla(2) & .7 tesla	9,797	9.7 miles	15.6 miles
7	**Stamford Advance Radiology Center**	**1.5 tesla**	**6,705**	**-------**	**7.7 miles**
8	Stamford Hospital	1.5 tesla	6,427	0.8 miles	6.8 miles
9	Tully Health Center	1.5 tesla	4,360	0.9 miles	8.3 miles
10	Hospital for Special Surgery *	1.5 tesla	1,981	2.2 miles	8.8 miles

Source: Statewide Healthcare Facilities and Services Inventory-2014

**Hospital for Special Surgery figure includes scans from February 2015 through January 2016*



Greer, Leslie

From: Greer, Leslie
Sent: Thursday, November 17, 2016 10:15 AM
To: michelemvolpe@aol.com; Jennifer Groves Fusco (jfusco@uks.com); Stephen Cowherd (SCowherd@jeffers-law.com)
Cc: Veyberman, Alla; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: Orthopedic & Neurosurgery Specialists, PC Proposed Final Decision
Attachments: 32063 Final Decision.pdf

Tracking:

Recipient	Delivery	Read
michelemvolpe@aol.com		
Jennifer Groves Fusco (jfusco@uks.com)		
Stephen Cowherd (SCowherd@jeffers-law.com)		
Veyberman, Alla	Delivered: 11/17/2016 10:16 AM	Read: 11/17/2016 10:16 AM
Riggott, Kaila	Delivered: 11/17/2016 10:16 AM	Read: 11/17/2016 10:43 AM
Hansted, Kevin	Delivered: 11/17/2016 10:16 AM	
Martone, Kim	Delivered: 11/17/2016 10:16 AM	

Attached is Orthopedic & Neurosurgery Specialists, PC.'s Proposed Final Decision for acquisition of a Magnetic Resonance Imaging Scanner.

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

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Proposed Final Decision

Applicant: **Orthopedic & Neurosurgery Specialists, PC**
6 Greenwich Office Park
Greenwich, CT 06831

Docket Number: **16-32063-CON**

Project Title: **Acquisition of a Magnetic Resonance Imaging Scanner**

Project Description: Orthopedic & Neurosurgery Specialists, PC ("ONS" or "Applicant") is proposing to acquire and operate a new 1.5 Tesla magnetic resonance imaging ("MRI") scanner to be located at 6 Greenwich Office Park, Greenwich, Connecticut at an associated capital cost of $1,500,337.

Procedural History: The Applicant published notice of its intent to file a Certificate of Need ("CON") application in *The Greenwich Time* and *The Advocate* (Stamford) on December 9, 10 and 11, 2015. On January 21, 2016, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project and deemed the application complete on June 10, 2016.

On August 5, 2016, the Applicant was notified of the date, time, and place of the public hearing. On August 8, 2016, a notice to the public announcing the hearing was published in the *The Advocate*. Commissioner Pino designated Attorney Kevin T. Hansted as the hearing officer in this matter. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a (f)(2), a public hearing regarding the CON application was held on August 30, 2016.

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Affirmative Action/Equal Opportunity Employer

On August 25, 2016, Advanced Radiology Consultants, LLC ("ARC") filed a petition requesting intervenor status. ARC was granted intervenor status with full rights in this matter on August 29, 2016.

By petition dated August 25, 2016, The Stamford Hospital requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Stamford Hospital was granted intervenor status with limited rights of cross-examination on August 29, 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) and the Hearing Officer heard testimony from witnesses for the Applicant and the Intervenors.

The public hearing record was closed on September 20, 2016.

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, November 17, 2016 10:15 AM
To: michelemvolpe@aol.com; Jennifer Groves Fusco (jfusco@uks.com); Stephen Cowherd (SCowherd@jeffers-law.com)
Cc: Veyberman, Alla; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: Orthopedic & Neurosurgery Specialists, PC Proposed Final Decision
Attachments: 32063 Final Decision.pdf

Tracking:

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Attached is Orthopedic & Neurosurgery Specialists, PC.'s Proposed Final Decision for acquisition of a Magnetic Resonance Imaging Scanner.

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Findings of Fact and Conclusions of Law

1. Orthopedic & Neurosurgery Specialists, PC ("ONS" or "Applicant") is a private physician practice with offices at 6 Greenwich Office Park, Greenwich, Connecticut and 5 High Ridge Road, Stamford, Connecticut. Ex. A, p. 14

2. ONS provides comprehensive, integrated physician and medical services in orthopedics, neurosurgery, sports medicine and physical therapy specialties. Ex. A, p. 14

3. On November 4, 2008, ONS received OHCA approval (Docket Number 08-31120-CON) to operate a fixed 1.5 Tesla (1.5T) Magnetom Espree Open Bore MRI scanner at its practice located at 6 Greenwich Office Park, Greenwich. Ex. A, p. 14

4. ONS proposes to obtain a second MRI scanner ("Proposed Scanner") for the Greenwich office. The proposed scanner, a Siemens Aera 1.5T MRI, will have the same strength and capability as the existing scanner. Ex. A, pp. 13-15

5. The proposed scanner offers various types of scans including orthopedic, arthrogram, spine, head, neck, chest and angiography. Ex. A, pp. 14, 15

6. ONS provides MRI services to patients who are under the direct care of ONS physicians. Ex. A, pp. 14, 20

7. ONS has extended its hours of operation to 86 hours per week including weeknights and both weekend days. Ex. A, p. 14, Ex. C, pp. 85-86

8. ONS contracts with Greenwich Radiology to provide professional radiological services, including review and interpretation of all MRI scans. ONS bills for all MRI services. Ex. A, p. 14.

9. ONS currently serves patients from Connecticut and New York towns. In 2015, 57% of scans were performed on persons residing within the Connecticut primary service area towns of: Greenwich, Stamford, Darien, New Canaan and Norwalk. Ex. A, p. 30

10. Based on time slot availability[1], in 2014 and 2015, the existing scanner had an average utilization of 91% and 92%, respectively[2]. Ex. A, p. 17, Ex. C, pp. 85-86

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[1] ONS offers approximately 21 slots each day, Monday-Friday, 15 slots on Saturday and 8 on Sunday (128 slots per week). Each slot is 40 minutes long. In 2014 and 2015, 6,276 and 6,300 slots were available, and 5,719 and 5,813 were used, respectively. Due to the nature of different types of scans, some scans might require more than one time slot.
ONS hours of operations are as follows: Monday-Friday 7am-9pm, Saturday 7am-5pm and Sunday 7am-1pm. Ex. C, pp. 85-86

[2] The 2012 Statewide Health Care Facilities and Services Plan established capacity guidelines indicating the possible need for an additional MRI scanner if 85% capacity is exceeded, however these guidelines have not been formally adopted into regulation.

11. The table below shows historical utilization for the existing scanner:

TABLE 1
UTILIZATION BY FISCAL YEAR*

Scan Type:	2012	2013	% change	2014	% change	2015	% change
Orthopedic	2,557	2,669	4%	2,991	12%	2,911	-3%
Neurologic	2,008	2,131	1%	2,198	3%	2,351	7%
Total Number of Scans	**4,565**	**4,800**	**5%**	**5,189**	**8%**	**5,262**	**1%**

*Applicant's fiscal year is January 1 to December 31.
\Ex. A, pp. 80, 82; Ex. C, pp. 85-86 and Ex. E, p. 94

12. The Applicant states that it has some available capacity to conduct MRI scans. Exhibit X, Transcript, Testimony of Dr. Mark Camel, Vice President of ONS, pp. 74-75

13. As shown in the table below, the Applicant projects a 22% increase in utilization during the first year after acquiring the proposed MRI.

TABLE 2
PROJECTED NUMBER OF SCANS BY FISCAL YEAR*

Scanner	2016	% change	2017**	% change	2018	% change	2019	% change
Existing	5,474		3,338		3,471		3,515	
Proposed	0		3,337		3,471		3,514	
Total	**5,474**	**4%**	**6,675**	**22%**	**6,942**	**4%**	**7,029**	**1%**

*Applicant's fiscal year is January 1 to December 31.
**The proposed MRI would become operational in 2017
Note: Projection is based on the Applicants 267 scans per physician.
Ex. A, p. 82 and Ex. C, p. 91

14. ONS had 19 physicians in 2012 and had expanded to 23 physicians by 2015. ONS projects growth by up to three physicians per year and having 27 physicians by 2019.

TABLE 3
SCANS PER PHYSICIAN BY FISCAL YEAR*

Description	2012	2013	2014	2015	2016
Number of Scans	4,565	4,800	5,189	5,262	5,474
Number of Physicians	19	21	21	23	26
Scans per Physician	240	229	247	229	211

*Applicant's fiscal year is January 1 to December 31.
Ex. A, p. 14; Ex. C, p.85; Ex. E, p. 94

15. Dr. Camel testified that it takes approximately 18 months for a new physician in the practice to operate at 90 to 100% of full patient case load. Exhibit X, Transcript, p. 79; Ex. E, p. 94.

16. ONS claims that it would realize a 1,200, or 22%, increase in volume in the first year the proposed scanner is operational. The Applicant based the increase in volume on the assumption of each physician performing 267 scans. Exhibit X, Transcript, Dr. Mark Camel, pp. 74-96

17. The table below shows the number of ONS patients requiring MRI scans in 2015 and who performed those scans.

TABLE 4
2015 PATIENT AND SCANS STATISTICS

Total # of ONS Patients	# of MRI Scans Required	# of MRI Scans Performed by ONS	# of MRI Scans Performed by Another Provider
51,597	6,769	5,262	1,507

Ex. O, p.31, Exhibit X, Transcript, Dr. Mark Camel, p. 22.

18. ONS states that it does not have data regarding reasons why its patients would have an MRI scan done by another provider. Exhibit X, Transcript Dr. Mark Camel pp. 72-75

19. The Applicant did state however, that its patients may opt for MRI scans by providers other than ONS when ONS' scanner type is clinically contraindicated, for insurance reasons, the availability of providers closer to a patient's home or a number of other reasons. Exhibit X, Transcript Dr. Mark Camel pp. 72-75

20. ONS states that for certain head injury patients, it is best to perform scans on a 3T scanner that can provide diffusion tensor imaging[3], which is not possible on a 1.5T scanner, such as the proposed scanner. Exhibit X, Transcript, Dr. Mark Camel, pp. 22, 59. Testimony of Dr. Scott Sullivan, Neuroradiologist of ONS, p. 59

21. In addition to head injury patients, patients with embedded hardware, patients who require diffusion tensor imaging or patients who cannot handle a longer duration scan may also require scans performed on a 3T scanner. Ex. O, p. 31

22. From 2012 through 2016 year-to-date, 366 ONS patients received MRI scans at ARC. Ex. X, Transcript, p. 50

[3] Diffusion tensor imaging is a method that provides a description of the diffusion of water through tissue, and can be used to highlight structural changes in tissue tracts. Johns Hopkins Medicine, *Diffusion Tensor Imaging (DTI),* available at http://www.hopkinsmedicine.org/psychiatry/research/neuroimaging/

23. There are nine MRI providers operating in ONS' service area that accept Medicaid. They are all located between 1.6 and 15.6 miles from the ONS Greenwich location.

TABLE 5
EXISTING PROVIDERS

ID	MRI FACILITY	TESLA STRENGTH	TOTAL SCANS 2014	Distance from ONS Practice
1	Darien Imaging Center	1.5	1,827	10.8 miles
2	Greenwich Hospital	1.5	4,693	1.6 miles
		3	3,128	
3	Greenwich Hospital Diagnostic Center	1.5	1,991	5.9 miles
4	ONS	1.5	4,800	-------
5	Norwalk Hospital	1.5	3,174	15.1 miles
6	Norwalk Hospital Radiology & Mammography Center	1.5 (2) & .7	9,797	15.6 miles
7	Stamford Advance Radiology Center	1.5	6,705	7.7 miles
8	Stamford Hospital	1.5	6,427	6.8 miles
9	Tully Health Center	1.5	4,360	8.3 miles
10	Hospital for Special Surgery *	1.5	1,981	8.8 miles

*Hospital for Special Surgery figure includes scans from February 2015 through January 2016 Source: *Statewide Healthcare Facilities and Services Inventory-2014*, Exhibit AA
http://www.huskyhealthct.org/provider_lookup.html

24. The Applicant claims that nearly all MRI providers in the service area are operating at capacity. Ex. O, p. 23

25. Six out of nine providers have some capacity. Greenwich Hospital is operating at 80% of its capacity, Norwalk Hospital is at 79%, Norwalk Hospital Radiology & Mammography Center is, among its three scanners, operating at 82% capacity. Two other providers within an 11 mile radius of ONS each have 50% or more available capacity. Ex O, p. 34

26. The Applicant does not anticipate any changes to the clinical services it offers. Ex. A, p. 20

27. The Applicant claims that quality and accessibility will be improved because "more ONS patients will be able to receive MRI scans at their physician's office and thus benefit from the enhanced communication and coordination that physician-based in-office imaging provides." Ex. O, p. 14

28. ONS will continue to be the sole referral source for the proposed scanner. Ex. A, p. 27

29. According to *The Practice of Imaging Self-Referral Doesn't Produce One-Stop Service,* self-referring entities provided same-day MRI imaging in only 15% of those cases studied. Ex. P, pp. 101-102

30. In an analysis of 65,517 "episodes of outpatient care," according to the *New England Journal of Medicine*, self-referring physicians obtain imaging examinations 4 to 4.5 times more often than radiologist-referring physicians. Ex. P, p. 71

31. In its 2012 study, the Government Accountability Office's review of Medicaid payments for scans found that self-referring providers refer patients for about two times as many scans as providers who do not self-refer. Ex Y, p. 6; Ex. P, p. 90; Ex. X, Transcript, Dr. Alan Kaye, Former CEO of ARC p. 37

