STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 7, 2010

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: 09-31441-CON
Central Connecticut Health Alliance Inc. and Hartford Health Care Corporation, Inc.	**Affiliation of Central Connecticut Health Alliance and Hartford Health Care Corporation, Inc.**

Claudio Capone
Director, Strategic Business Planning
Central Connecticut Health Alliance, Inc.
100 Grand Street
New Britain, CT 06050

Karen Goyette
Vice President, Strategic Planning
and Business Development
Hartford Health Care Corporation
80 Seymour Street
P.O. Box 5037
Hartford, CT 06102

Dear Mr. Capone and Ms. Goyette:

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 May 7, 2010, 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.

By Order of the
Office of Health Care Access
Department of Public Health

Cristine A. Vogel
Deputy Commissioner

CAV: cc

Enclosure

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicants:	Central Connecticut Health Alliance Inc. and Hartford Health Care Corporation, Inc.
Docket Number:	09-31441-CON
Project Title:	Affiliation of Central Connecticut Health Alliance and Hartford Health Care Corporation, Inc.
Statutory Reference:	Section 19a-638, C.G.S.
Filing Date:	February 19, 2010
Public Hearing Date:	March 29, 2010
Decision Date:	May 7, 2010
Default Date:	May 20, 2010
Staff:	Brian Carney Carmen G. Cotto Steven W. Lazarus

Project Description: Central Connecticut Health Alliance Inc. ("CCHA") and Hartford Health Care Corporation, Inc. ("HHCC") propose an affiliation, with no associated capital expenditure.

Nature of Proceedings: On February 19, 2010, the Office of Health Care Access ("OHCA") received the completed Certificate of Need ("CON") Application of CCHA and HHCC for an affiliation, with no associated capital expenditure. CCHA and HHCC (collectively known as the "Applicants") are considered to be health care facilities or institutions for purposes of this CON as defined by Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

Pursuant to Section 19a-638, C.G.S., notices to the public concerning OHCA's receipt of the Applicants' Letter of Intent were published in *The Hartford Courant* and *The Herald* on September 15, 2009. OHCA received no comments from the public concerning the Applicants' proposal.

Pursuant to Section 19a-638, C.G.S., a public hearing regarding the CON application was held on March 29, 2010. On March 17, 2010 the Applicants were notified of the date, time, and place of the hearing. On March 8, 2010, notices to the public announcing the hearing were published in *The Hartford Courant* and *The Herald.* Deputy Commissioner Cristine A. Vogel served as Presiding Officer. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-638, C.G.S.

OHCA's authority to review and approve, modify or deny this proposal is established by Section 19a-638, C.G.S. The provisions of this section as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

Clear Public Need
Impact on the Applicants' Current Utilization Statistics
Contribution of the Proposal to the Accessibility and Quality of Health Care Delivery in the Region

1. It is found that Hartford Health Care Corporation ("HHCC") is a Connecticut non-stock 501(c) (3) organization, located at 80 Seymour Street, Hartford, Connecticut. HHCC is the parent corporation of Hartford Hospital, in Hartford, MidState Medical Center in Meriden, and Windham Hospital in Willimantic. *(Applicant's Letter of Intent and Initial CON Application, 09-31441-CON)*

2. It is found that Central Connecticut Health Alliance ("CCHA") is a Connecticut non-Stock 501 (c) (3) organization, located at 100 Grand Street, New Britain, Connecticut. CCHA is

the parent corporation of The Hospital of Central Connecticut with campuses in New Britain and Southington, Connecticut. *(Applicant's Letter of Intent and Initial CON Application, 09-31441-CON)*

3. On March 24, 2005, under OHCA Docket No.: 04-30280, OHCA approved the consolidation of New Britain General Hospital and Bradley Memorial Hospital and Health Center to operate under a single Connecticut Department of Public Health's acute care license. *(Office of Health Care Access, Agreed Settlement, DN: 04-30280-CON)*

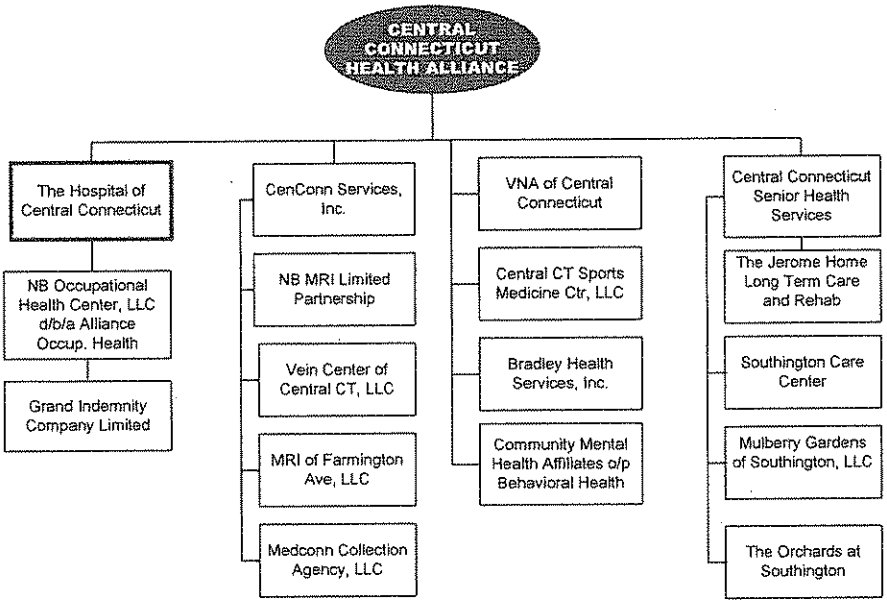
4. It is found that the combined total licensed bed capacity for HOCC for both campuses (formerly New Britain General Hospital and Bradley Memorial Hospital and Health Center) combined is 446 licensed beds. *(Office of Health Care Access, Agreed Settlement, DN: 04-30280-CON)*

