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1
2 STATE OF CONNECTICUT
3 DEPARTMENT OF PUBLIC HEALTH
4 OFFICE OF HEALTH STRATEGY
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7 Yale New Haven Hospital (24-32705-CON) & (24-32744-CON)
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10 CERTIFICATE OF NEED APPLICATION and PUBLIC HEARING
11 Re: Yale New Haven Hospital, Acquiring a New MRI
12 Scanner (32705) & Acquiring a New CT Scanner (32744)
13
14 HELD BEFORE: ALICIA NOVI, ESQ., THE HEARING OFFICER
15
16
17 DATE: October 30, 2024
18 TIME: 9 a.m.
19 PLACE: (Held Via Teleconference)
20
21
22 Reporter: Robert G. Dixon, N.P., CVR-M #857
23
24
25

1 **APPEARANCES**

2 **OHS Staff:**

3 **STEVEN LAZARUS,**

4 **CON Program Supervisor**

5

6 **OLIVIA MARIANO,**

7 **Planning Analyst**

8

9 **YADIRA McLAUGHLIN,**

10 **Healthcare Analyst**

11

12 **ORMAND CLARKE,**

13 **Healthcare Analyst**

14

15 **NICOLE TOMCZUK,**

16 **Healthcare Analyst**

17

18 **FAYE FENTIS,**

19 **Case Manager**

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1 **APPEARANCES (cont'd)**

2

3 **For THE APPLICANT (YALE NEW HAVEN HOSPITAL):**

4 **SHIPMAN & GOODWIN, LLP**

5 **942 Main Street**

6 **Hartford, Connecticut 06103**

7 **By: JOAN W. FELDMAN, ESQ.**

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1 (Begin: 9:00 a.m.)

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3 THE HEARING OFFICER: Okay. Good morning. It is now 9

4 a.m. I'm going to go ahead and ask Ms. Fentis if

5 she'll start the recording.

6 Okay. Good morning. This is an OHS hearing,

7 a combined hearing for Docket Numbers 24-32705-CON

8 and 24-32744-CON. This is the combined hearing

9 for Yale New Haven Hospital, the Applicant in both

10 matters. They seek certificates of need for the

11 acquisition of imaging equipment persaunt to

12 Connecticut General Statutes 19a-638(a)(10).

13 Specifically, Yale New Haven Hospital seeks

14 authorization to purchase one intraoperative MRI

15 machine and one PET/MR for -- I'm going to ask

16 this because -- is it Saint Ray-fee-el [phonetic]

17 or Saint Raff-aye-el [phonetic]?

18 ATTORNEY FELDMAN: Ray-fee-el's [phonetic].

19 THE HEARING OFFICER: That's what I thought but it

20 looks like Raff-aye -- okay. Saint Raphael's

21 campus under 24-32705-CON, and the acquisition of

22 two incremental CT scanners for the Saint

23 Raphael's campus as part of 24-32744-CON.

24 Throughout the proceeding, I'll be

25 interchangeably referring to Yale New Haven

1 Hospital as YNHH and the Saint Raphael's campus as
2 SRC for brevity purposes.
3 Today is October 30, 2024. My name is Alicia
4 Novi. Dr. Deidre S. Gifford, the Commissioner of
5 the Office of Health Strategy, designated me to
6 serve as Hearing Officer for this matter to rule
7 on all motions and recommend findings of facts and
8 conclusions of law upon completion of the hearing.
9 Public Act 21-2, as amended by Public Act
10 22-3, authorizes an agency to hold a public
11 hearing by means of electronic equipment. In
12 accordance with this legislation, any person who
13 participates orally in an electronic meeting shall
14 make a good-faith effort to state his, her, or
15 their name and title at the onset of each occasion
16 that such person participates orally during an
17 uninterrupted dialogue or series of questions and
18 answers. We ask that all members of the public to
19 mute the device they are using to access the
20 hearing and silence any additional devices that
21 are around them.
22 This public hearing being held for two CON
23 applications pursuant to Connecticut General
24 Statutes Sections 19a-639a(f)(2) which provides
25 that HSP may hold a public hearing with respect to

1 any certificate of need application submitted
2 under Chapter 368z.
3 Although this will be a discretionary
4 hearing, the manner in which OHS conducts these
5 proceedings will be guided by Chapter 54 of the
6 Uniform Administrative Procedures Act, the UAPA,
7 and the Regulations of Connecticut State Agencies,
8 Sections 19a, 9 through 24.
9 The Office of Health Strategy staff are here
10 to assist me in gathering facts related to this
11 application and may be asking the applicant
12 witnesses questions. I'm going to ask each person
13 assisting with questions today to identify
14 themselves with the name, the spelling of their
15 last name, and their OHS title.
16 We'll start with Mr. Lazarus.
17 MR. LAZARUS: Good morning. Steven Lazarus,
18 L-a-z-a-r-u-s, and I'm the supervisor of the
19 Certificate Of Need Program.
20 THE HEARING OFFICER: Thank you.
21 Ms. McLaughlin?
22 MS. McLAUGHLIN: Good morning, my name is Yadira
23 McLaughlin, M-c-L-a-u-g-h-l-i-n, and I'm a
24 planning analyst, OHS Certificate Of Need Program.
25 THE HEARING OFFICER: Thank you.

1 Ms. Mariano?
2 MS. MARIANO: Good morning. My name is Olivia Mariano,
3 M-a-r-i-a-n-o, and I'm a planning analyst with
4 OHS.
5 THE HEARING OFFICER: Thank you.
6 Mr. Clarke?
7 MR. CLARKE: Good morning. My name is Ormand Clarke,
8 and my last name is spelled C-l-a-r-k-e.
9 THE HEARING OFFICER: And Ms. Tomczuk?
10 MS. TOMCZUK: (No response.)
11 THE HEARING OFFICER: We are having some technical
12 difficulties with Ms. Tomczuk.
13 Are you able to be heard?
14 MS. TOMCZUK: (No response.)
15 THE HEARING OFFICER: Okay. It looks like she is not.
16 I will go ahead and say her name. It is Nicole
17 Tomczuk, T-o-m-c-z-u-k, and she is -- Steve, if
18 you can correct me if I'm wrong. She's a planning
19 analyst from the Office of Health Strategy.
20 MR. LAZARUS: She's a healthcare analyst.
21 THE HEARING OFFICER: Thank you. She's a healthcare
22 analyst for the Office of Health Strategy.
23 Ms. Tomczuk is having some technical difficulties
24 with her mic today, so you may not hear much from
25 her.

1 All right. Also present is Faye Fentis, who
2 is helping us with all of our behind-the-scenes
3 support and is a staff member for our agency. She
4 will be doing the hearing logistics and will be
5 gathering names for public comment which, by the
6 way, is now open at this time. If you would like
7 to register for public comment, please do so in
8 the chat function at this time if you would like
9 to make one.
10 The certificate of need process is a
11 regulatory process, and as such the highest level
12 of respect will be afforded to the Applicant,
13 members of the public, and our staff. Our
14 priority is the integrity and transparency of this
15 process. Accordingly, decorum must be maintained
16 by all present during these proceedings.
17 This hearing is being transcribed and
18 recorded, and the video will be made available on
19 the OHS website and its YouTube account. All
20 documents related to this hearing that have been
21 or will be submitted to the Office of Health
22 Strategy are available for review through our
23 certificate of need portal, which is accessible on
24 the Office of Health Strategy's CON webpage.
25 In making my decision, I will consider and

1 make written findings in accordance with Section
2 19a-639 of the Connecticut General Statutes.
3 Lastly, as Zoom notified you in the course of
4 either entering this hearing or right as the
5 recording started, I wish to point out that by
6 appearing on camera in this virtual hearing you
7 are consenting to being filmed. If you wish to
8 revoke your consent, please do so at this time.
9 All right. So as of 3:30 last night the CON
10 portal contained pre-hearing tables of record for
11 each CON. At this time -- at the time that I
12 looked it up, the exhibits are identified in the
13 table from A to O on Docket Number 24-32705-CON,
14 and A to K for a Docket Number 24-32744-CON.
15 There are some other exhibits I will get to
16 as well that we'll go in. And we did receive two
17 packets that went into each docket number of
18 community support, and those letters will also be
19 uploaded as an exhibit.
20 The Applicant is hereby noticed that I'm also
21 taking administrative notice of the following
22 documents; the Statewide Health Care Facility
23 Services Plan, the Facilities and Services
24 Inventory, the OHS Acute Care Hospital Discharge
25 Database, and the All-Payer Claims Database claims

1 data.