32. Dr. Alan D. Kaye criticized the practice of self-referrals, stating that there is a "financial incentive to maximize referrals to the scanner." He additionally highlights the $1.5 million cost of ONS' proposed additional scanner and the 1,071 scans that ONS would need to perform during the first year of operations to break-even financially. Ex. P, p. 65

33. In addition, Dr. Kaye stated that private radiology practices, which only perform examinations referred by non-affiliated providers, "make MRI referrals for one reason only, their need for information to take care of their patients…" Ex. P, p. 65

34. ONS does not have a written charity care policy or sliding fee scale. The Applicant states that it is "available to work one on one with patients who may be unable to pay part or all of the bill for any reason, including but not limited to insurance status or financial status...ONS will try and accommodate that patient and that patient's financial needs," however, the applicant has not provided any MRI services to the Medicaid population. Ex. A, p. 22; Ex. C, p. 86; Ex. D, p.94; Exhibit X, Transcript Dr. Mark Camel, pp. 65-66

35. The Applicant's payer mix will remain unchanged as a result of this proposal.

TABLE 6
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	FY 2015		Projected by Fiscal Year							
			2016		2017		2018		2019	
	Scans	%	Scans	%	Scans	%	Scans	%	Scans	%
Medicare	1,240	24%	1,294	24%	1,578	24%	1,642	24%	1,662	24%
Medicaid	0		0		0		0		0	
CHAMPUS & TriCare	1	>1%	1	>1%	1	>1%	1	>1%	1	>1%
NY Gov*	148	3%	154	3%	188	3%	196	3%	199	3%
Total Government	**1,389**	**26%**	1,450	**26%**	1,768	**26%**	1,839	**26%**	1,862	**26%**
Commercial Insurers	3,712	71%	3,875	71%	4,725	71%	4,914	71%	4,976	71%
Uninsured/ Self Pay	16	>1%	17	>1%	20	>1%	21	>1%	21	>1%
Private Pay	15	>1%	16	>1%	19	>1%	20	>1%	20	>1%
Workers Compensation	112	2%	117	2%	143	2%	148	2%	150	2%
Total Non-Government	**3,855**	**73%**	**4,024**	**73%**	**4,907**	**73%**	**5,103**	**73%**	**5,167**	**73%**
Total Payer Mix	**5,244**	**100%**	**5,474**	**100%**	**6,675**	**100%**	**6,942**	**100%**	**7,029**	**100%**

* New York State's employees covered by United/Oxford insurance contract
Note: Numbers may not add up due to rounding.
Ex. A, p. 33, Ex. C, p. 87

36. According to the Applicant, there is not an appreciable population of Medicaid beneficiaries in the service area, citing the Hospital for Special Surgery in Stamford's outreach efforts that resulted in only 1.9% of its MRI scans paid for by Medicaid. Ex. O, p. 16

37. GE's *Market At-a-Glance Report*, commissioned by ARC, projects that the Medicaid population in greater Stamford area[4] is expected to grow by 14% over the next five years. Ex. P, p. 28

38. According to ARC, it provided 79 scans to ONS patients in FY2015 and estimates it will, based on the year-to-date data, provide 110 scans in FY2016. It states that the majority of these patients were commercial payees, and were it to lose these referrals, its payer mix would further skew toward Medicaid and other governmental payers, which tend to reimburse approximately 50% compared to commercial payors. Ex. P, pp. 6-7

39. Ruth Cardiello, The Stamford Hospital's Vice President for Enterprise Risk Management, states that, as a "closed model" MRI provider, ONS has been able to "insulate itself from serving the large number of Medicaid and indigent patients, while hospitals such as The Stamford Hospital as well as the other established MRI providers in the Stamford, Darien

[4] The study looked at the following zip codes: 06612, 06807, 06820, 06830, 06831, 06840, 06850, 06851, 06853, 06854, 06855, 06870, 06878, 06880, 06883, 06896, 06897, 06901, 06902, 06903, 06905, 06906, 06907, 10576.

and Norwalk area take referrals from outside their own organizations and accept such patients. Ex. Q, p. 9

40. Mrs. Cardiello testified that adding another MRI in the Stamford area with a provider that does not accept Medicaid patients will "dilute the pool of commercially insured as well as Medicare patients" and would "add unnecessary cost to the health care delivery system and weaken rather than strengthen its financial health". Exhibit X, Testimony of Stamford Hospital VP Ruth Cardiello. pp. 41-42, Ex. R, pp. 3, 4-5

41. Since the Applicant does not currently provide, and is not projecting to provide, services to the Medicaid population, this proposal will not impact access by Medicaid recipients or indigent persons and as such will not reduce access to services by Medicaid recipients. Ex. A, p. 22

42. ONS does not charge facility fees. No change in billing or pricing is anticipated with the addition of the proposed scanner. Ex. A, p. 23

43. The Applicant will be leasing the proposed scanner from Siemens Corporation under a 60-month contract for $1,250,337. The lease payments will be paid by revenue from operations. The construction cost will be funded by the Applicant's existing line of credit with the bank serving the practice. Ex. A, pp. 23, 24

44. The proposal's total capital expenditure is shown below:

TABLE 7
TOTAL PROPOSED CAPITAL EXPENDITURE

Description	Cost
MRI scanner lease	$1,250,337
Leasehold improvements to accommodate the MRI	250,000
Total Cost	$1,500,337

Ex. A, p. 26

45. The Applicant projects an incremental increase in operating expenses but an overall gain from operations in each of the first three years following the proposed equipment acquisition.

TABLE 8
PROJECTED INCREMENTAL REVENUES AND EXPENSES

Description	FY 2017	FY 2018	FY 2019
Revenue from Operations	$1,584,305	$1,814,561	$1,880,427
Total Operating Expenses	$1,271,794	$1,334,800	$1,361,803
Gain/Loss from Operations	$ 312,512	$ 479,761	$518,624

Ex. A, p. 77, Ex. C, pp. 92-93

46. 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))

47. This CON application is not consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

48. The Applicant has not sufficiently demonstrated that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

49. The Applicant has demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

50. The Applicant has not sufficiently demonstrated that the proposal will improve the accessibility, quality or cost effectiveness of health care delivery in the region. (Conn. Gen. Stat.§ 19a-639(a)(5))

51. The Applicant has demonstrated that there would be no adverse change in the provision of health care services to the relevant population and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6))

52. The Applicant has not satisfactorily identified the population to be served by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7))

53. The Applicant's historical provision of treatment in the area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

54. The Applicant has not 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))

55. The Applicant has demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10))

56. The Applicant has 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))

57. The Applicant has 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 Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

The Applicant, Orthopaedic & Neurosurgery Specialists, P. C. ("ONS"), is a private physician practice with offices in Greenwich and Stamford. *FF1.* ONS provides comprehensive, integrated physician and medical services in the specialties of orthopedics, neurosurgery, sports medicine and physical therapy. *FF2.* The Applicant currently operates a 1.5T MRI scanner at its Greenwich office. *FF3.* ONS' practice has continued to grow and in order to accommodate the needs of its patients, ONS has extended its hours of operation to 86 hours per week, including nights and weekends. *FF7.*

The Applicant is seeking authorization to acquire a second 1.5T MRI scanner for its Greenwich office. *FF4.* ONS' proposal is based upon its assertion that a new MRI scanner would provide access to patients in a more efficient and timely manner while allowing for greater flexibility in patient scheduling.

The Applicant has not satisfactorily demonstrated that it has considered the utilization of existing providers

The Applicant acknowledges that the number of scans ordered will always be greater than the number of scans actually performed at ONS. ONS states that even though they do not track the reason why patients go to another MRI provider, in general it is based on a combination of different factors such as a scanner's required strength, insurance requirement or a patient's preference. *FF17-18.* In 2015, approximately 22% of scans required for ONS patients were performed at another provider's office. *FF17.* ARC testified that from 2012 through 2016 year-to-date, 366 ONS patients had their scans performed at ARC. *FF22.*

There are 13 MRI scanners (including ONS') that operate in the Applicant's service area. *FF23.* Two providers are within 10 miles of ONS, both with 50% or more available capacity. *FF23, 25.* Greenwich Hospital is operating at 80% of its capacity, Norwalk Hospital is at 79%, Norwalk Hospital Radiology & Mammography Center is, among its three scanners, operating at 82% capacity. *FF25.* This suggests that ONS' patients have access within ONS' service area to meet their imaging needs.

Additionally, unlike ONS, other area providers, including ARC, accept Medicaid. According to ARC, it provided 79 scans to ONS patients in FY2015 and estimates it will, based on the year-to-date data, provide 110 scans in FY2016. It states that the majority of these patients were commercial payees, and were it to lose these referrals, its payer mix would further skew toward Medicaid and other governmental payers, which tend to reimburse approximately 50% compared to commercial payors. *FF38.*

The Stamford Hospital has expressed similar concerns. Ruth Cardiello, The Stamford Hospital's Vice President for Enterprise Risk Management, stated that, as a "closed model" MRI provider, ONS has been able to "insulate itself from serving the large number of Medicaid and indigent patients, while hospitals such as The Stamford Hospital as well as the other established MRI providers in the Stamford, Darien and Norwalk area take referrals from outside their own organizations and accept Medicaid and indigent patients. *FF39.*

The Applicant has provided an insufficient basis for its projected patient population and utilization

ONS states that expanding the number of physicians in the practice increases demand for MRI scans. ONS had 19 physicians in 2012 generating 4,565 scans, and expanded to 23 by 2015, generating 5,262 scans. ONS plans to continue to grow by up to three physicians per year and projects having 27 physicians by 2019. *FF14.*

The Applicant projects it will perform an estimated 6,675 scans in FY2017, the first year during which the proposed MRI would be in operation. This represents an additional 1,201 scans over FY2016—or a 22% increase in volume during its first year. Prior year-to-year increases ranged from 1.06% to 8.1%. *FF13, 16.* The Applicant claimed this significant increase was based on the average number of scans performed per physician and the expected addition of physicians employed by ONS.

The Applicant's estimates, however, are not sufficiently founded in the historical data provided and conflicts with other assumptions it asserted. It stated that it expected each physician to generate 267 scans. According to the Applicant, it employed 19 physicians in 2012, increasing to 23 in 2015. Assuming the data provided by the Applicant is accurate, each physician would have generated an average of 240 scans in 2012, declining to 229 in 2015. *FF14.* The assumption of 267 scans per physician in FY2017 was not adequately explained or supported by the evidence put forth.

Furthermore, the Applicant's calculations purporting a direct increase in volume with the hiring of additional physicians seems to contradict statements made elsewhere. The Applicant states that it takes eighteen months for new physicians to develop a patient base and associated MRI volume. *FF15.* Based on that assertion, it is unclear whether new physicians recruited in 2016 would yield the immediate and dramatic increase in the number of MRIs generated in 2017 as projected by the Applicant.

The Applicant's analysis and assumptions of potential ONS growth and projected 267 scans per physician fail to support the estimated 1,200 scans or 22% increase in volume in the first year of the proposed scanner's operation. *FF16.* As such, the Applicant has not adequately identified its patient population to be served.

The Applicant has not shown the proposal will improve access to or quality and cost of care

The Applicant stresses that the additional scanner will help address capacity issues in lower Fairfield County. *FF24.* However, the proposed scanner will provide imaging services only to

patients who are under the direct care of ONS physicians, and therefore overall access or health care outcomes for Fairfield County patients will not improve as a result of this proposal.

According to *The Practice of Imaging Self-Referral Doesn't Produce One-Stop Service,* self-referring entities provided same-day MRI imaging in only 15% of those cases studied. *FF29.* As such, patients will likely be required to make multiple trips, regardless of whether an additional MRI is located in the physician's office. Additionally, ONS does not interpret images in-house and contracts with Greenwich Radiology to provide this, among other, services. *FF8.* Just as would occur if a patient received scans at an off-site radiology office, there is an additional party involved in performing and interpreting a patient's results, undermining claims that patients will benefit from enhanced communication.

Although the cost of performing an MRI at a non-hospital location may be less than at a hospital, evidence suggests that the practice of self-referring patients for scans may result in inflating the number of MRIs performed. *FF30.* In an analysis of 65,517 "episodes of outpatient care," according to the New England Journal of Medicine, self-referring physicians obtained imaging examinations 4 to 4.5 times more often than radiologist-referring physicians. *FF30.* In its 2012 study, the Government Accountability Office's review of Medicaid payments for scans found that self-referring providers referred patients for about two times as many scans as providers who did not self-refer. *FF31.*

Dr. Alan D. Kaye, former CEO of ARC, echoed this concern, stating there is a "financial incentive to maximize referrals to the scanner" and highlighted the $1.5 million cost of the additional scanner and the 1,071 scans that would need to be performed during the first year of operations to break-even. *FF32.* He compared this with private radiology practices which "only perform examinations referred by non-affiliated providers," and stated "providers make MRI referrals for one reason only, their need for information to take care of their patients…" *FF33.*

The quality of care afforded to ONS' patients is also unlikely to be improved. The proposed scanner is the same strength and capability of the existing MRI and henceforth no improvement in quality of care will be achieved.

Based on the existence of multiple other area providers that accept Medicaid patients, have more comprehensive charity care policies and are not self-referral based, the Applicant has not adequately demonstrated there is a clear public need for the proposal

ONS stated that it does not accept Medicaid and has no written charity care or sliding scale policy *FF34.* Instead the Applicant is "available to work one on one with patients who may be unable to pay part or all of the bill for any reason, including but not limited to insurance status or financial status...ONS will try and accommodate that patient and that patient's financial needs" *FF34.*

As stated above, there are multiple existing MRI providers in the service area that accept Medicaid patients. *FF23.* Adding an additional MRI that does not provide services to this population will raise the risk of diluting the pool of commercially-insured and Medicare

population payor mix and may have a negative impact on the financial strength of the imaging providers in lower Fairfield County. *FF439-40.*

Furthermore, there is a discrepancy as to the extent of the need for Medicaid-participating providers. According to the Applicant, there is not an appreciable population of Medicaid beneficiaries, citing the Hospital for Special Surgery in Stamford's outreach efforts that resulted in only 1.9% of its MRI scans paid for by Medicaid *FF36.* However, GE's *Market At-a-Glance Report*, commissioned by ARC, projects that the Medicaid population in the Stamford area is expected to grow by 14% over the next five years. *FF37.* Regardless of the ultimate need for Medicaid approved health care providers, Conn. Gen. Stat. § 19a-639(10) requires applicants that "fail to provide . . . services to Medicaid recipients," must demonstrate "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." The Applicant has not shown good cause for failing to provide MRI services to Medicaid patients.