5. The Applicants contend that under the proposed affiliation, HHCC will become the sole corporate member of CCHA. CCHA would continue as the sole corporate member of HOCC. *(November 19, 2009 Initial CON Application, Exhibit 6)*

6. The Applicants state that HOCC will remain a separate legal entity with a separate medical staff and a separate hospital license. *(November 19, 2009 Initial CON Application, Exhibit 6)*

7. The Applicants assert that the organizational chart of CCHA and its affiliates prior to the proposed affiliation with HHCC is as follows:

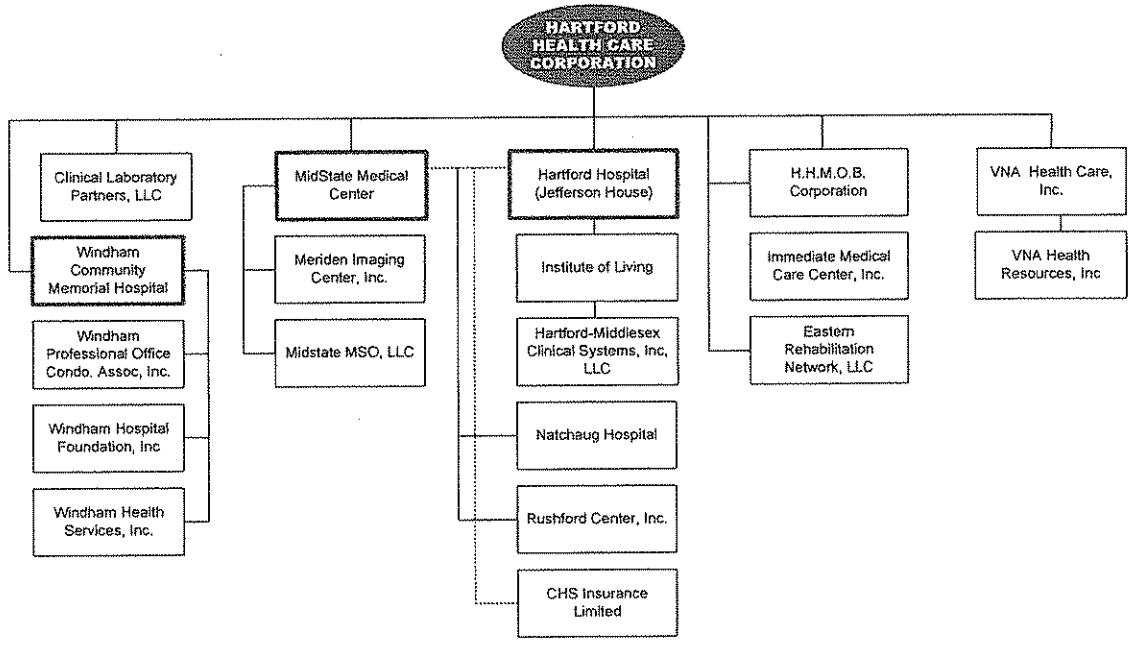
Chart One: CCHA Organizational Chart Prior to the Proposed Affiliation:



(November 19, 2009, Initial CON Application, Exhibit 8)

8. The Applicants assert that the organizational chart of HHCC prior to the proposed affiliation with CCHA is as follows:

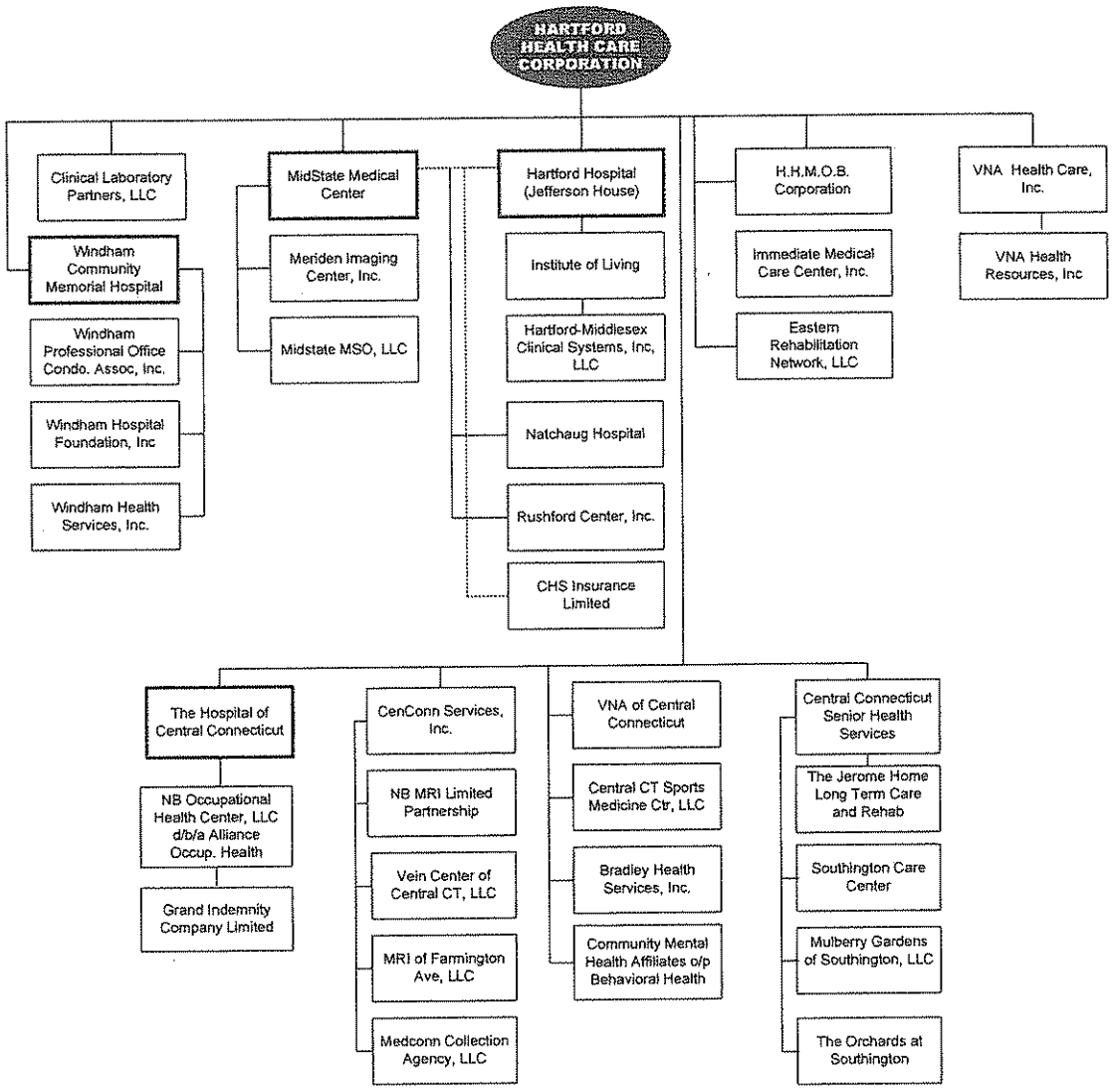
Chart Two: HHCC Organizational Chart prior to the Proposed Affiliation:



(November 19, 2009, Initial CON Application, Exhibit 8)

9. The Applicants contend that the proposed organizational chart of CCHA and its affiliates after the proposed affiliation is as follows:

Chart Three: CCHA Organizational Chart After the Proposed Affiliation:



(November 19, 2009, Initial CON Application, Exhibit 8)

10. According to the Memorandum of Understanding ("MOU") between the Applicants, HHCC will receive two (2) voting Ex Officio seats on the CCHA Board and two (2) voting Ex Officio seats on HOCC Board. *(November 19, 2009, Initial CON Application, Exhibit 6, page 161)*

11. According to the Memorandum of Understanding ("MOU") between the Applicants, the Board of HHCC shall be comprised of not less than twelve (12) nor more than sixteen (16) directors, two of whom shall be additional members. For the first three (3) years after closing, the Chairman and Vice Chairman of CCHA/HOCC will serve as the Additional Members of the Board of HHCC, Ex Officio, with vote. Thereafter HHCC shall appoint two (2) members to the HHCC Board that reside in the Central Connecticut service area region. *(November 19, 2009, Initial CON Application, Exhibit 6, page 161)*

12. Section VII of the MOU states that by the third anniversary of the closing, if the HHCC Board is not determined on a representational basis as reflected in their updated Bylaws, CCHA shall be entitled to withdraw from the System without HHCC approval, at which time the MOU shall terminate in its entirety. *(November 19, 2009, Initial CON Application, Exhibit 6, page 162)*

13. The MOU submitted with the proposal states that the following decisions as they relate to CCHA/HOCC are subject to System level approval:

(a). Annual operating and capital budgets as developed by CCHA/HOCC;
(b). The sale, pledges, leases, transfer or other disposition of substantial assets of CCHA/HOCC;
(c). Plans for the borrowing of any sum greater than $1,000,000, which has a term greater than one year or which is secured by a mortgage of any portion of CCHA or HOCC real estate;
(d). Dissolution or liquidation of CCHA, HOCC or any of their subsidiaries; and
(e). Amendments to the articles and Bylaws of CCHA and HOCC and their subsidiaries.
(November 19, 2009, Initial CON Application, Exhibit 6, page 163)

14. The Applicants contend the following:

(a). Summer 2008 - Representatives from both Applicant's boards met to discuss a possible affiliation and subsequently entered into a Confidentiality Agreement;

(b). Summer 2008 through Spring 2009 – The Applicant's Senior Management and Board Representatives met regularly to discuss opportunities for identifying efficiencies, and also met with CCHA's medical staff to discuss the Memorandum of Understanding;

(c). Spring to Summer 2009 - Due diligence was conducted by the Applicants, their respective Boards met to approve the proposed affiliation and a Memorandum of Understanding was negotiated and signed.
(November 19, 2009, Initial CON Application pages 14-15, and Exhibit 6, page 163)

15. The Applicants contend that the primary service area ("PSA") related to this proposal, based on HOCC, is as follows:

Table 1: HOCC's Primary Service Area

PSA	Berlin
	New Britain
	Plainville
	Southington

(November 19, 2009, Initial Certificate of Need Application, pages 15-16)

16. Based on hospital inpatient discharges, OHCA finds that the towns of New Britain, Southington, Berlin and Plainville comprise 71% of HOCC's discharged patients (see table below).