2 I also want to take notice of Yale New Haven

3 Hospital agreed settlement 22-32586-CON and the

4 previously issued Yale New Haven Hospital decision

5 24-32735-CON. I may also make or take

6 administrative notice of hospital reporting

7 system, HRS financial and utilization data, and

8 also prior OHS decisions, agreed settlements, and

9 determinations that may be relevant in this

10 matter.

11 Counsel for the Applicants, can you please

12 identify yourself for the record?

13 ATTORNEY FELDMAN: Yes. Good morning, Hearing Officer

14 Novi and OHS staff. My name is Joan Feldman and

15 I'm a partner with the law firm Shipman & Goodwin,

16 counsel for the Applicants.

17 THE HEARING OFFICER: Thank you. Attorney Feldman, are

18 there any objections to the exhibits in the table

19 of record for either 24-32705 or 24-32744?

20 ATTORNEY FELDMAN: I have no objections to the table of

21 records as they appear right now.

22 THE HEARING OFFICER: Okay. Do you have any objections

23 to the two packets of letters of support that went

24 into each one becoming a full exhibit as well?

25 ATTORNEY FELDMAN: None.

1 **THE HEARING OFFICER: Okay. All right. Or any of the**
2 **other noticed documents that I just mentioned?**
3 **ATTORNEY FELDMAN: No objection.**
4 **THE HEARING OFFICER: All right. I'm going to mark all**
5 **identified and marked exhibits are entered as full**
6 **exhibits.**
7
8 **(24-32705-CON Exhibit Letters A through O,**
9 **marked for identification and noted in index; and**
10 **24-32744-CON Exhibit Letters A through K, marked**
11 **for identification and noted in index.)**
12
13 **THE HEARING OFFICER: Attorney Feldman, do you have any**
14 **additional exhibits that you wish to enter at this**
15 **time?**
16 **ATTORNEY FELDMAN: No, we do not.**
17 **THE HEARING OFFICER: All right. Thank you.**
18 **We'll now proceed in the order established**
19 **for today's hearing. I would like to advise the**
20 **Applicants that we may ask questions related to**
21 **your applications that you feel you've already**
22 **addressed. We will do this for the purpose of**
23 **ensuring that the public has knowledge of your**
24 **proposals and for the purpose of clarification.**
25 **I want to reassure you that we have reviewed**

1 both applications, all completeness responses, and
2 pre-filed testimony for both applications, and I
3 will do so many times before issuing a decision.
4 As this hearing is being held virtually, we
5 ask that all participants to the extent possible
6 should enable the use of video cameras when
7 testifying or commenting during proceedings. All
8 participants shall mute their devices and should
9 disable cameras when we go off the record or take
10 a break.
11 Please be advised that although we try and
12 shut off the hearing recording during breaks, it
13 may continue. If the recording is on, any audio
14 or video not disabled will be accessible to all
15 participants to this hearing.
16 Public comment taken during the hearing will
17 likely go in order established by OHS during the
18 registration process. However, I may allow public
19 officials to testify out of order. I or OHS staff
20 will call each individual by name when it is his
21 or her turn to speak. Registration for public
22 comment is open and is scheduled to start after
23 the technical testimony portion this morning. The
24 Applicants' witnesses must be available after
25 public comment as OHS may have follow-up questions

1 based on public comment.
2 Are there any housekeeping matters or
3 procedural issues we need to address before we
4 start, Attorney Feldman?
5 ATTORNEY FELDMAN: No.
6 THE HEARING OFFICER: All right. So with that we are
7 going to head into the technical portion.
8 Attorney Feldman, is there an opening
9 statement you would like to make?
10 ATTORNEY FELDMAN: Just a few comments. Again, good
11 morning, Hearing Officer Novi and OHS staff. We
12 have a significant amount of information and
13 testimony to share with you today for two
14 extraordinary projects underway at Yale New Haven
15 Hospital. More specifically, the focus of today's
16 hearing will be on the need for iMRI, PET-MR, and
17 two CTs, all of which will be hospital-based on
18 the Yale New Haven Hospital Saint Raphael's
19 campus.
20 First, you will hear from Dr. Laurans who
21 will address the need for iMRI in the new
22 Neurosciences Center. Then, you will hear from
23 Dr. Goodman who will address the need for both
24 PET-MR and two CTs, or two photon-counting CT
25 scanners both for the Neurosciences Center and the

1 **expanded emergency department on the Saint**
2 **Raphael's campus.**
3 **I think now we're ready for Dr. Laurans to**
4 **provide his pre-filed testimony.**
5 **THE HEARING OFFICER: Okay. So I'm going to ask,**
6 **actually, if you can, are all of your -- or is**
7 **everyone providing testimony in the room with you**
8 **right now?**
9 **ATTORNEY FELDMAN: Yes, they are.**
10 **THE HEARING OFFICER: Okay. So we're going to do this**
11 **a little differently. I'm going to ask that you**
12 **say their names and then you're going to have them**
13 **raise their hands so that we can visually note**
14 **them, and then I will swear them in and then they**
15 **can begin their testimony.**
16 **ATTORNEY FELDMAN: Okay. So what I'm going to do is**
17 **I'm going to point to each of the individuals in**
18 **the room, ask them to say their name.**
19 **And could they all be sworn in together?**
20 **THE HEARING OFFICER: I'm going to swear them all in**
21 **together. I would just like to note visually**
22 **where they are in the room.**
23 **ATTORNEY FELDMAN: Okay.**
24 **THE HEARING OFFICER: If you could have them raise**
25 **their hand just so we could see them? We'll swear**

1 them in with their hands raised, anyways.
2 MAXWELL LAURANS: Dr. Maxwell Laurans, L-a-u-r-a-n-s.
3 ROB GOODMAN: Dr. Rob Goodman, G-o-o-d-m-a-n.
4 DANIEL ALEXA: Daniel Alexa, A-l-e-x-a.
5 THE HEARING OFFICER: If we could have Mr. Alexa's --
6 I'm sorry, his title.
7 DANIEL ALEXA: Oh, I'm the Executive Director for
8 System Radiology Operations.
9 THE HEARING OFFICER: Thank you.
10 ANTHONY GIACCO: Anthony Giacco, Senior Manager of
11 Finance, G-i-a-c-c-o.
12 PAMELA SCAGLIARINI: Pam Scagliarini, Senior Vice
13 President of Administration.
14 ATTORNEY FELDMAN: Hearing Officer Novi, we're
15 expecting one additional witness who has not yet
16 arrived. I'll let you know when she's here.
17 THE HEARING OFFICER: We can swear them in if and when
18 they're required to answer any questions.
19 ATTORNEY FELDMAN: That would be great.
20 THE HEARING OFFICER: Okay. So everybody who has just
21 noticed, or just said their names out loud, if you
22 could all please raise your right hands? I will
23 swear you in now.
24
25