Based on the aforementioned, the Applicant failed to demonstrate how this proposal would improve accessibility, quality or cost effectiveness of health care delivery in the region. OHCA's decision on the acquisition of an MRI is based, in part, on the demonstrated need for the acquisition, not whether an MRI will provide more convenient access for their patients or allow greater flexibility in scheduling. After considering all of the factors listed above, OHCA concludes that the Applicant also failed to demonstrate clear public need for its proposal.

The Applicant has shown that the proposal is financially feasible

The Applicant projects incremental gains from operations in each of the first three fiscal years following the proposed equipment acquisition. *FF45.* The proposed acquisition will be funded from the Applicant's operational cash. *FF43.* Although the Applicant has provided an insufficient basis for its projected MRI volume growth, OHCA finds that the Applicant overall has adequate funds to finance this proposal. Therefore, OHCA finds the proposal financially feasible.

The proposal does not meet the goals of the Statewide Health Care Facilities and Services Plans standards and guidelines pertaining to MRI

The 2012 Standards and Guidelines pertinent to the acquisition of an MRI indicate that the "ability of the applicant to serve an underserved population and not jeopardize the financial viability of the project" should be considered. Additionally the applicant "shall not deny MRI scanner services to any individual based upon the ability to pay or the source of payment, including uninsured, underinsured and Medicaid patients."

As stated above, ONS does not accept Medicaid as a form of payment. Furthermore, it has no written charity care or sliding scale policy, suggesting that self-pay and Medicaid patients would need to seek scans elsewhere.

Based on the aforementioned findings of fact, although the Applicant demonstrated that this proposal would increase the convenience of care for its patients, ONS has failed to satisfactorily demonstrate a clear public need for the proposal. In addition, the Applicant has neither satisfactorily demonstrated how this proposal would improve the accessibility of care nor how

the quality or cost effectiveness of health care delivery in the region would improve as a result of this proposal. After considering all of the factors listed above, OHCA concludes that this proposal is not consistent with The Statewide Health Care Facilities and Services Plan.

Order

Based upon the foregoing Findings of Fact and Discussion, I respectfully recommend that the Certificate of Need application of Orthopedic & Neurosurgery Specialists, PC for the acquisition of an MRI scanner be **DENIED**.

By Order of the
Department of Public Health
Office of Health Care Access

11/17/16
Date

Kevin T. Hansted
Hearing Officer

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VIA HAND DELIVERY AND EMAIL (kimberly.martone@ct.gov)

December 7, 2016

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue MS #13HCA
Hartford, Connecticut 06134-0308

RE: Docket No. 16-32063

Ms. Martone:

On behalf of Orthopaedic & Neurosurgery Specialists, P.C. ("Applicant") with respect to the above captioned matter, attached please find (1) Applicant's Brief in Opposition to Proposed Final Decision and Exceptions to Proposed Findings of Facts and Conclusions and Request for Oral Argument, (2) Applicant's Motion to Preclude as to Advanced Radiology MRI Centers Limited Partnership and (3) Applicant's Motion to Preclude as to The Stamford Hospital.

If you have any questions or need anything further, please do not hesitate to contact me. Thank you.

Very truly yours,

Michele M. Volpe
Bershtein, Volpe & McKeon, P.C.

Enclosures

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DEPARTMENT OF PUBLIC HEALTH	:	
DIVISION OF OFFICE OF	:	
HEALTH CARE ACCESS	:	**DOCKET NO. 16-32063-CON**
	:	
IN RE: ORTHOPAEDIC & NEUROSURGERY	:	
SPECIALISTS, P.C.	:	
ACQUISITION OF MAGNETIC	:	
RESONANCE IMAGING SCANNER	:	**DECEMBER 7, 2016**

APPLICANT'S BRIEF IN OPPOSITION TO PROPOSED FINAL DECISION AND EXCEPTIONS TO PROPOSED FINDINGS OF FACTS AND CONCLUSIONS AND REQUEST FOR ORAL ARGUMENT

In accordance with Section 4-179 of the Connecticut General Statutes, Orthopaedic & Neurosurgery Specialists, P.C., the applicant in the above-captioned matter ("ONS" or the "Applicant"), hereby submits the following Brief in Opposition to the Proposed Final Decision ("Brief in Opposition") issued by the Office of Health Care Access ("OHCA") through Hearing Officer Kevin T. Hansted on November 17, 2016 ("Proposed Final Decision") on ONS's application to acquire and operate a new 1.5 Tesla magnetic resonance imaging ("MRI") scanner at 6 Greenwich Office Park, Greenwich, Connecticut ("Application"). Applicant also submits its exceptions to the proposed findings of fact and conclusions in the said Proposed Final Decision ("Exceptions"). Applicant further requests oral argument in connection with its Brief in Opposition and Exceptions.

BRIEF IN OPPOSITION TO PROPOSED FINAL DECISION

I. Introduction and Summary

The Applicant is a private physician practice that employs nearly 200 people in lower Fairfield County, Connecticut including 23 physicians and other medical professionals. See Application at 14. It is the largest community based orthopedic and neurosurgery provider in the area with a patient base in excess of 56,000 in 2016. See Prefiled Testimony of Mark Camel, M.D. at p. 3. The Applicant currently operates a 1.5 Tesla Magnetom Espree Open Bore MRI scanner (the "Existing Scanner") at its 6 Greenwich Office Park, Greenwich, Connecticut office and, because the Existing Scanner is being operated well above any recommended capacity, the Applicant is proposing to acquire and operate an additional 1.5 Tesla MRI scanner at the same location ("Proposed Scanner"). See Application at p. 86.

There is an unmet public need for the acquisition of a second MRI unit for ONS's Greenwich office. The Applicant submitted clear and convincing evidence to establish this public need in its Certificate of Need Application, Completeness Question responses, Pre-filed Testimony as well as through testimony and other evidence proffered throughout the hearing held on this Application. Based on the need analysis of the Applicant's actual and projected capacity; the Certificate of Need Guidelines and Principles set forth in Connecticut General Statutes §19a-639; and the Need Methodology of Chapter 5.4 of the Statewide Healthcare Facilities and Services Plan ("SWHP"), the Applicant's Certificate of Need Application should be granted. The Proposed Final Decision should be corrected and the Applicant's Certificate of Need should be approved. Frankly, there is absolutely no compelling basis to support the existing Proposed Decision to deny the Application.

II. Applicable Law

The Proposed Final Decision contains findings, inferences, conclusions and decisions which are (i) in clear violation of statutory provisions; (ii) erroneous in view of the reliable, probative and substantial evidence on the record; and (iii) arbitrary, capricious and an abuse of OHCA's discretion. See Connecticut General Statutes §4-183(j). A Certificate of Need is required for the acquisition of an MRI scanner under Connecticut General Statutes §19a-638(a)(10). §19a-639(a) of the Connecticut General Statutes sets for the guidelines and principles which OHCA must take into consideration when deliberating on a Certificate of Need application and provides in relevant part as follows:

> *In any deliberations involving a certificate of need application filed pursuant to § 19a-638, the office shall take into consideration and make written findings concerning each of the following guidelines and principles:*
>
> (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, (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;*
(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.*

The Proposed Final Decision correctly determined that the Applicant and/or the Applicant's proposal has satisfied subsections (4), (6), (8), (10), (11) and (12) of §19a-639(a). Subsection (1) is inapplicable. So, while the Proposed Final Decision does correctly determine that 6 of the 11 applicable guidelines and principles of §19a-639(a) have been satisfied, it is clearly erroneous in determining that the remaining principles and guidelines were not satisfied. Based on the clear and convincing evidence on the record, OHCA should have properly concluded that the Applicant has satisfied the remaining 5 principles and

guidelines.[1] More specifically, The Proposed Final Decision should be corrected to find that:

(1) ONS's acquisition and operation of a 1.5 Tesla MRI scanner at its 6 Greenwich Office Park, Greenwich, Connecticut (the "Proposed Project") is consistent with the Statewide Health Care Facilities and Service Plan[2] (the "SWHP") (§19a-639a(2));

(2) there is a clear public need for the Proposed Project (§19a-639a(3));

(3) ONS has satisfactorily demonstrated how the Proposed Project will improve quality, accessibility and cost effectiveness of health care delivery in the region (§19a-639a(5));

(4) ONS 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 Project (§19a-639a(7); and that

(5) ONS has satisfactorily demonstrated that the Proposed Project will not result in an unnecessary duplication of existing or approved health care services or facilities (§19a-639a(9)).

III. Discussion.

(A) ONS's Proposed Project is consistent with the Statewide Health Care Facilities and Service Plan

(i) OHCA has illegally ignored the "Need Methodology" Criteria Set Forth in the Statewide Health Care Facilities and Services Plan.

Both OHCA and DPH are charged, by statute, with developing and maintaining a blueprint for health care delivery in Connecticut. See Conn. Gen. Stat. § 19a-634(b).[3] The SWHP is that blueprint. It

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[1]Importantly, an applicant is not required to satisfy all of the applicable principles and guidelines, even though in this matter, the Applicant clearly does. See OHCA's CON Guidebook, p. 20 "Some criteria directly relate to different applications more than others." Accordingly, OHCA concedes that the weight assigned to each condition enumerated in General Statutes § 19a-639 varies from case to case.

[2] Connecticut Department of Public Health, Office of Health Care Access, *Statewide Health Care Facilities and Services Plan*, October 2012; Supplemented 2014.

[3] Conn. Gen. Stat. § 19a-634(b) provides: "The office, in consultation with such other state agencies as the Commissioner of Public Health deems appropriate, shall establish and maintain a state-wide health care facilities and services plan. Such plan may include, but not be limited to: (1) An assessment of the availability of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) an evaluation of the unmet needs of persons at risk and vulnerable populations as determined by the commissioner; (3) a projection of future demand for health care services and the impact that technology may have on the demand, capacity or need for such services; and (4) recommendations for the expansion, reduction or modification of health care facilities or services. In the development of the plan, the office shall consider the recommendations of any advisory bodies which may be established by the commissioner. The commissioner may also incorporate the recommendations of authoritative organizations whose mission is to promote policies based on best practices or evidence-based research. The commissioner, in consultation with hospital representatives, shall develop a process that encourages hospitals to incorporate the state-wide health care facilities and services plan into hospital long-range planning and shall facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning. The office shall update the state-wide health care facilities and services plan not less than once every two years."

is the product of years of effort by an advisory body, an imaging workgroup, and "representatives from a cross-section of the health care industry and State government . . . ." The standards and guidelines of the SWHP are the result of the lengthy, onerous, and statutorily mandated process that ultimately produced the SWHP.

While OHCA acknowledges and finds that the utilization of ONS's existing MRI scanner clearly exceeds the SWHP's "Need Methodology" criteria and capacity guidelines, it somehow inexplicably dismisses the guidelines of the SWHP because they "have not been formally adopted into regulation." Proposed Final Decision, p. 3 & Footnote 2. This outright ignoring of the SWHP capacity guidelines, which are a mandated directive to OHCA, was in error and must be corrected. It is also directly contrary to OHCA's position, policy and decisions which rely, almost always, on the guidelines of the SWHP. More important, Connecticut General Statutes Section 19a-639(a)(2) clearly and unequivocally mandates that *"[i]n any deliberations involving a certificate of need application . . . the office **shall** take into consideration . . . the relationship of the proposed project to the [SWHP]."* (Emphasis added). OHCA's dismissal of the statutory mandate and the SWHP in a footnote to the Proposed Final Decision is indicative of the deficiencies and errors contained in said Decision.

Perhaps the most compelling reason to correct and reverse the Proposed Final Decision is the fact that OHCA failed and/or refused to properly apply the Need Methodology criteria set forth in Section 3 of the Standards and Guidelines Specific to MRI in Chapter 5.4 of the SWHP (the "SWHP Need Methodology"). See SWHP at p.61. In assessing ONS's Application, OHCA is required to analyze the detailed information it received from ONS within the framework set forth in Conn. Gen. Stat. § 19a-638, et seq., and the SWHP. See Conn. Gen. Stat. § 19a-639a(2). The SWHP Need Methodology criteria for MRIs provides as follows:

> *3. Need Methodology*
>
> *The Applicant shall demonstrate that the proposed scanner meets **either** of the following criteria:*
>
> *a. The applicant is expected to demonstrate that the Percent Utilization of Current Capacity in the Primary Service Area*

exceeds 85%.

b. If the applicant has an MRI scanner in the Primary Service Area, the applicant is expected to demonstrate that its Percent Utilization of Current Capacity exceeds 85%.

SWHP, p. 61 (emphasis added). Accordingly, an applicant can demonstrate that a need exists for a proposed MRI scanner by satisfying either of the foregoing criteria. The undisputed, clear and convincing evidence in the record plainly demonstrates that ONS has satisfied both criteria. See Application, p. 11, & Pre-Filed Testimony of Mark Camel, M.D., pp. 27–28.