Table 2: HOCC's Discharge Total and Market Share by Town for FY 2009

	Percentage of Hospital Total	Cumulative Hospital Total	Percentage of Town's Market Share
New Britain	42%	42%	75%
Southington	16%	58%	60%
Berlin	7%	65%	60%
Plainville	7%	71%	56%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

17. The following tables illustrates the historical and projected utilization by service category for HOCC:

Table 3: HOCC's Historical Utilization by Service Category

HOCC	FY 2007	FY 2008	FY 2009
ED Visits	90,358	94,736	103,056
Ambulatory Surgery	9,206	8,981	8,872
Admissions			
Medical /Surgical	17,314	15,740	14,952
Pediatric	596	435	407
Newborn	1,969	1,893	1,878
Psychiatric	778	904	815
Maternity	2,149	2,034	1,988
Total Admissions	22,806	21,006	20,040

Table 4: HOCC's Projected Utilization by Service Category

HOCC	FY 2010	FY 2011	FY 2012	FY 2013
ED Visits	99,655	100,628	102,641	104,693
Ambulatory Surgery	7,100	7,100	7,100	7,100
Admissions				
Medical /Surgical	15,629	15,733	15,837	15,941
Pediatric	390	390	390	390
Newborn	1,824	1,824	1,824	1,824
Psychiatric	882	882	882	882
Maternity	1,983	1,983	1,983	1,983
Total Admissions	20,708	20,812	20,916	21,020

Note: The Applicants made the following assumptions with respect to HOCC volumes as illustrated above:

i. ED volume experienced annual growth from FY07-FY09 which is projected to continue since HOCC believes that the lack of primary care in the Greater New Britain market is contributing to patients seeking care in the ED;
ii. Ambulatory surgery has seen a slight decrease over time due to lack of specialized surgeons practicing at HOCC. It is projected to stabilize due to advancements in medical treatment.
iii. Patient days and discharges have trended downward especially in med/surg since observation stay utilization has increased in the past three years; and
iv. The volume projections reflect the stabilization of the non med/surg trends as HOCC continues to see a decline in those populations. This will be offset by an increase in med/surg volume as HOCC believes this growth is driven by the aging of the population it serves.
(February 3, 2010, Response to OHCA's Second Completeness Letter, page 375)

18. OHCA finds that the ED utilization rate for the HOCC-reported primary service area is higher than the overall statewide average. In FY 2008 utilization was 610 per 1,000 population in the HOCC primary service area, compared to 452 per 1,000 statewide, a difference of 158 visits. Similar results were found in FY 2007 and FY 2006 indicating higher ED utilization in the service area, a concern for OHCA. Health care services that could have been delivered in the community setting at a lower cost to the patient and the hospital appear to be occurring more frequently at the HOCC ED and may indicate a lack of primary care services in the area, as illustrated in the table below.

Table 5: Emergency Department Utilization Rates

	ED Visits[2]			Population[3]			Utilization per 1,000 of Population		
	FY 2006	FY 2007	FY 2008	FY 2006	FY 2007	FY 2008	FY 2006	FY 2007	FY 2008
Primary Service Area	83,882	90,113	91,630	150,553	150,253	150,321	557	600	610
Statewide	1,488,331	1,563,835	1,584,171	3,510,787	3,502,309	3,501,252	424	447	452

[1] Per Applicants, Primary Service Area includes the following towns: Berlin, New Britain, Plainville, Southington
[2] Source: Connecticut Hospital Association Chime ED Data
[3] Source: Department of Public Health Population Estimates for CT's Counties and Towns

19. OHCA finds that utilization for ambulatory surgery and inpatient services has substantially declined. In fact, the projections for these two categories in year 2013 are lower than the actual volumes reported in 2007.

20. Dr. Steven Hanks testified that a significant portion of ED visits are potentially treatable in a primary care setting. Even with the commitment to clinics and primary care practices in the community, and the presence of a Federally Qualified Health Care Center (FQHC), access to primary care still can't meet the growing demand. *(March 29, 2010, Public Hearing Testimony of Steven Hanks, Executive Vice President and Chief Medical Officer of Hospital of Central Connecticut)*

21. Mr. Laurence Tanner testified that there are significant payer mix issues that are getting worse. Last month, alone, nearly 50% of ED patients were covered by Medicaid or SAGA or were uninsured and there has been significant growth in these payer types over the last few years. *(March 29, 2010, Public Hearing Testimony of Mr. Laurence Tanner, Chief Executive Officer of Central Health Connecticut Alliance, Inc.)*

22. Mr. Elliot Joseph testified that his organization, Hartford Health Care System is working on a structure that to provide critical preventative primary care services. Based on the Hartford Medical Group, he believes the model is sustainable and scalable and they are beginning to move this program into various local communities. *(March 29, 2010,Public Hearing Testimony of Mr. Elliot Joseph, President and Chief Executive Officer of Hartford Health Care System)*

23. The following tables illustrate the historical and projected utilization for Hartford Hospital volumes by service category, as provided by the Applicants:

Table 6: HHCC's Historical Utilization by Service Category

Hartford Hospital	FY 2007	FY 2008	FY 2009
ED Visits	80,269	82,327	90,108
Ambulatory Surgery	12,095	13,102	13,565
Discharges/Services			
Medical /Surgical	27,763	27,821	29,150
Newborn	4,201	4,150	3,962
Psychiatric	3,618	3,992	4,390
Maternity	4,025	3,877	3,780
Total Discharges	39,607	39,840	41,282

(December 28, 2009, Responses to OHCA's First Completeness Letter, page 331)

Table 7: HHCC Projected Utilization by Service Category

Hartford Hospital	FY 2010	FY 2011	FY 2012	FY 2013
ED Visits	93,168	98,159	103,417	108,956
Ambulatory Surgery	12,894	13,302	13,628	13,962
Discharges				
Medical /Surgical	30,893	31,429	31,946	32,721
Newborn	4,199	4,272	4,342	4,447
Psychiatric	4,652	4,733	4,811	4,928
Maternity	4,006	4,075	4,143	4,243
Total Admissions	43,750	44,509	45,242	46,339