1 M A X W E L L   L A U R A N S,
2 R O B   G O O D M A N,
3 D A N I E L   A L E X A,
4 A N T H O N Y   G I A C C O,
5 P A M E L A   S C A G L I A R I N I,
6 called as witnesses, being first duly sworn
7 by THE HEARING OFFICER, were examined and
8 testified under oath as follows:
9
10 THE HEARING OFFICER: Great. Thank you. All right.
11 And with that, you may begin testimony. When you
12 are -- sorry. Actually, let me give a few
13 instructions. I'm sorry.
14 When giving your testimony, please make sure
15 to state your full name and spell your last name
16 for our stenographer if you haven't already, and
17 make sure that you adopt any written testimony you
18 submitted on the record prior to starting your
19 testimony. And if you're using acronyms, please
20 define them so that the public listening will know
21 what you're talking about.
22 All Right. Go ahead, Attorney Feldman.
23 THE WITNESS (Laurans): Thank you very much. Good
24 morning, Hearing Officer Novi and OHS staff. My
25 name is Dr. Maxwell Laurans. I'm an actively

1 practicing neurosurgeon at Yale New Haven
2 Hospital, and I'm the Senior Vice President of
3 Neurosciences at YNHH.
4 I very much appreciate the opportunity to
5 speak with you today about the Neurosciences
6 Center and the need for the proposed
7 intraoperative MRI. I may refer to this during my
8 testimony as iMRI as the abbreviation, or
9 intraoperative MRI. I adopt this pre-filed
10 testimony as my own.
11 My colleagues and I are extraordinarily
12 excited about the Neurosciences Center project,
13 which we plan to have begin operations in 2027.
14 We're going to share just a couple of slides to
15 give a visual depiction of this significant
16 project that we're undertaking.
17 If you can follow my pointer on the screen,
18 on the right side here we have much of the
19 existing Saint Raphael's campus. The project
20 centers around these two towers, the Mcgivney
21 Tower here under my cursor and the Sherman Tower
22 next to it. These represent a significant
23 expansion of our abilities, capacities, and
24 capabilities. There are about 200 patient beds in
25 these, in these towers.

1 The -- this is a visual rendering, an
2 architectural rendering, of what we anticipate
3 these may look like upon completion. This is
4 taken obviously from across the street.
5 This is the new entrance of the facility.
6 For anyone who knows the Saint Raphael's campus,
7 this again represents a significant improvement in
8 how patients will be able to access and enter the
9 facility.
10 During the April 2019 press conference on
11 initiation of the project, we were thrilled to be
12 able to partner with much of the community, and as
13 represented here, Governor Lamont and former Mayor
14 Toni Harp joined us in announcing this substantial
15 project.
16 And then lastly, this is a more of a
17 real-time screenshot. You may recall the -- the
18 initial rendering that I provided, and this is
19 sort of the state of the state with the outside of
20 the Mcgivney facility on the right here, beginning
21 to take shape. And you can appreciate this is
22 called a curtain wall which represents the out --
23 the outside of the facility.
24 So that you're aware, inside there's still
25 quite a lot of work to do even on this, on this

1 building.
2 And then we have the steel going up in the
3 Sherman Tower which will be slightly taller than
4 the Mcgivney Tower, but this is where the project
5 stands as of today.
6 You can take these slides down.
7 As I mentioned, we're -- we're really excited
8 about this project and the plan for it to begin
9 operations approximately in early 2027. And this
10 excitement is based on the fact that this center
11 will provide access to state-of-the-art care for
12 patients suffering from significant neurologic
13 disorders as well as serving as a hub for
14 neuroscience innovation in the care and treatment
15 of patients who have such serious neurological
16 diseases.
17 If any of you have known patients or families
18 of patients who suffer from serious neurological
19 disease, I'm thinking of conditions like
20 Alzheimer's disease, Parkinson's and other
21 movement disorders, stroke or epilepsy, you know
22 how life-altering and debilitating it can be to --
23 to suffer these, these conditions. And if you've
24 known these patients, you know how it really
25 steals what makes us uniquely human.

1 It steals our mind, and you know how limited
2 some of our existing treatment modalities are in
3 these spaces and how important it is that we work
4 to restore -- we work to restore function for
5 individuals suffering from those, those
6 conditions.
7 So this brings us to the role of an
8 intraoperative MRI for neurosurgeons in its
9 ability to help us visualize and assess an area in
10 the patient's brain with targeted precision. I
11 want to spend just one moment distinguishing
12 between a traditional MRI and an intraoperative
13 MRI.
14 Imaging has really come a very long way and
15 Dr. Goodman will share some -- some more detail
16 when -- when he provides his testimony, but
17 imaging has come a long way in being able to -- to
18 provide us the detailed visualization of a
19 patient's anatomy.
20 The intraoperative portion allows real-time
21 visualization of those structures while we're
22 performing interventions and surgeries.
23 Specifically, it allows us as neurosurgeons to
24 monitor our patient's bleeding or other
25 complications; for damage to surrounding tissue,

1 allowing us to better protect brain function; and
2 reducing the need for additional surgeries,
3 bringing patients back to an operating room for an
4 additional procedure. We're able to complete our
5 interventions at the time of the original
6 procedure as -- as a result.
7 So most commonly currently, but increasingly
8 in other fields, the intraoperative MRI is used to
9 remove tumors with targeted precision, but it's --
10 but it can also be used to assist in surgery for
11 vascular malformations, aneurysms, and stroke.
12 The intraoperative imaging technology and
13 stimulation of brain centers can also be used
14 currently and in the future to treat more complex
15 conditions.
16 We can use deep-brain stimulators inserted
17 with sub-millimeter accuracy to treat movement
18 disorders now. More complex conditions like
19 intractable depression, post-traumatic stress
20 disorder are on the horizon, but even today
21 obsessive-compulsive disorder has a known target
22 that we can use with deep-brain stimulation to
23 provide treatment.
24 I'm going to provide a couple of examples
25 with some detail in terms of how this technology

1 can be effectively used in this new Neurosciences
2 Center, and this is where targeted precision and
3 accuracy is vital to the work that we do.
4 In epilepsy patients have a portion of their
5 brain which abnormally discharges signals that can
6 lead to a seizure. We can identify that focus,
7 that epileptogenic focus. We can provide a
8 resection of that brain tissue and stop patients
9 from having seizures so that they don't need their
10 seizure medications anymore, and many of them can
11 return to normal function. One of the biggest
12 problems that patients have who have epilepsy is
13 that they often can't drive because of the risk in
14 driving.
15 We can use traditional brain resection like
16 we do in a tumor. We can also use a technology
17 called laser interstitial thermal therapy or LiTT,
18 which can ablate that tissue, again removing that
19 epileptogenic focus.
20 We can also place another kind of stimulator
21 called a responsive neurostimulator, or RNS, if
22 patients have an epileptogenic focus that starts
23 in a part of the brain that we can't injure or
24 remove.
25 So imagine, for example, someone whose speech

1 center was the epileptogenic focus, and if we were
2 to remove that part of the brain that patient
3 would never speak again. In those cases, we can
4 insert a stimulator into that part of the brain.
5 Again, this requires use of advanced imaging
6 modalities and intraoperative MRI to be able to --
7 to insert those devices with the precision
8 necessary.
9 I'm sure everyone here has heard of a stroke
10 and understands that a stroke can lead to
11 significant neurological injury. Essentially, a
12 stroke is when a blood vessel is blocked and can
13 no longer feed a brain -- feed the brain properly.
14 That often occurs because of a thrombus that is
15 released from a part of the body and lands in a
16 blood vessel.
17 We can perform procedures called a
18 thrombectomy, which is a minimally invasive
19 technique of removing a blood clot, and this is
20 done in an imaging, in a biplane x-ray style
21 imaging room. By co-locating an intraoperative
22 MRI with this other technology we can vastly
23 improve our -- our diagnosis to treatment time.
24 There's a saying in stroke care that time is
25 brain; the faster we can get treatments for