Section 3b of the SWHP Need Methodology is directly applicable to ONS's Application. ONS has clearly and undisputedly demonstrated that the Percent Utilization of Current Capacity of its existing MRI scanner far exceeds 85%. See Application, p. 11, & Pre-Filed Testimony of Mark Camel, M.D., pp. 27–28. The SWHP's Need Methodology sets the Current Estimated Capacity of an MRI scanner at 4,000 scans per year. See SWHP, p. 61. With the SWHP established capacity of an MRI scanner being 4,000 scans per year, ONS need only demonstrate that its Existing MRI performs at least 3,400 scans annually (4,000 x .85) in order to establish need for a second MRI under the explicit criteria of the SWHP Need Methodology. In 2015, ONS performed 5,262 scans. See Pre-Filed Testimony of Mark Camel, M.D., p. 27. This equates to 132% Percent Utilization (5,262 ÷ 4,000) - far in excess of the 3,400 scans required under the SWHP Need Methodology to demonstrate need for a second MRI.

While ONS is not required to also satisfy Section 3a of the SWHP Need Methodology, it does nevertheless. The Percent Utilization of Current Capacity in the relevant Primary Service Area[4] far exceeds 85%. The Pre-filed Testimony of Mark Camel, M.D. at page 28 contains the following undisputed analysis:

Analysis under 3(a) of Chapter 5 of the SWHP is not required for ONS to receive approval from OHCA. However, even applying criteria under 3(a), the MRI Percent Utilization of Current Capacity in the Primary Service Area is over 85%.

[4] Despite the implication in Proposed Finding of Fact #9 in the Proposed Final Decision which curiously omits the Town of Wilton, the Primary Service Area was clearly established as including the towns of Greenwich, Stamford, Darien, New Canaan, Norwalk and Wilton ("Primary Service Area" or "Service Area"). See, Prefiled Testimony of Mark Camel M.D. at page 5 and 35.

Based on a Connecticut service area of Greenwich, Stamford, New Canaan, Darien, Norwalk and Wilton, the MRI Percent Utilization of Current Capacity is 94%.

*"**Utilization Rate per Capita**" – none published by OHCA, DPH population figures and Applicant analysis indicates **0.144***
*"**Utilization Rate**" – 0.144 * 339,728= **48,921***
*"**Current Estimated Capacity**" - 13*4,000 = **52,000***
*"**Percent Utilization of Current Capacity**"- 48,921/ 52,000 = **94%** utilization*

Total Service Area Population[5]:

Greenwich	*62,610*
Stamford	*128,278*
New Canaan	*20,314*
Darien	*21,689*
Norwalk	*88,145*
Wilton	*18,692*
Total:	***339,728***

The foregoing establishes that in the relevant Primary Service Area, the Percent Utilization of Current Capacity is 94%. Accordingly, ONS has satisfied both criteria of the SWHP Need Methodology. In sum, under any objective analysis of the SWHP, and, in particular, the SWHP Need Methodology, the Applicant's Existing Scanner is being operated well over recommended capacity, and the entire Service Area MRI capacity is well beyond any limits recommend under the SWHP. These capacity limits and potential barriers to access MRI services in the Service Area (when applying the SWHP Need Methodology) are precisely what the CON laws and OHCA division of the Department of Public Health is empowered to ensure do not occur. Therefore, ONS' request for a second MRI scanner to accommodate patients is not only necessary and justified, but it is required given the statutory and regulatory mandates of OHCA. In fact, as shown on page 28 of the Prefiled Testimony of Mark Camel, M.D., the Service Area can accommodate two additional MRI scanners for a total of 15 MRI scanners in the Service Area. The approval of one additional MRI scanner in the Service Area still results in a utilization above the SWHP's 85% threshold.

[5] Source: "ESTIMATED POPULATIONS IN CONNECTICUT AS OF JULY 1, 2014" published by the Department of Public Health http://www.ct.gov/dph/lib/dph/hisr/hcqsar/population/pdf/pop_towns2014.pdf (most recent).

(ii) Consistency with the Policy Concerns of the Statewide Health Care Facilities and Services Plan

The Proposed Scanner aligns with all standards and guidelines enumerated in the SWHP. The Applicant is the largest community based orthopedic provider in the service area. It employs nearly 60 professionals, 23 of whom are licensed physicians. See Application at p. 14. It has nearly 200 employees and a growing patient base in excess of 56,000 in 2016. See Prefiled Testimony of Mark Camel, M.D. at p. 3. Maintaining community based physicians and surgeons in the specialties of Orthopedic and Neurosurgery promotes and supports the long-term viability of the state's healthcare delivery system.[6] As important, approval of an additional MRI for the Applicant promotes its long-term viability, as it will be better equipped to adapt to the demands and needs of its patients to continue to receive the benefit of enhanced continuity of care, service, communication and coordination that in-office imaging provides.[7] See Prefiled Testimony of Mark Camel, M.D. at p 4. Further, the proposal will maintain access to ONS's in-office MRI services as all ONS patients will be able to receive the benefit of lower cost in-office MRI services and accommodate the volume and demand fluctuations. *Id.* ONS will be able to accommodate all its patients for MRI services even if one of the MRI machines is down or is being serviced. *Id.* The proposal encourages collaboration because ONS will be better able to track patient compliance with MRI and have immediate access to images that are of a higher quality for use in surgery because ONS produces more image sequences during scanning than other area providers. See Prefiled Testimony of Mark Camel, M.D. at p. 5.

The proposal supports the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner by having ONS patients receiving in-office imaging which offers a more appropriate level of care than hospital-based or other off-site alternatives. *Id.* The proposal also promotes planning to contain costs by being able to accommodate all ONS patients who require MRI services at its in-office location by offering a lower cost and more accessible alternative to hospital-based

[6] The vast majority of physicians and surgeons in Connecticut are now employed by hospital health systems leaving patients and payers with limited choice for accessing care.

[7] It is important to note here that MRI scans are read and interpreted by a radiologist in ONS's office as a radiologist is always present during MRI scans for this purpose. This was misrepresented by OHCA in its Findings of Fact. See Exception to Proposed Finding of Fact #8 below.

MRI. By acquiring the Proposed Scanner, ONS will be better equipped to measure and monitor specific MRI needs among its patients. See Prefiled Testimony of Mark Camel, M.D. at p. 4. The proposal will also maintain community based physicians and surgeons in the specialties of orthopedics and neurosurgery. This promotes and supports the long-term viability of the state's health care delivery system. *Id.*

Despite OHCA's conclusion to the contrary, ONS's Application is perfectly consistent with the goals and policies of the SWHP. For all of the reasons set forth herein, Finding of Fact #47 of the Proposed Final Decision that "[t]his CON application is not consistent with the Statewide Health Care Facilities and Service Plan" is simply and obviously erroneous and must be corrected.

(B) There is a Clear Public Need for ONS's Proposed Project.

Given that ONS has clearly satisfied both criteria of the SWHP Need Methodology for MRI despite needing to only satisfy one, OHCA must determine there is a definitive public need for ONS' second MRI. ONS has provided clear and convincing evidence based on historic, existing growth of volume and utilization showing the need for an additional MRI. See Application at p. 32. In 2014, the Existing Scanner averaged an internal utilization of 91% and in 2015, the Existing Scanner averaged an internal utilization of 92%. These percentages are based on an unsustainable taxing of the existing MRI of nearly 6,300 scans. Pursuant to the SWHP, an MRI's current capacity is 4,000 scans per year, ONS averaged an astonishing 132% utilization in 2015 and this cannot continue. Additionally, ONS has attested and documented that the practice is continually growing to include new physicians which has, in turn, increased its patient population and volume. This growth cannot be accommodated by other scanners in the area as all providers are operating at or above capacity in accordance with the SWHP. Specifically, Advanced Radiology Consultants ("ARC"), the other non-hospital provider of MRI services is operating at 165% capacity at its Stamford location. See Table 8, Statewide Healthcare and Facilities Services Inventory - 2014 ("Magnetic Resonance Imaging (MRI) Scanning Providers) published by DPH (2014). Even if ARC were to acquire an additional MRI, the increased demand projected by ONS would

still not be able to be met and the SWHP Need Methodology supports adding 2 additional MRI scanners to the Service Area.

OHCA provided a table at the hearing (OHCA Exhibit #1) that identified the 13 MRIs in the Service Area, the number of scans of each MRI and the distance in miles from the Applicant. The OHCA chart plainly showed that the volume for each of the immediate area MRI scanners was at capacity or nearly at capacity, as well as MRI scanners in Norwalk over 15 miles away, yet OHCA does not cite any standards or methods by which it came to the conclusion that need has not been met. Thus, it appears that OHCA either (i) erroneously applied or ignored the SWHP Need Methodology, (ii) applied a different standard without providing any information or analysis of such standard's use, or (iii) unfairly discriminated against ONS because it favors and/or is preferential to the competing CON application of ARC (Docket Number 16-32093-CON) (the "ARC Application"), the hearing for which was consolidated with that of the Applicant's application.[8] In any case, OHCA has not applied need-based criteria in its Proposed Final Decision.

In a case involving OHCA's predecessor, the Commission on Hospitals and Health Care, the court held that the procedures utilized by the agency in reviewing the expenditures budgets of various Connecticut hospitals were illegal, unconstitutional and arbitrary. New Britain General Hospital v. Commission on Hospitals and Health Care, (Ct. Com. Pleas. Hartford Co., D.N. 13-24-86-1 (June 21, 1977). The court so held because the agency's failure to define the criteria that it intended to apply made it impossible for the hospital to adequately present its case. The same can be said for OHCA's approach in this matter. By not applying recognized need-based criteria, including the SWHP Need Methodology, and effectively not applying any objective criteria at all, there is no support for a proposed denial of a

[8] Tellingly, ARC did not copy ONS or its counsel, nor did OHCA, on correspondence that went back and forth between ARC and OHCA on additional questions and answers in the ARC Application well after the docket was closed. See Ruling on a Petition Filed by ONS to be Designated as an Intervenor dated August 26, 2016 whereby OHCA ordered that ONS be …. "copied on all pleadings, correspondence and filings submitted from this point forward by [ARC] until the issuance of a final decision by OHCA." See also email communications between Jennifer Groves Fusco and David Fernandes of October 17, 2016 and October 19, 2016 (copies attached). I.e., it has also not gone unnoticed by the Applicant that ARC's Application, despite being filed June 14, 2016 was amazingly expedited by OHCA and deemed complete On July 21, 2016 while ONS's Application was filed on January 21, 2016 and not deemed complete for nearly five months from the filing of its initial application. ONS will not sit idly by and allow OHCA to ignore its statutory mandates and established criteria in favor of another applicant who was already approved for MRI upgrades that would've alleviated capacity issues in the Service Area but who failed to implement on OHCA approval.

CON. ONS had/has no ability to adequately meet the unknown criteria or refute its application.

ONS already has extended its hours of operation and added additional days for use of its Existing MRI. See Application at p. 11. It is impossible to accommodate ONS's existing and projected need without the addition of a second MRI scanner.[9] Accordingly, ONS requires a second MRI scanner to meet patient demand in as timely a clinical fashion as possible. OHCA's analysis should begin and end here.

OHCA's assertion that "Applicants estimates [concerning MRIs per physician per year] are not sufficiently founded" is unsupported. Whether each ONS physician is requesting that 229, 240 or 267 of their respective patients receive an MRI, applying even the lowest number of projected scans still creates significant additional volume that must be met. To suggest that a rapidly growing Orthopedic practice that is continuing to employ more doctors annually is not also adding additional patient volume and thereby causing increased use of ancillary services, i.e. MRI, is illogical and irresponsible. The reconciliation of the numbers concerning MRIs per physician per year has more to do with the fact that when ONS submitted its application nearly a year ago now, it's newly employed physicians were ramping up, additional physicians were added and ONS patient and provider base continues to grow and the numbers of scans continues to increase.[10] Any increase in scans, regardless of the amount, is too much for ONS and its Existing Scanner to absorb and is far too great for the other Primary Service Area MRI providers to accommodate.

Applicant is operating its existing scanner at 132% capacity based on the SWHP Need Methodology. Under any decision ever issued by OHCA as well as under the SWHP analysis, an imaging provider who is operating well beyond capacity under any analysis should be granted a CON to acquire an additional MRI. Appropriate planning to ensure access to MRI services is why the Standards and Guidelines Specific to MRI under Chapter 5.4 of the SWHP were created. OHCA should proceed with an

[9] Irrespective of ONS's projected MRI needs, ONS is operating above OHCA's defined MRI capacity of 85%. Even if ONS were to realize significantly less projected utilization that represented in the Application, ONS will still be well above OHCA's defined MRI capacity of 85%.
[10] See Footnote 9 above noting that ARC's Application received unprecedented expedited treatment by OHCA yet ONS's Application is nearly a year old and has not yet been granted.

abundance of caution denying a willing and financially viable provider from implementing a much needed healthcare service in the Service Area.

Instead of relying on the fact that ONS' current utilization will fully occupy the proposed MRI within acceptable industry time period, OHCA is attempting to rely on over utilized scanners in the Service Area to absorb all of ONS patient need. It has already been established that the Service Area is operating well above capacity limits established in the SWHP. OHCA also appears to be relying an existing MRI provider, ARC, who is currently operating in excess of 165% of capacity and who has failed to implement upgrades and has not provided additional imaging capacity to eliminate constraints to meet the access needs of any patients, let alone ONS patients.[11]

Additionally, the Proposed Final Decision inaccurately states that "[t]wo providers are within 10 miles of ONS, both with 50% or more available capacity." See Proposed Final Decision at p. 11. This is not a true statement based on OHCA's own chart provided at the hearing and included as Table 5 in the Proposed Final Decision.[12] First, OHCA's reliance on this chart is improper because it is immaterial to the analysis required in the SWHP. Chapter 5.4 of the SWHP solely requires a current MRI provider to prove it exceeds 85% utilization. ONS has clearly proven it has exceeded 85% utilization throughout the Application, Completeness Question responses, Prefiled Testimony and hearing testimony. The need analysis should begin and end with ONS's own utilization. Directly contrary to the mandate of the SWHP Need Methodology, OHCA has applied its own arbitrary methodology citing to Table 5. Even considering OHCA's own arbitrary methodology, the representations and resulting conclusion in Table 5 are wrong. Table 5 is put forth as proof that there is excess MRI capacity for some providers in the Service Area. However, a closer examination of Table 5 shows that Table 5 does not include all relevant and accurate information and there is not excess capacity in the Service Area. Presumably, OHCA is

[11] ARC has a pattern of not seeking CON approval for technology upgrades and equipment until other providers have come forward first to serve the need. ARC claims it has been operating over capacity in Stamford since 2011 yet it is just now filing its CON. Additionally, ARC requested and received OHCA approval to upgrade its Stamford scanner but never implemented the proposal. In 2008, ARC requested a waiver and was approved to upgrade the Stamford MRI to a 3.0 MRI. ARC was approved for the upgrade and although ARC stated it intended to start operations of the new scanner in June 2009, ARC never implemented the technology upgrade. OHCA Docket No. 08-31188-WVR.