Note: The Applicants made the following assumptions with respect to HHCC volumes as illustrated above: ED and ambulatory surgery volumes have seen a growth of over 5% and 2%, respectively, and the trend is expected to continue through 2013. Discharge projections are based on historical averages and have experienced slight growth over the past three years. Average length of stay is projected to decrease in 2010, but will likely be offset by an aging population in future years.
(December 28, 2009, Responses to OHCA's First Completeness Letter, page 332)

24. The Applicants contend that over the last five years, HOCC has found it increasingly difficult to recruit specialist physicians. *(February 19, 2010, CON Application, page 10)*

25. Mr. Laurence Tanner testified that access to capital, community based programs, access to technology, and the ability to recruit physicians are some of the paramount issues for HOCC moving forward. *(March 29, 2010, Public Hearing Testimony of Mr. Laurence Tanner, Chief Executive Officer of Central Health Connecticut Alliance, Inc.)*

26. Mr. Tanner further testified that CCHA's board, medical staff, administration and senior staff all concluded that the vision and the talent of HHCC provided the best opportunity for CCHA/HOCC. *(March 29, 2010, Public Hearing Testimony of Mr. Laurence Tanner, Chief Executive Officer of Central Health Connecticut Alliance, Inc.)*

27. Mr. Tanner testified that by being part of a coordinated integrated delivery system, HOCC can effectively leverage technology and improve access to the best medical talent available for our patients. *(March 24, 2010, Prefile Testimony of Mr. Laurence Tanner, Chief Executive Officer of Central Health Connecticut Alliance, Inc., page 4)*

28. Mr. Elliot Joseph testified that this proposal responds to current state and federal recommendations and health care reform initiatives that requires the providers of health care to focus on quality and reduced healthcare costs, rather than on the volume of services. *(March 24, 2010 and March 29, 2010, Prefile and Hearing Testimony of Mr. Elliot Joseph, President and Chief Executive Officer of Hartford Health Care System)*

29. Mr. Joseph testified that this proposal will aid in the receipt of funding to the Applicants under the proposed federal health care reform initiatives from the federal government and national insurers. *(March 29, 2010, Hearing Testimony of Mr. Elliot Joseph, President and Chief Executive Officer of Hartford Health Care System)*

30. Mr. Joseph testified that with the new federal health care reform, there would be approximately 32 million additional patients that would require medical care and health care providers will have to develop models of health care that can offer primary care and preventative care and approaches to models of total health systems (i.e. Hospital, Outpatient Clinics, FQHC's, Medical Homes, Look-Alikes, etc.) will be required. *(March 29, 2010, Hearing Testimony of Mr. Elliot Joseph, President and Chief Executive Officer of Hartford Health Care System)*

Financial Feasibility of the Proposal and its Impact on the Applicants' Rates and Financial Condition
Impact of the Proposal on the Interests of Consumers of Health Care Services and Payers for Such Services
Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines

31. The Applicants contend that access to capital and debt capacity will increase and the borrowing costs will decrease. One of the benefits of an obligated group structure is that it allows the lender/investor to have recourse against several debtors. Consequently, they are more willing to provide access to credit to an obligated group. *(February 3, 2010, 2nd Completeness Responses, page 2)*

32. The Applicants have made assumptions that with the proposed obligated group structure, CCHA/HHCC combined credit rating would likely be in the mid "A" category, which will translate into an approximate 0.5%-1.0% reduction to their cost of borrowing. *(February 3, 2010, 2nd Completeness Responses, page 2)*

33. The FY 2009-Audited Financial Statements submitted by the Applicants demonstrate that a credit rating improvement translates into a 1% improvement in the cost of borrowing for both systems as follows:

Table 8: Estimated Cost of Borrowing with and without the proposal for HHCC and CCHA

Description	HHCC	CCHA
Total Debt-FY 2009	$165,631,000	$56,958,603
Interest Rate * without the project	6.25%	7.23%
Total Cost without the project	$10,351,937	$4,118,107
Interest Rate with the project	5.25%	6.23%
Total Cost with the project	$8,695,627	$3,548,521
Total Savings	$1,656,310	$569,586
Total Percentage **	1%	1%

Source: FY 2009 Hospital's Annual Filings-Parent corporation Audited Financial Statements.
**Interest rate is based on the highest rate presented on Note 8-Audited Financial Statements for both systems.*
***For HHCC=$1,656,310 ÷$165,631,000=1%, and for CCHA=$569,586 ÷$56,958,603=1%.*

34. The Applicants contend that with approval of the proposal, the debt related savings will amount to $44.7 million for both HHCC and CCHA. The reduction in the cost of borrowing would equate to potential debt related savings of $32.2 million when applied to HHCC's and CCHA's current outstanding debt and $12.5 million when applied to future debt related to new projects and equipment. *(February 3, 2010, 2nd Completeness Responses, pages 2-3)*

35. The Applicants contend that cost savings will also be realized in banking, investment expense, and asset management. With the consolidation and pooling of cash management, custodial services, line of credit, and other services, fees would be renegotiated based on the larger pool of funds covered. The Applicants project a total amount of $15.5 million in banking and investment related savings for both systems. *(February 3, 2010, 2nd Completeness Responses, pages 1-2)*

36. OHCA finds that the total projected savings of $60.2 million related to the cost of borrowing, and banking and investment expenses are realistic savings that will improve the way in which both systems manage their current and future debt, and banking and investment assets.

37. The Applicants contend that cost savings of $1 million in year four, $2 million in year five and $3 million in year six will result from the consolidation of the Applicants' information technology system applications and HOCC's infrastructure and technology support functions with HHCC. *(February 3, 2010, 2nd Completeness Responses, pages 1-2)*

38. OHCA finds that the consolidation of the Applicants' IT systems and support functions will not only result in cost savings, but will also improve the continuity and quality of patient care.