1 patients, the more brain we can save and the
2 better the patient's outcome. So co-locating an
3 imaging machine like an intraoperative MRI with
4 the fluoroscopy and x-ray equipment required to do
5 thrombectomy dramatically reduces wasted minutes
6 that we spend moving patients around the facility.
7 There there's another condition called a
8 subarachnoid hemorrhage, which is bleeding in the
9 brain that occurs because of a weakness in a blood
10 vessel called an aneurysm. Fifteen percent of the
11 time, patients have multiple aneurysms and we
12 don't know which one has caused the bleeding.
13 Using MRI technology, we can do something
14 called vessel wall imaging which is, again with a
15 greater precision, look at the walls of that
16 aneurysm and understand which one has hemorrhaged.
17 So intraoperative MRI allows us for clear
18 identification of that source of bleeding, and
19 again, easy facilitation of transporting that
20 patient for treatment into an operating room.
21 These are highly unstable patients. This
22 condition is so, so dangerous, in fact, that about
23 half of patients who suffer a ruptured aneurysm
24 never even make it to the hospital and
25 transporting unstable patients with unsecured

1 aneurysms from imaging facilities to -- to
2 operating rooms and elsewhere is always a risk.
3 And so this facilitates patient safety. We can
4 use an intraoperative MRI to identify the extent
5 to which we're able to complete an operation
6 successfully.
7 A different kind of stroke is what's called a
8 hemorrhagic stroke, for when there's bleeding into
9 the brain parenchyma itself, into the substance of
10 the brain. One of the treatments necessary can be
11 to remove that, that blood clot that's sitting in
12 the brain and pushing on sensitive tissues. By
13 using an intraoperative MRI, we can identify that
14 the blood clot has been successfully removed and
15 we can do that immediately after the surgery,
16 again, instead of transporting the patient around
17 the hospital to -- to make that diagnosis.
18 Just a couple of more examples. Much like in
19 resecting brain tumors, we can use this technology
20 to identify if arteriovenous malformations or
21 abnormal connections between blood vessels and the
22 brain which become tangled and -- and are
23 similarly dangerous to aneurysms have been
24 completely removed. And we can provide
25 post-operative imaging in the -- in the

1 intraoperative MRI to ensure that this has been
2 done completely at the conclusion of the surgery.
3 I'm going to move into a little bit of a
4 different category of treatments that can be
5 provided with this technology. Deep-brain
6 stimulation can be done for patients with
7 Parkinson's disease and movement disorders.
8 Again, using the intraoperative MRI to provide
9 submillimeter accuracy using image guidance and
10 then post-operative confirmation means that we
11 don't have to bring the patient back to the
12 operating room multiple times and we can identify
13 that the treatment has been successfully executed.
14 So these are a few examples of how the
15 intraoperative MRI can currently be used. They
16 don't represent all of the current permutations
17 and combinations of -- of use, nor some of the
18 future opportunities.
19 I do want to emphasize that having this
20 technology in the operating room is safer for the
21 patient. I think I've provided a couple of
22 examples that highlight that, but to -- just to
23 reinforce it, patients who are sedated or have
24 unstable neurological conditions don't have to be
25 transported from the operating room to the imaging

1 suite in order to conduct MRIs in this situation.
2 So in addition to improved safety, that
3 co-localization also reduces delays and delays in
4 the actual surgery or procedure that is ongoing.
5 I want to highlight a couple of prospects for
6 innovation, what the future of this technology
7 could bring as well. We can praise -- place
8 deep-brain cannulas for the direct delivery of new
9 treatments including gene therapy, viral vectors,
10 and nanoparticles. In fact, we are one of the
11 very few centers in the country currently
12 conducting a gene therapy trial for Parkinson's
13 disease. The use of the intraoperative MRI is
14 required for the accuracy and safety of these
15 procedures.
16 To put a tiny cannula into a place in the
17 brain to provide a new treatment on a protocol, a
18 clinical trial protocol, we have to ensure that it
19 is placed in exactly the right location in order
20 to safely provide that, that new treatment.
21 There's a very new FDA-approved technology called
22 high-frequency ultrasound which actually allows us
23 to lesion the brain.
24 And when I say, lesion the brain, I make -- I
25 mean, I make small -- we would make small injuries

1 to a portion of the brain where the circuits are
2 abnormally conducting signals in order to
3 effectively rewire the signals in the brain. This
4 works remarkably well, as I've mentioned, in the
5 form of deep-brain stimulation for Parkinson's
6 disease, but the high-frequency ultrasound now
7 allows us to do this kind of a procedure without
8 ever making an incision in the patient's scalp.
9 The ultrasound can be directed and provide that
10 tiny little injury in the right location.
11 At the moment, the most common indication is
12 Parkinson's disease and movement disorders. We
13 have that part of the brain mapped out pretty
14 well, but in the future we expect this kind of
15 technology to apply -- to apply to depression and
16 such things like -- like anxiety.
17 We also soon expect another kind of
18 ultrasound technology to soon be approved by the
19 FDA called low-frequency ultrasound. In the
20 brain, blood vessels are -- have very tight
21 connections. It's called the blood-brain barrier,
22 and that means that certain things can't cross
23 that blood-brain barrier, and that's protective
24 for our brain in many ways. But unfortunately, it
25 also means that the medicines that we provide for

1 patients also can't cross that blood-brain barrier
2 and can't treat the brain, and that's one of
3 the -- been one of the biggest challenges we've
4 faced trying to find treatments for Alzheimer's
5 disease and brain tumors, and other conditions.
6 Low-frequency ultrasound allows us to
7 functionally open that blood-brain barrier to
8 allow the passage of medicines or other treatments
9 from the blood into the brain. This will have to
10 be done in a facility like the Neurosciences
11 Center, because in opening the blood-brain barrier
12 there are also risks created, in particular risks
13 of brain hemorrhage. And so we would need to
14 perform these interventions in a facility that can
15 care for those kinds of complications.
16 As we further map the complex circuitry of
17 the brain which contributes to neuropsychological
18 disorders, we'll have the opportunity to perform
19 these kinds of treatments as well as to place
20 stimulators, use high-frequency ultrasound, and
21 other techniques to effectively treat conditions
22 such as depression, post-traumatic stress disorder
23 and autism, again, conditions -- and if you've
24 seen patients or family members suffering from
25 these conditions that really rob patients of their

1 full lives.
2 I do want to make one last note. Again,
3 unlike a traditional MRI which has its own set of
4 billing codes, the intraoperative MRI is done for
5 patients who are staying in the hospital. And
6 because they're already in the hospital and billed
7 typically under a DRG, there's not an incremental
8 cost to patients or to insurers as a result of
9 that, of that technology.
10 I believe that establishing the
11 intraoperative MRI platform in the Neurosciences
12 Center really paves the way for Connecticut to
13 become a leader in delivering novel and
14 life-changing clinical treatments for patients
15 suffering from serious neurological conditions.
16 I'd be happy to take any of your questions.
17 Thank you.
18 THE HEARING OFFICER: I just have one question. You
19 did say that it's billed under a DRG. Can you
20 just elaborate on that in case we have members of
21 the public who are listening and might not know
22 that acronym?
23 THE WITNESS (Laurans): Yeah. I may -- I may phone a
24 friend. I believe the acronym stands for
25 diagnosis-related grouping.

1 Diagnosis-related grouping.

2 THE HEARING OFFICER: Okay.

3 THE WITNESS (Laurans): That's a -- that's a way in

4 which we provide a bill to -- to insurers that

5 accounts for all of the care that a patient

6 receives while admitted to the hospital.

7 So if a patient came in for -- for any

8 condition, let's say removal of a brain tumor,

9 they would be admitted through the emergency --

10 they may be admitted to the emergency room. They

11 may have an inpatient stay, an ICU stay. They may

12 have an operation done, a series of imaging, or an

13 after-surgery, but the bill is the same regardless

14 of the number of interventions that we provide

15 while that patient is here.

16 So -- so we as the institution take the risk

17 in this circumstance because the intraoperative

18 MRI is already included as part of the -- as part

19 of the bill.

20 THE HEARING OFFICER: Wonderful. Thank you.

21 We'll go through all of your -- well, both of

22 your witnesses first and then we'll take a quick

23 break. We'll come back -- and then come back with

24 OHS questions.

25 So Attorney Feldman, if you'd like to have

1 your second witness, second/third.