[12] See Table 5 attached.

including Hospital for Special Surgery ("HSS") as one such provider with 50% or more capacity. However, OHCA fails to acknowledge that HSS self-limits its capacity to a mere 2,540 scans per year (opposed to the SWHP capacity of 4,000 scans per year).[13] This self-limit was reviewed and acknowledged by OHCA in its approval of the HSS MRI. Therefore, HSS cannot be included as a provider with 50% or more capacity as it falls outside the SWHP capacity recommendations. Further, Table 5 fails to acknowledge that the Greenwich Hospital Diagnostic Center had upgraded from a 1.5T to a 3.0T MRI at the time Table 5 was distributed. This upgrade indicates this MRI provider has the patient base and financial capacity to upgrade. As important, Darien Imaging Center, the only other provider with some available scan capacity within the acceptable limits of the SWHP is beyond 10 miles from ONS. Thus, OHCA's reliance on Table 5 to indicate available capacity is not supported and is unfounded in light of Chapter 5.4. Aside from OHCA's improper reliance on its own contrived methodology through the use of Table 5, when applied to the SWHP Need Methodology, Table 5 actually indicates that there is a need for MRI in the Service Area.

(C) The applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region.

The quality, accessibility and cost-effectiveness of health care in the region will be improved because more patients will be able to receive MRI scans at their physician's office and thus benefit from the enhanced communication and coordination that physician based in-office imaging provides. See Prefiled Testimony of Mark Camel, M.D. at p. 4. ONS has highly qualified radiologists to interpret MRI scans in the ONS office and maintain compliance with community and industry standards. See Prefiled Testimony of Mark Camel, M.D. at p. 9. ONS will also be able to accommodate patients should the Existing Scanner be down for repairs or servicing. See Prefiled Testimony of Mark Camel, M.D. at p. 15. ONS will be able to accommodate all of its scan volume and projected future growth in a timelier manner. See Prefiled Testimony or Mark Camel; M.D. at p. 14.

[13] OHCA Docket No. 12-32780-CON, Application at 16.

ONS is an independent community based physician practice and as such, its patients enjoy lower cost MRI and will not be subject to additional facility fees. See Prefiled Testimony or Mark Camel; M.D. at p. 15. Hospital providers account for the majority of the scanners in the service area. *Id.* Connecticut has seen a massive influx of community-based providers be employed by hospitals and hospital-based systems. *Id.* Intensive consolidation of providers leaves patients and payers with little choice in many Connecticut markets. *Id.* ONS is an independent community based provider whose physicians are not employed by a health system. *Id.* With the Proposed Scanner, more patients will be given a choice to receive their MRI at ONS and potentially avoid additional costs for the MRI, facility charges or higher contracted rates. *Id.*

(D) ONS 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 Project.

The population to be served is ONS' patients from not only the Service Area, but as set forth in detail in CON application, many other Connecticut area cities and towns. The Applicant's patient base continues to grow and neither the ONS MRI scanner, nor the existing providers of MRI in the Service Area, are able to accommodate ONS patient volume. The Primary Service Area has been identified in the Application as towns and cities of Greenwich, Stamford, New Canaan Darien, Norwalk and Wilton. See Footnote 4. This patient population has a need for MRI services because, as noted above, ONS's capacity is clearly well in excess of the SWHP's 85% utilization.[14] Pursuant to OHCA's 4,000 scan per year figure, ONS averaged 132% utilization in 2015. The Docket objectively establishes nearly all of the other MRI scanners in the service area are operating above capacity.[15] In short, the patient population is the Primary Service Area in need of the additional MRI scanner.[16]

(E) ONS has satisfactorily demonstrated that the Proposed Project will not result in an unnecessary duplication of existing or approved health care services or facilities.

[14] SWHP at 61.
[15] ARC Application at 15.
[16] In addition, the analysis under Section 3a of Chapter 5.4 of the SWHP supports 2 additional MRIs in the Service Area.

By any analysis performed in accordance with OHCA standards and criteria as well as the SWHP, the MRI Percent Utilization of Current Capacity in the Service Area far exceeds 90%. Of the 13 MRI scanners in the Service Area within in a 10-mile radius, all but one, Greenwich Hospital, exceed recommended capacity limits. As important, this Greenwich Hospital scanner with capacity was just upgraded from a 1.5 to a 3T so clearly it is a financially viable MRI site with sufficient utilization. OHCA chose to quote that "ARC testified that from 2012 through 2016 year to date, 366 ONS patients had their scans performed at ARC." See Proposed Final Decision Finding of Fact #22. This is a useless statement that doesn't support denial of Applicant's CON or any other CON review or analysis. What is does show is that ONS MRI use and patient base has nearly no impact on ARC whatsoever. See Exception to Finding of Fact 22 and Discussion of same below. This number of scans is insignificant compared to ONS's and ARC's current MRI volumes. In 2015, ARC stated it performed 79 MRI scans on ONS patients. See Hearing Transcript at 50. ARC also indicated that it performed 29,413 MRI scans in 2015. See ARC Application at 48. Using ARC's own volume figures (ONS does not track patient referrals and cannot verify ARC's purported referral volume), ONS patients would account for approximately a quarter of a percent of ARC's 2015 volume (79/29,413 = 0.00268 or 0.268%) As important, even assuming ARC's figure is correct, these referred patients account for such a de minimis portion of the annual MRI volume for ARC or ONS it is not worthy of notation.

The Proposed Final Decision statement that "Two providers are within 10 miles of ONS, both with 50% or more available capacity" is false. This is not a true statement based on OHCA's own chart provided at the hearing and included as Table 5 in the Proposed Decision. Presumably, OHCA is including Hospital for Special Surgery ("HSS") as one such provider with 50% or more capacity, however, HSS self limits its capacity to 2,540 scans per year.[17] Thus, HSS cannot be included as a provider with 50% or more capacity. As important, Darien Imaging Center, the only provider with some available scan capacity within the acceptable limits of the Statewide Health Plan is beyond 10 miles from

[17] OHCA Docket No. 12-32780-CON, Application at 16.

ONS.

The Proposed Scanner will not negatively impact other providers in the service area as ONS only provides MRI services to its own patients. Contrary to ARC's assertion that approval of the Application will result in ARC being inundated with Medicaid recipients, Fairfield County has a low Medicaid MRI population and there does not appear to be any access issues for the Medicaid population.[18] This is evidenced by the fact that the HSS's significant efforts to attract Medicaid recipients to its Stamford MRI have only resulted in 1.9% percent of its total patient population. With respect to its Stamford MRI, HSS has enrolled in Medicaid, sent letters to professionals and facilities informing area providers of its Medicaid participation status, offered clinic hours, hosted community education events, and done many other steps to increase its Medicaid population. In spite of these efforts, HSS's Medicaid patient population remains under 2%. This indicates that the Medicaid need for MRI is low in Fairfield county. In opposition to OHCA's Finding of Fact #37, reliance should not be made on information presented in the GE study in ARC's own application. The GE study was drafted by an MRI vendor, GE, for its potential buyer, ARC, and the study's conclusions are self serving and likely proffered to entice the buyer. There is no indication that GE considered or incorporated the SWHP or other indicators of Medicaid recipient's need for MRI in the Service Area. Because the basis behind the GE study is questionable; and the volume by payer of established MRI providers in the Service Area as well as HSS data proves that the Medicaid recipient needs are being met in Fairfield county, there will be no influx of Medicaid recipients to ARC or other MRI providers and thus no adverse impact on other MRI providers.

(F) Other Important Issues and Arguments which compel OHCA to Correct the Proposed Final Decision and Grant Applicant's CON Application.

There is demonstrated and documented evidence of existing MRI providers in the Service Area who have failed to implement needed MRI services whether in the form of equipment upgrades and/or acquisition. Specifically, ARC has a pattern of not seeking CON approval for technology upgrades and

[18] OHCA Docket No. 12-32780-CON, Attachment 6 to Agreed Settlement Annual Report dated April 15, 2016.

equipment until other providers have come forward first to serve the need. ARC claims it has been operating over capacity since 2011. See ARC Application at p. 13. Pursuant to its own data, in FY 2013 ARC's capacity was 167%, in FY 2014 it was 175%, and in FY 2015 it was 165%. *Id.* Additionally, ARC requested and received OHCA approval to upgrade its Stamford scanner but never implemented the proposal. In 2008, ARC requested a waiver and was approved to upgrade the Stamford MRI to a 3.0 MRI. See OHCA Docket No. 08-31188-WVR. ARC was approved for the upgrade and although ARC stated it intended to start operations of the new scanner in June 2009, ARC never implemented the technology upgrade. *Id.* It is questionable if this Waiver Request was put forth to be obstructionist to other CON filings in the same time frame, specifically ONS's request to upgrade its own MRI in Greenwich. It is also questionable if ARC is committed to providing the best options for patients considering its history of obstructing other providers from serving their patients. ARC has only been pushed to upgrade its technology or acquire additional imaging capability when another provider comes forth in the service area to acquire new technology and upgrade equipment for the benefit of the population in the service area.

ONS has always taken the proactive approach to upgrade to the best technology for its patients. To address its patient's needs, ONS went through a CON process to upgrade its MRI. It should be noted that shortly after ONS was required to go through the lengthy and expensive regulatory process to upgrade its existing MRI from a 1.0T to a 1.5T, the law was updated to only require notice as opposed to a CON in order to upgrade imaging equipment. ONS proactively considers the needs of its patients and is seeking to meet these needs in the Application. ONS is again taking action on behalf of its patients and it can not rely on other providers who are nearly at or in excess of their MRI capability to provide needed services for its patients, nor should OHCA.

EXCEPTIONS TO FINDINGS OF FACT AND CONCLUSIONS OF LAW

ONS takes exception to the following findings of fact:

3. On November 4, 2008, ONS received OHCA approval (Docket Number 08-31120-CON) to operate a fixed 1.5 Tesla (1.5T) Magnetom Espree Open Bore MRI scanner at its practice located at 6 Greenwich Office Park, Greenwich. Ex. A, p. 14.

This finding implies that ONS only began operating an MRI in late 2008 which is not correct. Prior to the issuance of the Certificate of Need referenced in Docket Number 08-31120-CON, ONS had already been operating a 1.0 Tesla LX HiSpeed MRI which did not require a Certificate of Need pursuant to Sections 19-638 and 19-639 of the Connecticut General Statutes. See March 30, 2006 CON Determination Docket Number 06-30704-DTR. The November 4, 2008 OHCA approval in Docket Number 08-31120-CON was for an upgrade of ONS's original scanner to a 1.5 Tesla Magnetom Espree Open Bore MRI.

4. ONS proposes to obtain a second MRI scanner ("Proposed Scanner") for the Greenwich office. The proposed scanner, a Siemens Aera 1.5T MRI, will have the same strength and capability as the existing scanner. Ex. A, pp. 13-15.

The Prefiled testimony of Mark Camel, M.D. established that "[t]he Proposed Scanner offers new and unique MRI functionality on account of its enhanced software allowing for faster scan time and improved noise suppression. Accordingly, the Proposed Scanner has better functionality and capacity than the existing scanner. See Prefiled Testimony of Mark Camel, M.D. at p. 12.

8. ONS contracts with Greenwich Radiology to provide professional radiological services, including review and interpretation of all MRI scans. ONS bills for all MRI services. Ex. A, p. 14.

This finding is incomplete and when read in conjunction with the statement in the Proposed Decision in the Discussion Section at page 13 which states that "ONS does not interpret images in-house," it is factually incorrect. The correct facts are that ONS does contract with Greenwich Radiology to (i) review and interpret all MRI scans, (ii) make adjustments to imaging parameters and protocols, (iii) make decisions regarding magnetic field risks and (iv)

consult with the technologists on technical factors related to the study acquisition and work with ONS to be responsible for maintaining the MRI scanner, its operations and interpreting images. See Prefiled Testimony of Mark Camel M.D. at p. 10. These services are performed by the radiologist while at ONS's office. See Hearing Transcript at p. 18. So, contrary to OHCA's statement, ONS, through a Greenwich Radiology radiologist, does interpret scans **in its offices.** Further, ONS complies with Chapter 5.4, #4 Quality and Accessibility, which addresses radiologist requirements for MRI services and specifically requires that the Applicant demonstrate the following applicable criteria: "(c.) A full-time board certified radiologist, who is a member in good standing with the American College of Radiology, shall be responsible for managing the operation of the MRI scanner and for the written interpretation of the MRI scan; (d.) Personnel shall be trained, consistent with guidance of the American College of Radiology, in the use of the MRI scanner and the safety procedures to follow in the event of an emergency; (e.) When imaging is performed a physician must be available either on-site or with immediate access to remote viewing of images as they are acquired. The physician in this case must be qualified to interpret images, make adjustments to imaging parameters or protocols, make decisions regarding magnetic field strength risks, and consult with the technologists on technical factors related to the study acquisition. This physician must be board certified to perform and interpret the examinations so produced." ONS has demonstrated it meets all of these requirements in its Application. See Prefiled Testimony of Mark Camel, M.D. at pp. 9 - 10.[19]

9. ONS currently serves patients from Connecticut and New York towns. In 2015, 57% of scans were performed on persons residing within the Connecticut primary service area towns of: Greenwich, Stamford, Darien, New Canaan and Norwalk. Ex. A, p. 30.