39. The Applicants contend that cumulative savings for CCHA and HHCC with the proposed merger will be at least $230 million for FY 2010 through FY 2015 as indicated below:

Table 9: Cost savings by year

Year	Savings
FY 2010	$5,000,000*
FY 2011	$19,500,000
FY 2012	$41,666,667
FY 2013	$59,666,667
FY 2014	$59,667,667
FY 2015	$30,000,000*
Inflation	$15,000,000
Total	**$230,500,001**

* Data is for 6 months only

(February 3, 2010, Completeness Responses, Exhibit 21, pages 316)

40. The Applicants contend that the proposed affiliation will allow for potential administrative cost savings of at least $230.5 million in the first five years of the proposal as illustrated in the table below. The projected savings will be achieved by the centralization and consolidation of "back office " administrative functions in the areas related to:

(a) Administration, fringe benefits, finance and turnover savings. (Salaries & Benefits Expenses)
(b) Materials Management, food services and pharmacy. (Supplies and Drugs Expenses)
(c) Improvement on Bad Debts and denials. (Bad Debts Expense)
(d) Printing services, transcription services, information services, purchased goods and services, physician and patient billing, library services, clinical opportunities and quality improvements. (Other Expenses)
(February 3, 2010, 2nd Completeness Responses, Exhibit 18, pages 380-381)

Table 10: Administrative Cost Savings

	TOTAL CCHA	TOTAL HHCC	5 YRS. TOTAL COST SAVINGS FOR BOTH APPLICANTS
Salaries & Benefits	$14,990,000	$22,920,000	$37,910,000
Supplies & Drugs	$5,930,000	$17,790,000	$23,720,000
Bad Debts	$6,125,000	$18,375,000	$24,500,000
Other Expenses	39,984,168	$119,052,500	$159,036,668
Total	**$67,029,168**	**$178,137,500**	**$245,166,668***

- **This figure includes 6 months of savings for FY 2010, 12 months for FY 2015 and does not include an inflation adjustment. To reconcile to the 5 year estimate of $230.5M in Table 9, add the savings projected over 5 years from inflation ($15M) and deduct 6 months of administrative savings from FY 2015 = $245M+$15M - $30M($60M * 6/12months) = ≈$230.5M estimated cost savings for the 5-year period.* (December 28, 2009, Completeness Responses, pages 329 and 333; February 3, 2010, Completeness Responses, Exhibit 18, pages 380-381)

41. OHCA finds that the Applicant's projection of approximately $230.5 million in administrative cost savings for the period of FY 2010-2015, as a result of centralization and consolidation of "back office" functions, appears to be reasonable and achievable.

42. The Applicants contend that CCHA will realize $67.1 million total cost savings in operating expenses and a total of $230.5 million in total cumulative savings as the result of the affiliation:

Table 11a: Projected CCHA's operating expenses cost savings, FY 2010-FY 2015

Description	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	Savings
Salaries & Fringe Benefits	$810,000	$1,815,000	$2,585,000	$3,260,000	$3,260,000	$3,260,000	$14,990,000
Supplies and Drugs	$237,500	$325,000	$1,100,000	$1,422,500	$1,422,500	$1,422,500	$5,930,000
Bad Debts	$125,000	$500,000	$1,000,000	$1,500,000	$1,500,000	$1,500,000	$6,125,000
Other Operating Expenses*	$482,500	$3,157,500	$6,834,167	$9,836,667	$9,836,667	$9,836,667	$39,984,168
Total Operating Expenses-Savings	$1,655,000	$5,797,500	$11,597,167	$16,019,167	$16,019,167	$16,019,167	$67,029,168
Total Savings Cumulative for both systems	$5,000,000**	$19,500,000	$41,666,667	$59,666,667	$59,666,667	$59,666,667	$245,166,668***

**Includes savings from the following departments: Printing Services, Physician Billing, Library, Patient billing, transcription services, information services, clinical opportunities, purchased goods and services, and quality improvements.*
***FY 2010 period only six months-the Applicant assumes that once the proposal is approved the affiliation will occur at least six months into the Fiscal Year.*
*****This figure includes 6 months of savings for FY 2010, 12 months for FY 2015 and does not include an inflation adjustment. To reconcile to the 5 year estimate of ≈$230.5M in Table 9, add the savings projected over 5 years from inflation ($15M) and deduct 6 months of administrative savings from FY 2015 = $245M+$15M - $30M($60M * 6/12months) = $230.5M estimated cost savings for the 5-year period.*
(February 3, 2010, 2nd Completeness Responses, Exhibit 18, pages 380-381, and Exhibits 21 and 22, pages 415-418)

Table 11b: Projected HHCC's operating expenses cost savings, FY 2010-FY 2015

Description	FY 2010 (6months)	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	Savings
Salaries & Fringe Benefits	$870,000	$1,875,000	$3,525,000	$5,550,000	$5,550,000	$5,550,000	$22,920,000
Supplies and Drugs	$712,500	$975,000	$3,300,000	$4,267,500	$4,267,500	$4,267,500	$17,790,500
Bad Debts	$375,000	$1,500,000	$3,000,000	$4,500,000	$4,500,000	$4,500,000	$18,375,000
Other Operating Expenses*	$1,387,500	$9,352,500	$20,322,500	$29,330,000	$29,330,000	$29,330,000	$119,052,500
HHCC's Total Operating Expenses-Savings	$3,345,000	$13,702,500	$30,147,500	$43,647,500	$$43,647,500	$43,647,500	$178,138,000
Total Savings Cumulative for both systems	$5,000,000**	$19,500,000	$41,666,667	$59,666,667	$59,666,667	$59,666,667	$245,166,168***