2 THE WITNESS (Goodman): So good morning, Attorney Novi

3 and OHS staff. My name is Dr. Rob Goodman and I'm

4 pleased to have this opportunity to present to you

5 my thoughts on the importance of this application,

6 the PET-MRI application in my role as Chief of

7 Radiology for Yale New Haven Hospital. I believe

8 that I am able to express my thoughts on the

9 importance of this application for the patients of

10 Connecticut and for the community at large for

11 which we serve.

12 Firstly, I'd like to adopt my pre-filed

13 testimony.

14 So it's my absolute privilege as Chief of

15 Radiology for the Yale New Haven Hospital to help

16 develop progressive, world-class imaging here in

17 the heart of the state, and I take great pride in

18 doing this because I feel it's what the people of

19 Connecticut deserve.

20 For this application we're asking your

21 approval for a PET-MRI scanner. That's a positron

22 emission tomography magnetic resonance imaging

23 scanner, PET-MRI scanner, which would be the first

24 in the state and, if approved, would be located in

25 the neuroscience tower in Saint Rafe's Campus.

1 PET-MRI is an established technology. It's
2 available in New York, it's available in
3 Massachusetts, and it's available in many states
4 across the country, but it's not available in
5 Connecticut. And this means that the patients of
6 Connecticut have to travel out of state if they're
7 going to obtain the benefits of this technology.
8 I believe that it's time for the patients of
9 Connecticut to be able to have this option within
10 their home state.
11 So PET-MRI is the first synchronous,
12 integrated, cross-modality scanner that really
13 demonstrates capability for advancing with
14 absolute extreme precision the ability for
15 physicians at Yale New Haven Hospital to diagnose,
16 to stage, and to manage a myriad of different
17 disease conditions.
18 I think it's also important to note that
19 PET-MRI is very different from PET-CT, PET
20 computer tomography, for three main reasons;
21 PET-MRI has far superior soft tissue definition;
22 number two, PET-MRI has a much lower dose than
23 PET-CT scans; and number three, PET-MRI eliminates
24 the need for patients who need a PET scan and an
25 MRI scan as part of their disease process to have

1 multiple imaging tests at examinations.
2 So let me give you some examples of why
3 PET-MRI would be so advantageous to the people of
4 Connecticut. Let me start with oncology.
5 Patients who have cholangiocarcinoma, that's a
6 cancer of the liver, if they have a PET-MRI scan,
7 it changes the management of the disease process
8 30 percent of the time. We know that for patients
9 with rectal cancer PET-MRI is better than MRI
10 alone in determining disease planning. In the
11 field of cardiology PET-MRI is now the
12 investigation of choice for infiltrative or
13 inflammatory cardiac diseases such as myocarditis
14 or sarcoidosis.
15 But let me focus really on the benefits of
16 PET-MRI in the neuroscience field, because this is
17 really the most important component here. PET-MRI
18 allows us to visualize the metabolic activity in
19 neurodegenerative diseases like Alzheimer's,
20 Parkinson's disease, movement disorders. And with
21 drugs now available for Alzheimer's disease, this
22 allows us for the very first time to be able to
23 use imaging to determine success with drugs.
24 Dr. Laurans also spoke about stroke. PET-MRI
25 is also exquisitely good at determining

1 neuroplasticity. That's the amount of brain that
2 can recover after a stroke, and that helps us
3 determine recovery plans for patients with stroke.
4 And also you heard about epilepsy already.
5 PET-MRI with exquisite detail allows us to see
6 where the metabolic and anatomical focus of
7 epilepsy is starting from to allow Dr. Laurans and
8 his colleagues to do surgical treatment for those
9 patients.
10 And also, in neuropsychiatric diseases
11 PET-MRI really opens the door for understanding
12 schizophrenia, depression, OCD, post-traumatic
13 stress disorder, and it allows us to deal with
14 that large group of neuropsychiatric patients.
15 So in summary, I feel very strongly that
16 PET-MRI will play a major role in our goal in the
17 Neurosciences Center of making sure that you stay
18 you, and I'd be happy to answer any questions.
19 THE HEARING OFFICER: I think we're going to wait and
20 do questions after, but do you want to go ahead
21 and now move to the testimony for the CT scanners?
22 ATTORNEY FELDMAN: Yes, please.
23 THE WITNESS (Goodman): Thank you again. So I'll --
24 I'd like to adopt my pre-filed testimony as my
25 own.

1 And this application is for two
2 hospital-based CT scanners for the neuroscience
3 tower at Saint Raphael's campus. And I think it's
4 important to emphasize that currently we have two
5 CT scanners at the Saint Rafe's campus, which are
6 acting at 186 percent utilization rate, which is
7 far beyond OHS's benchmark and industry standards
8 for utilization.
9 With the opening of the neuroscience tower we
10 will have 214 additional beds in the Saint Rafe's
11 campus, and we are doubling the emergency
12 department's capacity. These two developments
13 make two additional CT scanners absolutely
14 essential.
15 What we're proposing is that we -- we
16 implement two next-generation CT scanners that
17 have dose reduction and image -- image clarity
18 advantages over conventional CT scanners. These
19 photon CT scanners are the next generation for CT
20 scanners and will become the industry standard CT
21 scanners moving forwards, but in the field of
22 neuroscience these scanners have -- have exquisite
23 ability to detail things such as the skull base,
24 they allow us to determine leaks from
25 cerebrospinal fluid of the brain, and they also

1 allow us to determine spinal imaging very clearly.
2 So in summary, the CT scanners are essential
3 for the Saint Raphael's campus. All our scanners
4 in Yale New Haven Hospital are working above --
5 above utilization for OHS benchmarks, both
6 hospital and ambulatory. If we were to put these
7 two new CT scanners in operation today, we would
8 still be operating over utilization for benchmarks
9 across our enterprise, and that's including the
10 two -- two CT scanners that were approved
11 previously by OHS.
12 Being able to have the CT scanners approved
13 now allows us to move forward with our planning
14 process and our construction timeline to allow the
15 neuroscience tower to be the success that it ought
16 to be.
17 Thank you.
18 THE HEARING OFFICER: All right. I'm going to go ahead
19 and ask Attorney Feldman, do you have any
20 follow-up questions you'd like to ask? I'm
21 thinking at this time we'll take a quick break and
22 then come back for OHS questions.
23 ATTORNEY FELDMAN: I do not have any follow-up
24 questions.
25 THE HEARING OFFICER: Okay. I'm going to -- we'll take

1 a 15-minute break. We'll come back at -- actually
2 we'll come back at ten. We will follow up with
3 questions from OHS at that time. And then
4 Attorney Feldman, if you have any questions after
5 our questions, you can ask those, and then we'll
6 go into public comment.
7 So we will go on break for about 18 minutes
8 now and then come back at 10 a.m. for questions.
9 Thank you, everybody, and I will see you in
10 18 minutes.
11 ATTORNEY FELDMAN: Yeah. Thank you.
12
13 (Pause: 9:42 a.m. to 10:00 a.m.)
14
15 THE HEARING OFFICER: Good morning, everybody. It is
16 now 10 a.m. I'm going to go ahead and ask
17 Ms. Fentis if she can start the recording again.
18 All right. As you were just informed, your
19 being on camera in this meeting is your consent to
20 being filmed. If you wish to revoke that consent,
21 please exit this meeting at this time.
22 All right. Thank you everybody for staying.
23 At this point I'm going to go ahead and
24 welcome everybody back to the continued hearing
25 for Yale New Haven Hospital's two CON filings for

1 Docket Number 24-32705-CON and 24-32744-CON.
2 We're going to begin with OHS questions now.
3 I'm going to go ahead and ask those questions. I
4 think I'm going to go in the order that is very
5 similar to Attorney Feldman's questions. We will
6 start with questions for the iMRI machine first.
7 And Doctor -- it's Loh-ren [phonetic].
8 Correct?
9 THE WITNESS (Laurans): Loh-rens [phonetic].
10 THE HEARING OFFICER: Laurans. All right. Okay.
11 Dr. Laurans, or whoever is best to answer these
12 questions, these are -- there are two questions
13 and -- or actually, before we do that, let's go
14 ahead and ask for your late file, a late file of
15 the slides that you used just so that we have
16 those on the record for the public as well to view
17 after the hearing.
18 We will mark those as Late-File 1.
19
20 (Late-Filed Exhibit Number 1, marked for
21 identification and noted in index.)
22
23 THE HEARING OFFICER: If you see me looking down, I
24 take notes by hand. It's slow, but it works for
25 me. So if I'm a little slow at getting back to

1 you, I am still writing.