This finding is inaccurate and misleading. First, OHCA appears to have curiously left

[19] Dr. Scott Sullivan, a board-certified radiologist with Greenwich Radiology who reads and interprets ONS MRI scans, was present at the OHCA hearing on August 30, 2016, was sworn in, and was available to answer any questions from OHCA staff.

out the Town of Wilton from the Primary Service Area applicable to this Application. The Primary Service Area was clearly established as including the towns of Greenwich, Stamford, Darien, New Canaan, Norwalk and Wilton. See Prefiled Testimony of Mark Camel M.D. at page 5 and 35. It appears from this proposed finding that OHCA must have been relying on the data contained in revised Table 8 which is set forth in Exhibit C at page 88-89, not Exhibit A page 30. As set forth in Table 8, 114 scans were performed on Wilton residents in fiscal year 2015. If these scans are included, 60% of ONS's scans for 2015 are within the Primary Service Area towns.

10. Based on time slot availability, in 2014 and 2015, the existing scanner had an average utilization of 91% and 92%, respectively. Ex. A, p. 17, Ex. C, pp. 85-86.

These utilization percentages are not what OHCA is mandated to apply. Rather, it should be percentages that are based on the SWHP. As noted above, this finding and the effort to dismiss the SWHP in Footnote 2 as a mandated directive to OHCA is illegal, misleading, inconsistent with OHCA's past practices and decisions, and quite frankly, shocking. OHCA cannot simply avoid the MRI capacity guidelines set forth in the SWHP by saying that the guidelines "have not been formally adopted into the regulation." Connecticut General Statutes Section 19a-639(a)(2) provides that "[i]n any deliberations involving a certificate of need application . . . the office ***shall*** take into consideration . . . the relationship of the proposed project to the [SHCFSP]." (Emphasis added). The recitation of the percentage of utilization of ONS's existing scanner, while accurate, is misleading. The 91% and 92% figures are based on MRI utilization as compared to overstressed available time slots that ONS has with its expanded hours and for which ONS, without a second MRI, has been forced to implement in order to accommodate need of its patients and is not sustainable. See Prefiled Testimony of Mark Camel M.D. at p. 25. Using the SWHP capacity guideline of 4,000 scans per year, which OHCA is statutorily obligated to do, ONS's current MRI scanner is operating at 132% of capacity.

12. The Applicant states that it has some available capacity to conduct MRI scans. Exhibit X, Transcript, Testimony of Dr. Mark Camel, Vice President of ONS, pp. 74-75.

As noted above, any available capacity of ONS's current MRI scanner is *de minimis* at best. This proposed finding conveniently mischaracterizes the testimony of Dr. Camel and is quite frankly, irresponsible given the fact that ONS's current utilization of the Existing Scanner vastly exceeds the SWHP mandated capacity of 4,000 scans per year.

16. ONS claims that it would realize a 1,200, or 22%, increase in volume in the first year the proposed scanner is operational. The Applicant based the increase in volume on the assumption of each physician performing 267 scans. Exhibit X, Transcript, Dr. Mark Camel, pp. 74- 96.

This proposed finding of fact, while accurately setting forth raw data, is misleading. As noted several times previously, the utilization of the Existing Scanner is so far in excess of the SWHP recommended capacity of 4,000 scans per year, even if each of ONS's 23 physicians performed far less than the projected 267 scans per year, the need for a second scanner is justified and warranted under Connecticut General Statute guidelines and principles for CON (§19a-639(a)) as well as the SWHP Need Methodology. See discussion above.

18. ONS states that it does not have data regarding reasons why its patients would have an MRI scan done by another provider. Exhibit X, Transcript Dr. Mark Camel pp. 72-75.

There is no purpose for this proposed finding of fact and it is in error. It is irrelevant and immaterial. In any event, Dr. Camel did not simply testify that ONS did not have data regarding the reasons why patients would have an MRI scan done by another provider. Rather, he said that ONS does not maintain such data. There is information in Exhibit X as well as in Dr. Camel's testimony as to why an ONS patient may have an MRI scan done by another provider. See Findings of Fact 19 and Attachment D to Prefiled Testimony of Mark Camel M.D. Such Prefiled Testimony states: "[S]ome patients will require an MRI on a 3.0T or can only tolerate an open MRI and certain NY residents may

choose to have an MRI scan closer to their home in New York, the same is true for other ONS Connecticut patients who work in New York. Certain ONS patients may not receive scans on ONS's scanner even if the Proposed Scanner is approved, such patients will continue to require scans at other providers for reasons including but not limited to scanner capability. Specifically, certain head injury patients, patients with varying kinds of embedded hardware, patients who require diffuse tensor imaging, and patients who cannot handle a longer duration scan may require scans performed on a 3.0T scanner. In addition, certain patients may receive scans on other MRIs based on commercial insurance participating provider status, for example, workers' compensation does not allow patients to be scanned at ONS....." See Prefiled Testimony of Mark Camel, M.D. at 31.

20. *ONS states that for certain head injury patients, it is best to perform scans on a 3T scanner that can provide diffusion tensor imaging, which is not possible on a 1.5T scanner, such as the proposed scanner. Exhibit X, Transcript, Dr. Mark Camel, pp. 22, 59. Testimony of Dr. Scott Sullivan, Neuroradiologist of ONS, p. 59.*

Once again, this proposed finding of fact seems irrelevant and immaterial. This testimony was offered to support the contention that a second MRI for ONS will NOT have an adverse impact on existing providers; and the testimony was provided in reference to the fact that ONS even with a second MRI cannot possibly scan every patient at its office, so other providers will continue to be utilized, at an even greater rate given the projected growth of ONS. See Findings of Fact 19 and Exhibit X. ONS is not required to show that it will do every MRI needed for its patients with its new scanner. OHCA appears to be arbitrarily creating different criteria for a CON.

22. From 2012 through 2016 year-to-date, 366 ONS patients received MRI scans at ARC. Ex. X, Transcript, p. 50.

The inclusion of this finding in the Proposed Final Decision is another indicator that ONS's CON application appears to have been prejudged and/or disfavored. See Footnote 9 above. In short, the finding has no relevance or materiality. The 366 figure is so insignificant when compared to ONS or ARC MRI volume and equates to such a de minimis amount of scans for either ONS or ARC. Thus, the number of ONS patients receiving scans at ARC is irrelevant.

24. The Applicant claims that nearly all MRI providers in the service area are operating at capacity. Ex. 0, p. 23.

Noting what a party claims is simply not a finding of fact. The fact is that, based on SWHP Need Methodology, nearly all MRI providers are operating at capacity based on undisputed data provided to OHCA by the providers themselves. OHCA has again ignored the SWHP Need Methodology which it cannot do under Connecticut's statutory mandates. Accordingly, OHCA's findings relative to MRI capacity and Percent Utilization are flawed and must be corrected.

25. Six out of nine providers have some capacity. Greenwich Hospital is operating at 80% of its capacity, Norwalk Hospital is at 79%, Norwalk Hospital Radiology & Mammography Center is, among its three scanners, operating at 82% capacity. Two other providers within an 11 mile radius of ONS each have 50% or more available capacity. Ex O, p. 34

As stated in Exception to Proposed Finding #24 above, based on SWHP Need Methodology, nearly all MRI providers are operating at capacity based on undisputed data provided to OHCA by the providers themselves. OHCA has again ignored the SWHP Need Methodology which it cannot do under OHCA's statutory mandates. OHCA's reliance on an arbitrary need analysis rather than the SWHP ignores the mandate of subsection 3A of Chapter 5.4 of the SWHP. See Section II B above. Accordingly, OHCA's findings relative to MRI capacity and Percent Utilization are flawed and must be corrected.

27. The Applicant claims that quality and accessibility will be improved because "more ONS patients will be able to receive MRI scans at their physician's office and thus benefit from the enhanced communication and coordination that physician-based in-office imaging provides." Ex. O, *p.* 14.

It cannot be disputed that more ONS patients will be able to receive MRI scans at ONS's office if the CON for the second MRI scanner is granted. Similarly, it cannot be disputed that a necessary corollary to more patients having MRI scans done at their own physician's office will lead to enhanced communication and coordination. In short, this is not a claim, it is a fact and the Proposed Final Decision must be corrected to recognize it as such.

29. According to The Practice of Imaging Self-Referral Doesn't Produce One-Stop Service, *self-referring entities provided same-day MRI imaging in only 15% of those cases studied.* Ex. P, *pp. 101-102.*

30. In an analysis of 65,517 "episodes of outpatient care," according to the New England Journal of Medicine, *self-referring physicians obtain imaging examinations 4 to 4.5 times more often than radiologist-referring physicians.* Ex. P, *p. 71.*

31. In its 2012 study, the Government Accountability Office's review of Medicaid payments for scans found that self-referring providers refer patients for about two times as many scans as providers who do not self-refer. Ex Y, p. 6; Ex. P, p. 90; Ex. X, Transcript, Dr. Alan Kaye, Former CEO of ARC p. 37

32. Dr. Alan D. Kaye criticized the practice of self-referrals, stating that there is a "financial incentive to maximize referrals to the scanner." He additionally highlights the $1.5 million cost of ONS' proposed additional scanner and the 1,071 scans that ONS would need to perform during the first year of operations to break-even financially. Ex. P, p. 65.

The foregoing proposed findings 29-32 all imply that if ONS receives a CON for a second MRI scanner, it will overutilize and self refer more patients for MRI scans which are unnecessary. The proposed findings purport to cite articles, studies and the testimony of a physician affiliated with ARC, a competitor of the Applicant and opponent of ONS's CON Application. However, OHCA neglects to cite to the most compelling data on the record pertaining to the issues of self-referral and potential overutilization – namely the actual historical utilization per physician of the Applicant. Dr. Camel testified that the number of scans ordered per physician has been stable "even when compared to before we owned our own MRI machine." See Hearing Transcript at P. 111. The entire self-referral/overutilization argument proffered by ARC in its opposition to the ONS Application also fails to recognize that MRI utilization and prevention of MRI overutilization is more than adequately governed and controlled by the payers. Payers track utilization and require prior authorization of MRI services and have the ability to deny approval of an MRI or not grant credentialing or privileging of MRI services if the payer has concerns with overutilization.

Lastly, it is beyond the scope of the review of this Application, or any other competing application, for OHCA to analyze and adjudicate the federal laws and regulations relating to self-referral. Far greater analysis has been conducted and federal laws have already been put into place

providing safeguards and protections for self referral. Regardless, the MRI services by ONS are legally permissible.

In sum, analyzing the actual historical data of the Applicant's utilization, as regulated and controlled by the payers, is a far better way to determine whether and if self-referral overutilization of an MRI scanner is occurring as opposed to reliance upon non-specific articles and studies and the assertions of an opposing physician competitor. Additionally, ONS performs more detailed and timely scans on its MRI compared to ARC as ONS's scans are utilized during surgery by ONS surgeons. Longer scan times results in more sequences and better quality images. This gives ONS surgeons a better quality image to use during surgery. Unlike ARC, who may seek to increase volume by using shorter scan times and getting patients in and out of the MRI quicker, ONS must spend time to produce quality scans and thus ONS's self-referral does not result in overutilization. Applying this analysis, based upon the facts in the record, ONS has not overutilized its Existing Scanner due to self-referral and actually performs more detailed and timely scans than other MRI providers in the Service Area.

33. In addition, Dr. Kaye stated that private radiology practices, which only perform examinations referred by non-affiliated providers, "make MRI referrals for one reason only, their need for information to take care of their patients..." Ex. P, p. 65.

This proposed finding is perhaps the most compelling evidence of the discrimination exercised by OHCA against ONS and in favor of ARC. Even if this were true, what is the possible relevance? Is this an accusation that ONS makes MRI referrals for reasons other than needing information to care for its patients and have quality images to operate on their patients? This provocative proposed finding is irrelevant, unnecessary and immaterial, and it is likely not true in any respect. It should be eliminated from the Proposed Final Decision.

34. ONS does not have a written charity care policy or sliding fee scale. The Applicant states that it is "available to work one on one with patients who may be unable to pay part or all of the bill for any reason, including but not limited to insurance status or financial status...ONS will try and accommodate that patient and that patient's financial needs," however, the applicant has not provided any MRI services to the Medicaid population. Ex. A, p. 22; Ex. C, p. 86; Ex. D, p.94; Exhibit X, Transcript Dr. Mark Camel, pp. 65-66.

The implication here is that ONS refuses to treat Medicaid patients, or is otherwise offering a subordinate level of care to such patients. Indeed, OHCA unfairly cites to the testimony of Ruth Cardiello of Stamford Hospital who incorrectly asserts that ONS has "insulated itself" from serving the Medicaid population. This is false and incorrect. There is countless testimony in the docket describing the large capacity of Medicaid population that regularly obtain care by Applicant doctors both within ONS' office as well as the Greenwich Hospital clinic. See, Prefiled Testimony of Mark Camel M.D. at p. 15-16. Applicant makes no money off the Medicaid program or its patient population, rather every year it donates hundreds of thousands of dollars in physician services and provider resources to the Medicaid population. This crucial fact that has either been missed by or blatantly ignored in the Proposed Final Decision.

37. GE's Market At-a-Glance Report, *commissioned by ARC, projects that the Medicaid population in greater Stamford area[20] is expected to grow by 14% over the next five years.* Ex. P,p. 28.