**Includes savings from the following departments: Printing Services, Physician Billing, Library, Patient billing, transcription services, information services, clinical opportunities, purchased goods and services, and quality improvements.*
***FY 2010 period only six months-the Applicant assumes that once the proposal is approved the affiliation will occur at least six months into the Fiscal Year.*
****This figure includes 6 months of savings for FY 2010, 12 months for FY 2015 and does not include an inflation adjustment. To reconcile to the 5 year estimate of ≈$230.5M in Table 9, add the savings projected over 5 years from inflation ($15M) and deduct 6 months of administrative savings from FY 2015 = $245M+$15M - $30M($60M * 6/12months) = $230.5M estimated cost savings for the 5-year period.* (February 3, 2010, 2nd Completeness Responses, Exhibit 18, pages 380-381, and Exhibits 21 and 22, pages 415-418)

43. The Applicants contend that they utilized the Thomson-Reuters Action O-I benchmarking tool, which includes statistics from over 700 hospitals and health systems nationwide, to calculate cost savings for the proposal. *(December 28, 2009, Completeness Responses, pages 333)*

44. The Applicants contend that they also calculated the attrition of employees of both CCHA and HHCC when estimating potential cost savings. *(December 28, 2009, Completeness Responses, pages 333)*

45. The Applicants contend that there will be no change in the entity billing for services provided by acute care hospitals under CCHA after the proposal. HOCC will continue to bill and collect in its own name as it does now. *(December 28, 2009,Completeness Responses, page 337)*

46. The projected incremental revenue from operations, total operating expense and gains from operations associated with the proposal are presented in the table below for six months of FY 2010 and the first three years with the proposed project:

Table 12: HHCC's Incremental Financial Projections

Description	FY 2010	FY 2011	FY 2012	FY 2013	Total 4 years
Incremental Revenue from Operations	$462,543,333	$476,884,278	$492,090,256	$508,139,547	$1,939,657,414
Incremental Total Operating Expense	$453,235,179	$454,048,396	$455,044,513	$450,241,478	$1,812,569,566
Incremental Gain from Operations	**$9,308,154**	**$22,835,882**	**$37,045,743**	**$57,898,069**	**$127,087,848**

(December 28, 2009, Completeness Responses, Financial Attachment I, pages 338-341)

47. OHCA finds that the incremental gain of $127.1 M from operations appears to be reasonable since it reflects the expected cost savings from operations between FY 2010 and FY 2013. In four years, HHCC expects savings from operations to total $90.1 million ($3.3 M in FY 2010, $13.7 M in FY 2011, $30.1 M in FY 2012 and $43.6 M in FY 2013). Savings from operations account for 71% of the incremental gains; the remaining gains would result from additional revenues generated from operations.

48. The Applicants contend that CCHA expects to see a slight shift from non government to government payers due to an aging population. CCHA's current patient population mix and projected population mix with the CON proposal is as follows:

Table 13: Current and Three-Year Projected Population Mix with the CON Proposal

Total CCHA	**2008 Current Payer Mix**	**2010 Projected Payer Mix**	**2011 Projected Payer Mix**	**2012 Projected Payer Mix**
Medicare	44.6%	44.8%	45.1%	45.3%
Medicaid	17.5%	17.6%	17.7%	17.8%
TRICARE and CHAMPUS	0.1%	0.1%	0.1%	0.1%
Total Government	**62.2%**	**62.5%**	**62.8%**	**63.1%**
Commercial Insurers	34.4%	34.1%	33.8%	33.5%
Uninsured	2.5%	2.5%	2.5%	2.5%
Workers Compensation	0.9%	0.9%	0.9%	0.9%
Total Non-Government	**37.8%**	**37.5%**	**37.2%**	**36.9%**
Total Population Mix	**100%**	**100%**	**100%**	**100%**

Table represents Inpatient volumes from the HOCC.
(November 19, 2009, Initial Certificate of Need Application, page 22)

HHCC's current population mix and projected population mix with the CON proposal is as follows:

Table 14: Current and Three-Year Projected Population Mix with the CON Proposal

Total HHCC	**2008 Current Payer Mix**	**2010 Projected Payer Mix**	**2011 Projected Payer Mix**	**2012 Projected Payer Mix**
Medicare	40%	40%	40%	40%
Medicaid (includes other medical assistance)	20%	20%	20%	20%
TRICARE and CHAMPUS	1%	1%	1%	1%
Total Government	**61%**	**61%**	**61%**	**61%**
Commercial Insurers*	37%	37%	37%	37%
Uninsured Workers Compensation	2%	2%	2%	2%
Total Non-Government	**39%**	**39%**	**39%**	**39%**
Total Population Mix	**100%**	**100%**	**100%**	**100%**

**Includes Worker's Compensation.*
Table represents Inpatient volumes from HHCC hospitals (Windham Community Memorial Hospital, MidState Medical Hospital and Hartford Hospital).
(November 19, 2009, Initial Certificate of Need Application, page 22)

49. The Applicants contend that this proposal is consistent with each of their respective long-range plans in that HHCC will continue to spread the risk and rewards across the system, CCHA will continue to sustain its tradition of quality by working in a collaborative manner to allow the most efficient use of health care dollars and services, and to attain best staff and technology in the most cost-effective manner. *(November 19 2009 Initial Certificate of Need Application, page 25)*

50. The Applicants contend that the proposal will allow for the development of system-wide cross-coverage arrangements which will allow the hospital's patients and staff greater access to technology, clinical research and the most qualified physicians. A joint recruitment and appointment structure will allow their staff to enjoy expanded professional, educational and collegial relationships beyond those normally available in stand-alone community-based hospitals. *(November 19 2009 Initial Certificate of Need Application, page 11*

51. OHCA finds that the ability to recruit and retain high quality physicians will be enhanced through this affiliation due to greater access to technology and clinical research opportunities.