2 All right. On page 31 of the pre-file

3 testimony -- it's marked on mine as 31, however at

4 the bottom of the page when it was filed, in the

5 right-hand corner that page is marked as 12. It

6 says -- of the pre-filed testimony it states that

7 the PSA is at 114 percent for MRI, or

8 hospital-based MRIs.

9 Does this include the MRI that was recently

10 granted in decision 24-32735?

11 ATTORNEY FELDMAN: You refer to this as the pre-file,

12 but are you referring to the issue statement?

13 THE HEARING OFFICER: Actually, it says response to

14 public hearing issues. Yes, I'm sorry.

15 ATTORNEY FELDMAN: Oh, okay. Just a second.

16 THE HEARING OFFICER: Yeah.

17

18 (Pause.)

19

20 ATTORNEY FELDMAN: So you're referring to --

21 THE HEARING OFFICER: The second sentence under the

22 table that has the official town name and reason

23 for inclusion. It says, utilization at these

24 sites in the PSA was 114 percent of capacity.

25 Actually, first and second question -- or first

1 and second sentence. Sorry.
2
3 (Pause.)
4
5 THE HEARING OFFICER: Does that include the recently
6 granted MRI machine from decision 24-32735?
7
8 (Pause: 10:03 a.m. to 10:04 a.m.)
9
10 ATTORNEY FELDMAN: Hearing Officer Novi, I think there
11 is a little confusion because there's a lot of
12 moving parts here, and I just want to make sure we
13 answer the question correctly.
14 The MRI that was approved most recently, I
15 believe it was this week or last week, the 21st.
16 Correct?
17 THE HEARING OFFICER: Yes.
18 ATTORNEY FELDMAN: We're talking about that MRI.
19 THE HEARING OFFICER: Yes.
20 ATTORNEY FELDMAN: That is not an intraoperative MRI.
21 THE HEARING OFFICER: I understand, but you're pointing
22 to the hospital-based MRIs and the utilization of
23 those sites as a reason for the need for the iMRI.
24 So as someone who's read all of your imaging
25 filings, I want to make sure I'm getting this

1 correct on which part.
2 ATTORNEY FELDMAN: Right. There's no relationship
3 between that data and the need for iMRI. It's
4 used solely in the operating room. The
5 utilization is much lower because of the, you
6 know, the time of the procedure. If you have
7 somebody in a surgical room, they're going to be
8 there as long as the surgery, not -- it's not like
9 a CT machine or an MRI machine where people go in
10 and out, in and out. Right?
11 THE HEARING OFFICER: Uh-huh.
12 ATTORNEY FELDMAN: This is a surgical procedure, so it
13 really has no relevance.
14 For relevance, do you want to --
15 THE WITNESS (Alexa): Well, I think what I want to --
16 ATTORNEY FELDMAN: Why don't you state your name?
17 THE WITNESS (Alexa): Okay. I'm Dan Alexa. I'm the
18 Executive Director for System Radiology
19 Operations.
20 I just want to make sure I'm understanding
21 this correctly. So what you're referring to is a
22 service area for the iMRI that we're proposing,
23 and that is a larger service area than what our
24 service area is that we would normally do for our
25 MRI scans. So I believe that that percentage that

1 we're talking about includes all of the service
2 areas that we're covering under the iMRI plan.
3 So what I would say, you know, reserve the
4 right -- so we'll make sure that we check up on
5 this later, but the new MRI that was just proposed
6 would not be included in that, but remember that
7 it's not focused -- our -- our service area for
8 our MRI is different than the service area for the
9 iMRI.
10 THE HEARING OFFICER: Understood, but I am seeing here
11 quite a good bit of dedication to the MRI
12 machines.
13 So, I want to make sure in the -- what was
14 titled, response to public hearing issues. So, I
15 just want to make sure that, because I've been
16 reading quite a few applications from you guys
17 lately --
18 THE WITNESS (Alexa): Yeah.
19 THE HEARING OFFICER: -- that we are getting an
20 accurate and complete picture. So if I could just
21 ask you to do a late file with the new -- for the
22 utilization rate that would include the newly
23 approved machine.
24 ATTORNEY FELDMAN: Right. So, Hearing Officer Novi, I
25 just want to be clear that we've provided this

1 information directly in response to your query.
2 It's not that we were using it to advocate for
3 need related to the iMRI. So it's really not --
4 THE HEARING OFFICER: I understand, but I'm just going
5 to put that on record so that, you know -- and
6 there are going to be some things you'll see me
7 ask for that maybe are -- maybe not with the iMRI,
8 but especially with the PET-MR, that you might --
9 I'm going to ask for just for public
10 clarification.
11 ATTORNEY FELDMAN: Okay. Thank you.
12 THE WITNESS (Alexa): Yeah.
13
14 (Late-Filed Exhibit Number 2, marked for
15 identification and noted in index.)
16
17 THE HEARING OFFICER: All right. And that is the
18 extent of my questions for the iMRI.
19 ATTORNEY FELDMAN: Okay. Thank you.
20 THE HEARING OFFICER: So next we'll move to the
21 PET-MRI. And, again, you may hear me ask for
22 something that is going to -- it's more for public
23 clarification than for anything that would be --
24 was a question out of this hearing.
25 I would like to ask for a late -- we'll call

1 this Late-File 3. If you could do a visual
2 representation of the -- compare the PET-MR scans
3 and the process to doing a PET scan and an MRI
4 separately so that the public can visually see
5 what the differences would look like how, you
6 know, what the time differences might be.
7 Indicate what the timelines are for each one
8 from order to test results and indicate when
9 additional people, appointments, and times are
10 needed.
11 ATTORNEY FELDMAN: Okay. I just want to clarify.
12 THE HEARING OFFICER: Yes. Please feel free.
13 ATTORNEY FELDMAN: Okay. Thank you. These are totally
14 different advanced pieces of imaging equipment.
15 THE HEARING OFFICER: Yes.
16 ATTORNEY FELDMAN: One is a simultaneous image of the
17 patient. The other are two distinct studies that
18 are not integrated. So they're different.
19 So for the purpose of comparison, I respect
20 your question, and we will provide those time
21 differences, but the indications for which way you
22 go as an ordering physician are completely
23 separate and apart from whether having two
24 separate studies that don't result in the same
25 type of information as the PET-MRI is really going

1 to be dictated by the physician and the need for
2 the study, and the precision that is necessary.
3 But we will provide the timelines for your
4 request.
5 THE HEARING OFFICER: Again, some of these are for
6 public knowledge and information so that they can
7 see what the advantages and what types of things
8 might -- because you can do both of these
9 separately. It may take more time --
10 ATTORNEY FELDMAN: Yes, yes.
11 THE HEARING OFFICER: -- to see so that we can lay out
12 for needs.
13 ATTORNEY FELDMAN: Okay. And you said that was
14 Late-File 3.
15
16 (Late-Filed Exhibit Number 3, marked for
17 identification and noted in index.)
18
19 ATTORNEY FELDMAN: What happened to Late-File 2?
20 THE HEARING OFFICER: Late-File 2 is the including of
21 the new MRI machine in the MRI -- that's my only
22 question from the iMRI.
23 ATTORNEY FELDMAN: Can we go off record, please?
24 THE HEARING OFFICER: Sure. Of course.
25

1 (Pause: 10:11 a.m. to 10:14 a.m.)