This proposed finding is incorrect, overstated and misleading. OHCA should not lend any credence to a self-serving study performed for free on behalf of GE, an MRI vendor that stands to be paid millions of dollars by ARC for purchasing an MRI from GE. Any population figures published by the state clearly show that Fairfield County is losing more residents than any other county in Connecticut. As important, this so called growing Medicaid population is likely the result of converting uninsured indigent population to Medicaid as a result of Access Health. This only means greater reimbursement to the providers who accept Medicaid as the shift is from uninsured to Medicaid, not a shift in commercial. Lastly, any impact of determining greater Medicaid eligibility for Connecticut residents has already

[20] The study looked at the following zip codes: 06612, 06807, 06820, 06830, 06831, 06840, 06850, 06851, 06853, 06854, 06855, 06870, 06878, 06880, 06883, 06896, 06897, 06901, 06902, 06903, 06905, 06906, 06907, 10576.

occurred since this initiative started nearly six years ago. The historical volume of Medicaid patient population of the MRI providers in the Primary Service Area has been the same since before ONS obtained an MRI and has certainly shown to be at a consistent number for all of the Intervenors since ONS obtained its first scanner. ARC itself does not show in increase in Medicaid payer percentage in its own application and indicates its Medicaid payer percentage at 3.89% for all projected years. See ARC Application at 41. As important, there is no unmet need for Medicaid patients in the Service Area.

38. According to ARC, it provided 79 scans to ONS patients in FY2015 and estimates it will, based on the year-to-date data, provide 110 scans in FY2016. It states that the majority of these patients were commercial payees, and were it to lose these referrals, its payer mix would further skew toward Medicaid and other governmental payers, which tend to reimburse approximately 50% compared to commercial payors. Ex. P, pp. 6-7.

39. Ruth Cardiello, The Stamford Hospital's Vice President for Enterprise Risk Management, states that, as a "closed model" MRI provider, ONS has been able to "insulate itself from serving the large number of Medicaid and indigent patients, while hospitals such as The Stamford Hospital as well as the other established MRI providers in the Stamford, Darien and Norwalk area take referrals from outside their own organizations and accept such patients. Ex. Q, p. 9.

40. Mrs. Cardiello testified that adding another MRI in the Stamford area with a provider that does not accept Medicaid patients will "dilute the pool of commercially insured as well as Medicare patients" and would "add unnecessary cost to the health care delivery system and weaken rather than strengthen its financial health". Exhibit X, Testimony of Stamford Hospital VP Ruth Cardiello. pp. 41-42, Ex. R, pp. 3, 4-5.

Proposed Findings 38-40 all imply that the granting of a CON to ONS will lead to the loss of commercial paying patients to other providers and that their patient population will be skewed toward Medicaid and other government payers. Of course, this assertion comes from the two parties opposing ONS's Application – ARC and Stamford Hospital. There is no basis to support these assertions. Please refer to the Exception to Proposed Finding 37.

47. This CON application is not consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2)).

As noted above, this conclusion is clearly erroneous and unsupported. It should be corrected to read: "This CON application is consistent with the Statewide Health Care Facilities and Service Plan.

(Conn. Gen. Stat. § 19a-639(a)(2))." See detailed discussion and analysis in Article III of this Brief.

48. The Applicant has not sufficiently demonstrated that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3)).

As noted above, this conclusion is clearly erroneous and unsupported. It should be corrected to read: "The Applicant has sufficiently demonstrated that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3))." See detailed discussion and analysis in Article III of this Brief.

50. The Applicant has not sufficiently demonstrated that the proposal will improve the accessibility, quality or cost effectiveness of health care delivery in the region. (Conn. Gen. Stat.§ 19a-639(a)(5)).

As noted above, this conclusion is clearly erroneous and unsupported. It should be corrected to read: "The Applicant has sufficiently demonstrated that the proposal will improve the accessibility, quality or cost effectiveness of health care delivery in the region. *(Conn. Gen. Stat.§ 19a-639(a)(5).*" See detailed discussion and analysis in Article III of this Brief.

52. The Applicant has not satisfactorily identified the population to be served by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7))."

As noted above, this conclusion is clearly erroneous and unsupported. It should be corrected to read: "The Applicant has satisfactorily identified the population to be served by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7)). See detailed discussion and analysis in Article III of this Brief.

54. The Applicant has not 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))."

As noted above, this conclusion is clearly erroneous and unsupported. It should be corrected to read: "The Applicant has 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)).*" See detailed discussion and analysis in Article III of this Brief.

IV. Conclusion

There is a clear public need for the acquisition of a second MRI unit for ONS's Greenwich office. The Applicant submitted compelling evidence to establish and support this public need in its Certificate of Need Application, Completeness Question responses, Pre-filed Testimony as well as through testimony and other evidence proffered throughout the hearing held on this Application. Based on the need analysis of the Applicant's actual and projected capacity; the Certificate of Need Guidelines and Principles set forth in Connecticut General Statutes §19a-639; and the Need Methodology for MRI in Chapter 5.4 of the Statewide Healthcare Facilities and Services Plan, the Applicant's Certificate of Need Application should be granted. The Proposed Final Decision should be corrected and the Applicant's Certificate of Need should be approved.

REQUEST FOR ORAL ARGUMENT

In accordance with § 19a-9-29(h) of the Regulations of Connecticut State Agencies, ONS hereby requests oral argument with respect to its challenge to the Proposed Final Decision issued by the Office of Health Care Access ("OHCA") through Hearing Officer Kevin T. Hansted on November 17, 2016.

Respectfully submitted:

THE APPLICANT,
ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

By: _____

Michele M. Volpe, Esq.
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105 Court Street—Third Floor
New Haven, CT 06511
Juris: 412124
Telephone: (203) 777-5800
Facsimile: (203) 777-5806

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, on December 7, 2016, to the following:

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
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Karen P. Wackerman, Esq.
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2319 Whitney Avenue, Suite 1-D
Hamden, CT 06518
pmonahan@pppclaw.com

Michele M. Volpe, Esq.

Copies of ARC Correspondence

Greer, Leslie

Subject: FW: CON-32093 Questions
Attachments: DOCS-#1391852-v1-ARC_STAMFORD_MRI_CQ_RESPONSES_(2).docx

---

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Wednesday, October 19, 2016 9:42 AM
To: Fernandes, David
Cc: Riggott, Kaila
Subject: RE: CON-32093 Questions

Good morning, David & Kaila,

Attached are response to your follow-up requests. Please let me know if you need anything further.

Thanks,
Jen

From: Fernandes, David [mailto:David.Fernandes@ct.gov]
Sent: Monday, October 17, 2016 10:26 AM
To: Jennifer Groves Fusco
Cc: Riggott, Kaila
Subject: CON-32093 Questions

Good Morning Ms. Fusco,
OCHA is currently in the process of drafting a decision for CON 16-32093 and in doing so, would like clarification/updates on a few things.

1. Please update the below table to include FY2019.

Payer	Projected by Fiscal Year	
	2019	
	Discharges	%
Medicare		
Medicaid		
CHAMPUS & TriCare		
Total Government		
Commercial Insurers		
Uninsured/Self Pay		
Workers Compensation		
Total Non-Government		
Total Payer Mix		

2. Please complete the below table to reflect ARC's overall financial health.

	FY 2017	FY 2018	FY 2019

Revenue from Operations			
Total Operating Expenses			
Gain/Loss from Operations			

3. Can you explain why the loan in the amount of $2,910,000 is different from the total capital expenditure of $2,916,000 as found on page 39 of the application? How will the difference of $6,000 be financed?

If you could provide this information at your earliest convenience, that would be appreciated.

Thank you,

David Fernandes
Planning Analyst (CCT)
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032 | F: (860) 418-7053 | E: David.Fernandes@ct.gov

ADVANCED RADIOLOGY MRI CENTERS, LIMITED PARTNERSHIP
RESPONSES TO OHCA QUESTIONS
DOCKET NO. 16-32093
OCTOBER 19, 2016

1. Please update the below table to include FY2019.

Payer	Projected by Fiscal Year	
	2019	
	Discharges	%
Medicare	1,398	17.39%
Medicaid	313	3.89%
CHAMPUS & TriCare	0	0%
Total Government	**1,711**	**21.28%**
Commercial Insurers	5,733	71.30%
Uninsured/Self Pay	303	3.77%
Workers Compensation	294	3.65%
Total Non-Government	**6,330**	**78.72%**
Total Payer Mix	**8,041**	**100%**

2. Please complete the below table to reflect ARC's overall financial health.

	FY 2017	FY 2018	FY 2019
Revenue from Operations	19,910,286	20,507,595	21,122,822
Total Operating Expenses	12,401,206	12,959,260	13,542,427
Gain/Loss from Operations	**7,509,080**	**7,548,334**	**7,580,395**

3. Can you explain why the loan in the amount of $2,910,000 is different from the total capital expenditure of $2,916,000 as found on page 39 of the application? How will the difference of $6,000 be financed?

RESPONSE:

The estimated total capital expenditure for the Stamford MRI proposal is $2,916,224 (CON Application, p. 39). In providing its approval of financing for the project, Bank of America used whole numbers to approximate the amount at $2,910,000 (CON Application, p. 137). ARC is certain that, to the extent necessary, Bank of America will increase the amount of financing to reflect the additional $6,224. However, as noted at the public hearing on this matter, ARC anticipates that the cost of the 3.0 Tesla scanner will be less than projected and the total capital expenditure will be within the confirmed amount of financing.

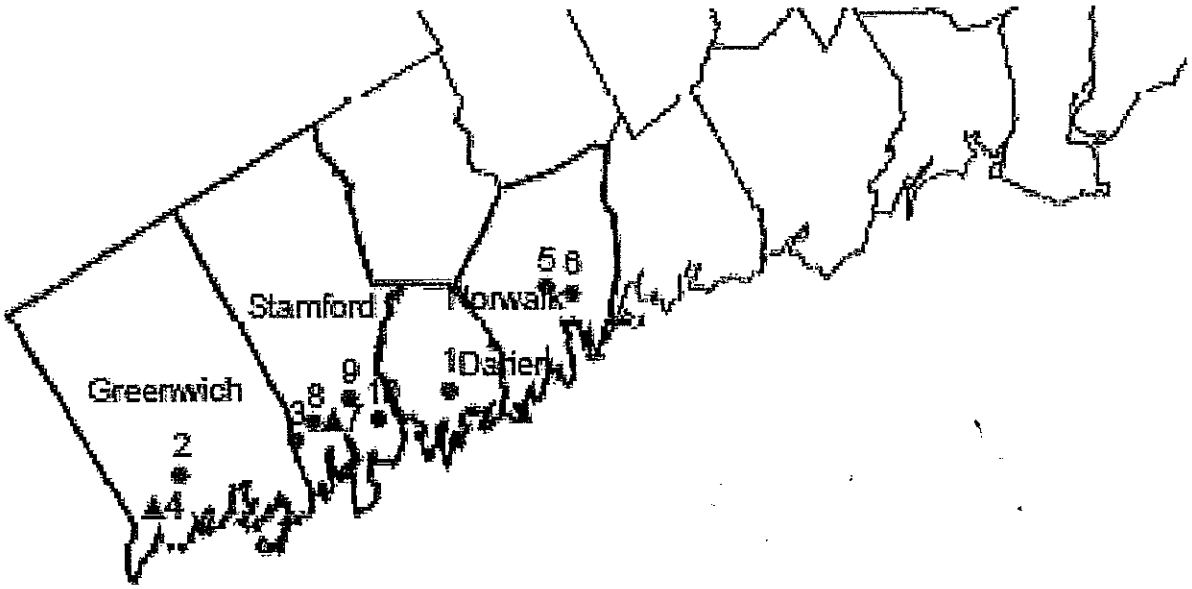
Table 5

OHCA Exhibit

ID	MRI FACILITY	MRI TYPE	TOTAL SCANS FY 14	Distance from Stamford Advance Radiology Center	Distance from Greenwich ONS Practice
1	Darien Imaging Center	1.5 tesla	1,827	5.0 miles	10.8 miles
2	Greenwich Hospital	1.5 tesla 3.0 tesla	4,693 3,128	7.5 miles	1.6 miles
3	Greenwich Hospital Diagnostic Center	1.5 tesla	1,991	1.9 miles	5.9 miles
4	Orthopedic Neurosurgical Specialist	1.5 tesla	4,800	7.7 miles	-------
5	Norwalk Hospital	1.5 tesla	3,174	9.2 miles	15.1 miles
6	Norwalk Hospital Radiology & Mammography Center	1.5 tesla(2) & .7 tesla	9,797	9.7 miles	15.6 miles
7	Stamford Advance Radiology Center	1.5 tesla	6,705	-------	7.7 miles
8	Stamford Hospital	1.5 tesla	6,427	0.8 miles	6.8 miles
9	Tully Health Center	1.5 tesla	4,360	0.9 miles	8.3 miles
10	Hospital for Special Surgery *	1.5 tesla	1,981	2.2 miles	8.8 miles

Source: Statewide Healthcare Facilities and Services Inventory-2014

**Hospital for Special Surgery figure includes scans from February 2015 through January 2016*



DEPARTMENT OF PUBLIC HEALTH	:	
DIVISION OF OFFICE OF HEALTH	:	
CARE ACCESS	:	**DOCKET NO. 16-32063-CON**
	:	
IN RE: ORTHOPAEDIC & NEUROSURGERY	:	
SPECIALISTS, P.C.	:	
ACQUISITION OF MAGNETING	:	
RESONANCE IMAGING SCANNER	:	**DECEMBER 7, 2016**

MOTION TO PRECLUDE AS TO ADVANCED RADIOLOGY MRI CENTERS LIMITED PARTNERSHIP

Orthopaedic & Neurosurgery Specialists, P.C., ("Applicant") respectfully moves the Department of Public Health division of Office of Health Care Access ("OHCA") from accepting any correspondence, filing or communication from and precluding Advanced Radiology MRI Centers Limited Partnership ("Intervenor") from participating in any manner concerning the Applicant's opposition and exceptions to OHCA's November 17, 2016 "Proposed Final Decision" ("Proposed Decision"). For the reasons articulated hereinbelow under law, the Intervenor is barred from providing any submission or participating in said proceedings.