52. The Applicants contend that there are no distinguishing characteristics of their patient/physician mix that makes the proposal unique. *(November 19 2009 Initial Certificate of Need Application, page 26)*

53. The Applicants provided resumes of its executive leadership team associated with this proposal demonstrating that they have sufficient managerial and financial experience in managing health care organizations to provide efficient and adequate service to the public. *(November 19 2009 Initial Certificate of Need Application, pages 18 and Exhibit 9)*

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g., the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

Hartford Health Care Corporation ("HHCC") is the parent corporation of Hartford Hospital, MidState Medical Center and Windham Hospital. Central Connecticut Health Alliance ("CCHA") is the parent corporation of Hospital of Central Connecticut ("HOCC"), which has campuses in New Britain and Southington, Connecticut. HHCC and CCHA/HOCC are proposing the affiliation of CCHA and HHCC, with no associated capital expenditure.

The proposed affiliation is intended to help strengthen their access to capital, generate cost savings and leverage recruitment and retention of high quality physicians. In addition, the proposed affiliation is expected to enhance the ability of the Applicants to create a stronger health care system that will maintain services and preserve access to care.

OHCA finds that the Applicants' projected $230.5 Million in administrative cost savings over the first five years following the affiliation is reasonable and achievable. The cost savings will result from the consolidation of administrative functions, including: debt savings, information technology system applications, infrastructure and technology support functions, banking and investment expenses, and asset management. (FoF 41) In addition, the Applicants contend that the consolidation of their IT systems and support functions will result in additional cost savings of $1M beginning in year four, $2 M in year five, and $3 M in year six. OHCA further finds that the incremental gain of $127.1 M from operations appears to be reasonable; and in four years, HHCC anticipates savings from operations to total $90.1 M. Such operational savings will offer stability in the hospital delivery system in the New Britain area. (FoF 47) OHCA finds the financial projections and volumes upon which they are based appear to be reasonable and achievable. OHCA expects that the consolidation of the Applicant's IT systems will provide cost savings and will improve the continuity and quality of patient care. (FoF 38)

OHCA heard testimony from the Applicants that acknowledged a significant portion of ED visits are potentially treatable in a primary care setting. (FoF 20)

Furthermore, OHCA finds that the ED utilization rate for the HOCC-reported primary service area is substantially higher than the overall statewide average. HOCC's ED utilization for FY 2008 was 610 per 1,000 population and exceeds the state's overall ED utilization rate of 452 per 1,000. OHCA is concerned about the use of the ED for health care services that can be delivered in the community setting at a lower cost to the patient and the hospital. (FoF 18) Despite the existing clinics, primary care practices in the community and a federally qualified health center, ED utilization rates continue to rise and may indicate an insufficient number of primary care services in the area. According to Mr. Elliot Joseph's testimony, Hartford Health Care System is working on a model that will provide preventative and primary care services to the area that will be sustainable and consistent with federal health care reform recommendations.

OHCA finds that the proposed affiliation will allow better access to capital, technology and provide cost efficiencies for both Applicants to create a stronger health care system. Shared best practices, an integrated IT system and the ability to recruit and retain top-level physicians will enhance the Applicants' ability to respond to new federal health care reform initiatives that require health care providers to re-align all aspects of the delivery system and better coordinate those services around the patients' needs. Hospitals, such as HOCC, would find it difficult to meet the future requirements and financial challenges as a stand-alone hospital; and therefore, OHCA concludes that this proposal will create a larger and financially stronger health care delivery system that will better address these demands and continue access to quality care in the area.

ORDER

Based on the foregoing Findings and Rationale, the Certificate of Need application of Central Connecticut Health Alliance ("CCHA") and Hartford Health Care Corporation ("HHCC") (together referred to as "Applicants") for an affiliation, with no associated capital expenditure, is hereby **Approved,** subject to the following conditions:

1. Within 60 days of the completion of the affiliation between CCHA and HHCC, the Applicants shall file with OHCA; a full copy of any and all signed, dated and completed final affiliation agreements, including attachments indicating the affiliation of CCHA with HHCC has occurred.

2. If in the future there is any change in the ownership structure of CCHA, HHCC or its affiliates or any change in the affiliation agreement, the Applicants shall file a CON Determination Form with OHCA.

3. If in the future there is any change in CCHA service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA.

4. Within 60 days of the completion of the affiliation between CCHA and HHCC, the Applicants shall file with OHCA a comprehensive plan that includes the following:

   (i) A detailed environmental assessment of the need for primary care in the HOCC service area;

   (ii) The locations of current primary care providers in the HOCC service area;

   (iii) A discussion of how the Applicants will recruit primary care physicians in the HOCC service area;

   (iv) A discussion of how the Applicants will specifically address the need for additional primary care in the HOCC service area, including, but not limited to, increasing existing primary care staff and/or hours, implementing new or expanding current primary care services; and

   (v) A discussion of any plans the Applicant has to pursue 2010 Patient Protection and Affordable Care Act federal funding opportunities related to primary care.

5. The Applicants shall schedule a meeting with OHCA to occur within 30 calendar days of the filing of the comprehensive plan to discuss the Applicants' provision of findings pursuant to Condition #4.

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

5-7-10
Date

Cristine A. Vogel
Deputy Commissioner