2

3 ATTORNEY FELDMAN: We're back, Hearing Officer.

4 THE HEARING OFFICER: All right.

5 ATTORNEY FELDMAN: I want to get some clarification

6 with respect to Late-File 2.

7 THE HEARING OFFICER: Uh-huh.

8 ATTORNEY FELDMAN: Related to the PSA and the MRI

9 station, you're asking for projections on which

10 MRI? Let me just be clear about that.

11 THE HEARING OFFICER: The hospital-based MRI that

12 was -- because there it says that 16 hospital MRIs

13 in the PSA and that utilization at these sites in

14 the PSA was at 114 percent of capacity.

15 ATTORNEY FELDMAN: So when you talk about the

16 hospital-based MRI, are you referring to the one

17 that was approved last on the 21st?

18 THE HEARING OFFICER: Yes.

19 ATTORNEY FELDMAN: Okay. So the data that's in that

20 chart -- right? Is 2022 utilization data. I just

21 want to be clear that when we provide the late

22 file, the data will be projections only.

23 THE HEARING OFFICER: Okay.

24 ATTORNEY FELDMAN: Because we don't -- it was just

25 approved last week.

1 THE HEARING OFFICER: That's understandable. We'll
2 take the projections about what that usage rate
3 will be with the other 16.
4 ATTORNEY FELDMAN: And it's not including the iMRI?
5 THE HEARING OFFICER: Not including the iMRI.
6 ATTORNEY FELDMAN: Okay. And I just want to be clear
7 that with respect to the PET-MR or MRI --
8 THE HEARING OFFICER: Yes?
9 ATTORNEY FELDMAN: The indications for that are totally
10 distinct and specialized by patient condition and
11 diagnosis.
12 THE HEARING OFFICER: I understand. I have questions
13 on that.
14 ATTORNEY FELDMAN: Okay. I'll let you ask your
15 questions.
16 THE HEARING OFFICER: Okay.
17 ATTORNEY FELDMAN: Thank you.
18 THE HEARING OFFICER: I want -- we'll start off with,
19 my first question is how many people will be
20 eligible for scans using the patient selection
21 criteria?
22 ATTORNEY FELDMAN: In with what?
23 THE HEARING OFFICER: In the PET-MRI.
24 ATTORNEY FELDMAN: Yeah, go ahead, Doctor.
25 THE WITNESS (Goodman): So with a PET-MRI scan, we can

1 do approximately one patient per hour. The
2 PET-MRI will be operational from 8 a.m. to 5 p.m.,
3 five days a week, because we need to have the
4 radio tracer availability, which isn't available
5 after hours. So we'll be able to do five times
6 eight each week, 40 patients per week.
7 THE HEARING OFFICER: I'm sorry. You said 14, or
8 four-zero?
9 THE WITNESS (Goodman): Four-zero.
10 THE HEARING OFFICER: Okay. So we'll go to --
11 ATTORNEY FELDMAN: And again, just for clarification so
12 we're all on the same -- we all have the same
13 understanding, this PET-MR will be located in the
14 Neurosciences Center and it will primarily be used
15 for patients that are in the Neurosciences Center
16 who suffer from mobility issues, let's say,
17 generally speaking. Right?
18 And so there are unique advantages with
19 respect to they're not having to come and schedule
20 two separate exams on several -- on two separate
21 days and come back to the hospital, or --
22 THE HEARING OFFICER: Understood. Right now I'm just
23 trying to establish with some questions who -- how
24 many people they can put in the machine.
25 ATTORNEY FELDMAN: Okay.

1 **THE HEARING OFFICER: And we'll get a little further in**
2 **after that.**
3 **How will patients be assessed for PET-MR**
4 **scans, and what criteria will you use?**
5 **ATTORNEY FELDMAN: We'll have Dr. Goodman answer that**
6 **question.**
7 **THE WITNESS (Goodman): So for PET-MRI requests,**
8 **radiology will always protocol and authorize**
9 **requests for PET-MRI to make sure that the**
10 **indications are correct.**
11 **And I -- I expect that many of the referrals**
12 **will be discussed at our interdisciplinary tumor**
13 **boards across the enterprise where a patient's**
14 **case is discussed and the option to solve a**
15 **question with PET-MRI will be proposed. And if**
16 **agreed upon, that would be a way to determine**
17 **whether a PET-MRI is indicated for that patient.**
18 **THE HEARING OFFICER: Do you have a patient selection**
19 **criteria defined?**
20 **THE WITNESS (Goodman): There are patient selection**
21 **criteria defined by bodies, national bodies that**
22 **determine which conditions PET-MRI is beneficial**
23 **in, and we would adopt those criterion.**
24 **THE HEARING OFFICER: What are these bodies?**
25 **ATTORNEY FELDMAN: The bodies, the accrediting bodies.**

1 THE WITNESS (Goodman): It's the International
2 EANM-SNMMI-ISMRM consensus recommendation for
3 PET-MRI.
4 ATTORNEY FELDMAN: It's in the application. What --
5 Carol, do we have it?
6 A VOICE: It's Exhibit 1.
7 THE HEARING OFFICER: I'm sorry, I couldn't hear you.
8 Exhibit 1? I'm sorry.
9 THE WITNESS (Goodman): Exhibit 1, yes.
10 THE HEARING OFFICER: And where in Exhibit 1?
11 THE WITNESS (Goodman): It's a paper. It's a consensus
12 recommendation paper.
13 THE HEARING OFFICER: Okay. So I know we did discuss
14 just a little bit about -- actually that was for
15 the -- sorry, that was for the billing for another
16 one.
17 Please detail what the billing for this
18 service would include.
19 I think I may have lost Yale New Haven.
20 A VOICE: No, we're here.
21 THE HEARING OFFICER: Oh, okay. You're just not moving
22 on the screen now.
23 ATTORNEY FELDMAN: We're going to have Dan Alexa take
24 the first stab and then, and then Deremius
25 Williams for followup, because they both have --

1 THE WITNESS (Alexa): Can they clarify the question?
2 ATTORNEY FELDMAN: Yes, yes --
3 THE HEARING OFFICER: I just want to note that you guys
4 have frozen on the video feed, at least my video
5 feed. So I'm not seeing anybody -- and
6 Mr. Lazarus has nodded his head.
7 So if you could be very descriptive when
8 someone starts to speak because we -- oh, there we
9 go. We got you back again.
10 ATTORNEY FELDMAN: Okay. Can you please restate the
11 question?
12 THE HEARING OFFICER: Sure. Please explain in detail
13 what the billing for the service would include.
14 ATTORNEY FELDMAN: Which service are you referring to?
15 THE HEARING OFFICER: The PET-MRI. We're on questions
16 only about PET-MRI right now.
17 ATTORNEY FELDMAN: You mean, are you referring to --
18 when you talk about billing, are you talking about
19 the CPT code? What exactly are you --
20 THE HEARING OFFICER: Well, you can start there.
21 Are there CPT codes?
22 DEREMIUS WILLIAMS: There are not --
23 ATTORNEY FELDMAN: Wait. Wait. Wait. Wait.
24 So Deremius Williams, our expert is here now.
25 So she will need to be sworn in before she

1 provides her testimony .

2 THE HEARING OFFICER: Okay. All right. Ma'am, if you

3 could please raise your right hand?

4 D E R E M I U S W I L L I A M S,

5 called as a witness, being first duly sworn

6 by THE HEARING OFFICER, was examined and

7 testified under oath as follows:

8

9 THE HEARING OFFICER: Please state your name and title

10 for the record, ma'am.

11 THE WITNESS (Williams): Deremius Williams, Senior Vice

12 President of Payer Strategy and Innovation for

13 Yale New Haven Health.

14 THE HEARING OFFICER: All right. Go ahead.

15 ATTORNEY FELDMAN: Dan, the first part?

16 THE WITNESS (Alexa): Well, the first thing that I

17 would like to say about this is this is a new and

18 novel technology that is gaining ground in

19 academic medical centers across the country.