I. RELEVANT FACTS & PROCEDURAL HISTORY

On January 20, 2016, the Applicant submitted a "Certificate of Need Application" to OHCA ("Application") regarding its proposed acquisition and operation of a 1.5 Tesla magnetic resonance imaging scanner ("Proposed MRI") at its Greenwich, Connecticut, office. On August 25, 2016, the Intervenor filed a petition seeking intervenor status in the above-captioned matter ("Petition"). OHCA granted the Intervenor's Petition on August 29, 2016.

On November 17, 2016, OHCA, acting by and through hearing officer Kevin T. Hansted, issued the Proposed Decision, in which it recommends that the Applicant's Application be denied. The Applicant has filed, concomitantly herewith, a brief in opposition, as well as exceptions, to OHCA's Proposed Final Decision.

II. RELEVANT LAW

The statutes and regulations that govern the Applicant's present challenge to OHCA's Proposed Decision provide in relevant part:

> Unless otherwise ordered by the presiding officer, any ***party*** who wishes to challenge a proposed final decision under [General Statutes § 4-179[1]] shall file exceptions or a brief or request oral argument, within twenty-one (21) days of the mailing of the decision. Any ***party*** who wishes to present a brief or requests oral argument in support of a proposed final decision shall do so within thirty-five (35) days of the mailing of the decision.

(Emphasis added.) Regs. Conn. State Agencies § 19a-9-29(h).

For the purposes of the foregoing regulation, the term "party" is defined in General Statutes § 4-166. Regs. Conn. State Agencies § 19a-9-1(17) ("'[p]arty' has the meaning provided in [General Statutes § 4-166]). Section 4-166(10) provides that the term "party" means:

> [E]ach person (A) whose legal rights, duties or privileges are required by statute to be determined by an agency proceeding and who is named or admitted as a party, (B) who is required by law to be a party in an agency proceeding, or (C) who is granted status as a party under [General Statutes § 4-177a(a)[2]] . . . .

The definition of the term "intervenor" differs from the definition of the term "party." *See* Regs. Conn. State Agencies § 19a-9-1(17) ("party," defined); General Statutes § 4-166(10)

---

[1]General Statutes § 4-179(a) provides: "When, in an agency proceeding, a majority of the members of the agency who are to render the final decision have not heard the matter or read the record, the decision, if adverse to a party, shall not be rendered until a proposed final decision is served upon the parties, and an opportunity is afforded to each party adversely affected to file exceptions and present briefs and oral argument to the members of the agency who are to render the final decision."

[2]General Statutes § 4-177a(a) provides: "The presiding officer shall grant a person status as a party in a contested case if that officer finds that: (1) Such person has submitted a written petition to the agency and mailed copies to all parties, at least five days before the date of hearing; and (2) the petition states facts that demonstrate that the petitioner's legal rights, duties or privileges shall be specifically affected by the agency's decision in the contested case."

(same); Regs. Conn. State Agencies § 19a-9-1(13) ("intervenor," defined); General Statutes § 4-166(7) (same). The relevant regulations define the term "intervenor" as follows:

> "Intervenor" means a person, ***other than a party***, who is allowed to participate in either a contested case or a hearing on a request for declaratory ruling, as set forth in [General Statutes § 4-177a[3]], and [Regs. Conn. State Agencies § 19a-9-27[4]].

(Emphasis added.) Regs. Conn. State Agencies § 19a-9-1(13). Similarly, General Statutes § 4-166(7) provides:

> "Intervenor" means a person, ***other than a party***, granted status as an intervenor by an agency in accordance with the provisions of [General Statutes § 4-176(d)] or [General Statutes § 4-177a(b)] . . . .

(Emphasis added.) Accordingly, a "party" is separate and distinct from an "intervenor." *See* Regs. Conn. State Agencies § 19a-9-1(17) ("party," defined); General Statutes § 4-166(10) (same); Regs. Conn. State Agencies § 19a-9-1(13) ("intervenor," defined); General Statutes § 4-166(7) (same).

III. ARGUMENT

The Intervenor is barred from providing any submissions or participating in any proceedings concerning the Applicant's challenge and exceptions to OHCA's Proposed Decision. The relevant law affords only a "party," not an "intervenor," with the right to challenge, or file exceptions to, a "proposed final decision." *See* General Statutes § 4-179(a) (agency must afford each *party* adversely affected by proposed final decision opportunity to file

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[3]General Statutes § 4-177a(b) provides: "The presiding officer may grant any person status as an intervenor in a contested case if that officer finds that: (1) Such person has submitted a written petition to the agency and mailed copies to all parties, at least five days before the date of hearing; and (2) the petition states facts that demonstrate that the petitioner's participation is in the interests of justice and will not impair the orderly conduct of the proceedings."

[4]Regs. Conn. State Agencies § 19a-9-27(c) provides in relevant part: "The presiding officer shall determine whether and to what extent the proposed intervenor may participate in the hearing, taking into account whether such participation will furnish assistance to the agency in resolving the issues."

exceptions and present briefs and oral argument); Regs. Conn. State Agencies § 19a-9-29(h) (same). Because OHCA already has determined that the Intervenor is not a "party," the Intervenor has no right whatsoever to participate in the aforementioned proceedings.

The Applicant is a "party" within the meaning of applicable law because it is required to secure a certificate of need before it may acquire the Proposed MRI. *See* Conn. Gen. Stat. § 19a-638(a)(10) (certificate of need required as precondition to acquisition of MRI); General Statutes § 4-166(10) (person whose legal rights, duties or privileges are required by statute to be determined by agency proceeding is "party"); Regs. Conn. State Agencies § 19a-9-1(17) ("party" defined in General Statutes § 4-166).

OHCA has determined that the Intervenor is just that—an "intervenor." *See* Proposed Decision, p. 2. The Proposed Decision provides, in relevant part: "On August 25, 2016, [the Intervenor] filed a petition requesting intervenor status. [The Intervenor] was granted intervenor status with full rights in this matter on August 29, 2016." Id. An "intervenor" is, *by definition*, not a "party." *See* Regs. Conn. State Agencies § 19a-9-1(17) ("party," defined); General Statutes § 4-166(10) (same); Regs. Conn. State Agencies § 19a-9-1(13) ("intervenor," defined); General Statutes § 4-166(7) (same). Accordingly, the Intervenor is barred from participating in any proceedings concerning the Applicant's challenge and exceptions to OHCA's Proposed Decision.

IV. CONCLUSION

The Intervenor is barred from providing any submissions or participating in any proceedings concerning the Applicant's challenge and exceptions to OHCA's Proposed Decision. Accordingly, the Applicant respectfully moves OHCA to preclude the Intervenor from: (1) filing any brief, written argument, written testimony, correspondence, communication,

or writing of any kind; (2) submitting any verbal argument or testimony; and (3) participating in any proceedings including, but not limited to, oral argument concerning the Applicant's opposition and exceptions to OHCA's Proposed Decision.

Respectfully submitted:

THE APPLICANT,
ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

By: _____

Michele M. Volpe, Esq.
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pmonahan@pppclaw.com

Michele M. Volpe, Esq.

DEPARTMENT OF PUBLIC HEALTH	:	
DIVISION OF OFFICE OF HEALTH	:	
CARE ACCESS	:	**DOCKET NO. 16-32063-CON**
	:	
IN RE: ORTHOPAEDIC & NEUROSURGERY	:	
SPECIALISTS, P.C.	:	
ACQUISITION OF MAGNETING	:	
RESONANCE IMAGING SCANNER	:	**DECEMBER 7, 2016**

MOTION TO PRECLUDE AS TO THE STAMFORD HOSPITAL

Orthopaedic & Neurosurgery Specialists, P.C., ("Applicant") respectfully moves the Department of Public Health division of Office of Health Care Access ("OHCA") from accepting any correspondence, filing or communication from and precluding The Stamford Hospital ("Intervenor") from participating in any manner concerning the Applicant's opposition and exceptions to OHCA's November 17, 2016 "Proposed Final Decision" ("Proposed Decision"). For the reasons articulated hereinbelow under law, the Intervenor is barred from providing any submission or participating in said proceedings.

I. RELEVANT FACTS & PROCEDURAL HISTORY

On January 20, 2016, the Applicant submitted a "Certificate of Need Application" to OHCA ("Application") regarding its proposed acquisition and operation of a 1.5 Tesla magnetic resonance imaging scanner ("Proposed MRI") at its Greenwich, Connecticut, office. On August 25, 2016, the Intervenor filed a petition seeking intervenor status in the above-captioned matter ("Petition"). OHCA granted the Intervenor's Petition on August 29, 2016.

On November 17, 2016, OHCA, acting by and through hearing officer Kevin T. Hansted, issued the Proposed Decision, in which it recommends that the Applicant's Application be denied. The Applicant has filed, concomitantly herewith, a brief in opposition, as well as exceptions, to OHCA's Proposed Final Decision.

II. RELEVANT LAW

The statutes and regulations that govern the Applicant's present challenge to OHCA's Proposed Decision provide in relevant part:

> Unless otherwise ordered by the presiding officer, any ***party*** who wishes to challenge a proposed final decision under [General Statutes § 4-179[1]] shall file exceptions or a brief or request oral argument, within twenty-one (21) days of the mailing of the decision. Any ***party*** who wishes to present a brief or requests oral argument in support of a proposed final decision shall do so within thirty-five (35) days of the mailing of the decision.

(Emphasis added.) Regs. Conn. State Agencies § 19a-9-29(h).

For the purposes of the foregoing regulation, the term "party" is defined in General Statutes § 4-166. Regs. Conn. State Agencies § 19a-9-1(17) ("'[p]arty' has the meaning provided in [General Statutes § 4-166]). Section 4-166(10) provides that the term "party" means:

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(same). Because OHCA already has determined that the Intervenor is not a "party," the Intervenor has no right whatsoever to participate in the aforementioned proceedings.

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OHCA has determined that the Intervenor is just that—an "intervenor." *See* Proposed Decision, p. 2. The Proposed Decision provides, in relevant part: "On August 25, 2016, [the Intervenor] filed a petition requesting intervenor status. [The Intervenor] was granted intervenor status with limited rights in this matter on August 29, 2016." Id. An "intervenor" is, *by definition*, not a "party." *See* Regs. Conn. State Agencies § 19a-9-1(17) ("party," defined); General Statutes § 4-166(10) (same); Regs. Conn. State Agencies § 19a-9-1(13) ("intervenor," defined); General Statutes § 4-166(7) (same). Accordingly, the Intervenor is barred from participating in any proceedings concerning the Applicant's challenge and exceptions to OHCA's Proposed Decision.

IV. CONCLUSION

The Intervenor is barred from providing any submissions or participating in any proceedings concerning the Applicant's challenge and exceptions to OHCA's Proposed Decision. Accordingly, the Applicant respectfully moves OHCA to preclude the Intervenor from: (1) filing any brief, written argument, written testimony, correspondence, communication, or writing of any kind; (2) submitting any verbal argument or testimony; and (3) participating in

any proceedings including, but not limited to, oral argument concerning the Applicant's opposition and exceptions to OHCA's Proposed Decision.

Respectfully submitted:

THE APPLICANT,
ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

By: _____

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Bershtein, Volpe & McKeon, P.C.
105 Court Street—Third Floor
New Haven, CT 06511
Juris: 412124
Telephone: (203) 777-5800
Facsimile: (203) 777-5806

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, on December 7, 2016, to the following:

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
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Karen P. Wackerman, Esq.
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Michele M. Volpe, Esq.

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

December 16, 2016

Attorney Michele M. Volpe
Bershtein, Volpe & McKeon, P.C.
105 Court Street
New Haven, CT 06511

In RE: Certificate of Need Application, Docket Number 16-32063-CON
Orthopaedic & Neurosurgery Specialists, P. C.
Acquisition of Magnetic Resonance Imaging Scanner

NOTICE OF ORAL ARGUMENT

Orthopaedic & Neurosurgery Specialists, P.C. has requested an oral argument regarding the recommendation of Hearing Officer Kevin Hansted, Esq. Pursuant to Section 4-179 C.G.S., Oral Argument for the above cited case has been scheduled as follows:

January 31, 2017 at 11:00 a.m.
Department of Public Health
3rd Floor, DPH Hearing Room
410 Capitol Avenue, Hartford, Connecticut

On January 31, 2017, you will have fifteen minutes to make your argument. Please call Barbara Olejarz at (860) 418-7005 if you have any questions.

Yvonne T. Addo, MBA
Deputy Commissioner

12/16/2016
Date

C: Raul Pino, M.D., M.P.H., Commissioner

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

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

December 16, 2016

Attorney Michele M. Volpe
Bershtein, Volpe & McKeon, P.C.
105 Court Street
New Haven, CT 06511

In RE: Certificate of Need Application, Docket Number 16-32063-CON
Orthopaedic & Neurosurgery Specialists, P. C.
Acquisition of Magnetic Resonance Imaging Scanner

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Yvonne T. Addo, MBA
Deputy Commissioner

12/16/2016
Date

C: Raul Pino, M.D., M.P.H., Commissioner

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Olejarz, Barbara

From: Michele Volpe <mmv@bvmlaw.com>
Sent: Friday, December 16, 2016 3:52 PM
To: Olejarz, Barbara
Cc: Casagrande, Antony A; Martone, Kim
Subject: Re: Oral argument

Thank you Barbara.

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On Dec 16, 2016, at 3:39 PM, Olejarz, Barbara <Barbara.Olejarz@ct.gov> wrote:

> 12/16/16
>
> Please see attached Notice of Oral Argument for Orthopaedic & Neurosurgery Specialists, P.C.
>
> 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
>
> <notice 32063.pdf>