20 So this is something that has not completely

21 yet been established and is continuing to grow.

22 And we do expect over the next several years with

23 our involvement as well that there will be billing

24 that will be aligned with PET-MR.

25 Currently, there aren't codes specific to

1 PET-MRI on its own. And so most other
2 institutions are getting reimbursed for the scans.
3 There it's not exactly clear on how that's doing
4 that yet, but we will -- we will figure that out.
5 This is -- like we're saying, this is a novel
6 new technology that we're trying to bring to the
7 state of Connecticut that will help us treat our
8 patients, our family members, our friends from our
9 state, from our region and from across the
10 country. So that is really what we're trying to
11 do with this.
12 And so the fact that we are kind of at the
13 tip of the sphere with it there will be some
14 learning involved. So I'm saying this, you know,
15 for the benefit of the community, that this is
16 something that will develop, but it's something
17 that is going to be -- it is really the future in
18 really combining metabolic and anatomic imaging.
19 So do you want to add anything?
20 THE WITNESS (Williams): I was only going to add to
21 what I think Dan said, today there are not CPT
22 codes that exist for the PET-MR.
23 THE HEARING OFFICER: Are there HCPCS codes for this
24 service?
25 THE WITNESS (Williams): No, there are not. There are

1 currently no codes that could be used specifically
2 for billing apropos specifically to this service.
3 THE WITNESS (Alexa): And there are other hospitals in
4 our region, such as MGH, NYU, that are doing this
5 as well.
6 THE HEARING OFFICER: Okay. Does Medicaid currently
7 cover scans on this machine?
8 ATTORNEY FELDMAN: We don't know because we don't have
9 the machine. And typically, if we had new
10 technology, once we get that approved we would
11 then go to the department and request a rate.
12 THE HEARING OFFICER: If the machine is not covered by
13 Medicaid, how will indigent patients get access to
14 the scanner?
15 ATTORNEY FELDMAN: Did you hear the question, if it's
16 not covered by Medicaid (unintelligible) --
17 THE WITNESS (Alexa): Yeah. So, you know, I -- I think
18 that -- and I'm going to take a little freedom
19 here and basically say, like, I -- I believe this
20 to be like any other service that we provide at
21 the hospital. You know, not only are we an
22 academic medical center, but we are also a
23 community safety-net hospital. And we're not
24 going to deny the right level of care to any
25 patients.

1 So if a patient presents and they need this
2 type of care, it doesn't matter what their
3 insurance carrier is or who's providing it. It --
4 it's really based on what is needed. And then we
5 will have -- we'll make sure that it is part of a
6 Medicaid plan. And we will have self-pay rates
7 due to our, you know, I think we have a generous
8 policy right now, you know.
9 So this is going to be accessible to anybody
10 who needs this care. It's not going to be
11 differentiated by -- by pay or by amount of the
12 money people have. It's going to be based on the
13 condition they have.
14 ATTORNEY FELDMAN: Just to follow up -- response?
15 THE WITNESS (Williams): Sure. I would just add that
16 right now, it's not covered under any of our payer
17 arrangements, commercial or Medicaid. And so that
18 would be explored after the CON approval. Then we
19 would understand the coverage requirements by
20 payer and ensure that it is accessible across the
21 board, including for Medicaid.
22 THE HEARING OFFICER: Okay. Would prior approval be
23 needed for these types of scans?
24 THE WITNESS (Williams): Can you clarify the question?
25 THE HEARING OFFICER: Would prior approval be needed

1 for these scans?
2 THE WITNESS (Alexa): Do you mean, like --
3 THE WITNESS (Williams): You mean with prior
4 authorization?
5 THE HEARING OFFICER: Yes. Prior authorization, yes.
6 THE WITNESS (Williams): It is likely that prior
7 authorization would be required for these scans as
8 it's required for other high-tech imaging scans.
9 THE HEARING OFFICER: All right. So you did say that
10 there are currently 50 MRI machines in use in the
11 country.
12 Can you provide any information such as the
13 scans and costs for the machines in the Northeast
14 in New York that are currently around you?
15 ATTORNEY FELDMAN: Just for clarification, when you
16 say -- costs for what?
17 THE HEARING OFFICER: The cost for scans, what they're
18 charging.
19 ATTORNEY FELDMAN: The study, you're asking about the
20 study?
21 THE HEARING OFFICER: I'm asking -- I assume that if
22 you're going in to get a piece of new technology
23 and you know that there are machines located
24 nearby in the state next door, two states next
25 door, that you would have looked at how they are

1 charging for these scans, what the costs are prior
2 to deciding to purchase one, and seeing what they
3 are doing with this machine.
4 And are they billing Medicaid for these, for
5 their scans right now?
6 ATTORNEY FELDMAN: Okay. I just want to clarify the
7 question so we can answer it appropriately.
8 THE HEARING OFFICER: Uh-huh.
9 ATTORNEY FELDMAN: I think what we said is that
10 currently across the nation there is no CPT code.
11 THE HEARING OFFICER: Uh-huh.
12 ATTORNEY FELDMAN: And that the hospitals -- or mostly
13 academic medical centers that have a PET-MR are
14 working on a case-by-case basis with the payers
15 that they are contracted with and are negotiating
16 a rate.
17 So there is no specific trend that we're
18 aware of, but I'll let Deremius --
19 THE WITNESS (Williams): Sure. So that's the first
20 clarification, is by cost you meant really price.
21 THE HEARING OFFICER: Yeah.
22 THE WITNESS (Williams): What is the price of the scan?
23 And so our contracts are specific to our
24 relationships with payers. And so regardless of
25 what the price may be in neighboring states with

1 other entities, that would not be indicative of
2 what the price would be for us. And so we would
3 not use that specific information in our
4 indication.
5 So we are not currently aware of pricing that
6 is applicable to other entities in other
7 neighboring states.
8 THE HEARING OFFICER: But if this is a new
9 technology -- and I'm going to ask this. I
10 understand that you might not, but you wouldn't
11 get a machine that is completely out of the price
12 range, or encourage patients at your hospital to
13 go into medical debt to get this, this scan.
14 So I have a hard time with -- and we can make
15 this a late file, that you said that this is
16 novel, it's new. There are 50; there are two
17 right next door.
18 How are they -- because this is going to be
19 the first in Connecticut, we want to give the
20 public an understanding of what they could get if
21 they went to a different state and what that would
22 look like in Connecticut.
23 ATTORNEY FELDMAN: Okay. Thank you for that
24 clarification. We're just going to take a minute,
25 if we could go be muted?

1 THE HEARING OFFICER: Uh-huh.

2 ATTORNEY FELDMAN: So we can make sure we have the

3 right people answering. Okay?

4 THE HEARING OFFICER: All right.

5

6 (Pause: 10:30 a.m. to 10:36 a.m.)

7

8 THE HEARING OFFICER: All right. Yale, you look

9 frozen. We want to make sure that you are here.

10 Oh, there you go. You've moved again.

11 Sorry, we got stuck with a doctor with his

12 hands like this. We wanted to make sure that you

13 weren't frozen-frozen.

14 ATTORNEY FELDMAN: Thank you.

15

16 (Pause: 10:37 a.m. to 10:38 a.m.)

17

18 ATTORNEY FELDMAN: Hearing Officer Novi?

19 THE HEARING OFFICER: Yes.

20 ATTORNEY FELDMAN: Thank you for the additional time,

21 just because we took some time making sure we

22 understand the question.

23 Could you restate the question once again,

24 please?

25 THE HEARING OFFICER: Sure. There are currently 50

1 PET-MRs in use in the country, including two in
2 neighboring states. Please provide information on
3 the scans and costs for the machine in the
4 Northeast, in New York, and compare how your costs
5 and usage of that machine would compare to those.
6 Because we don't, we want to make sure
7 that --
8 ATTORNEY FELDMAN: I just want to clarify when you say
9 costs, that are you talking about price, what we
10 charge for the study? Or are you talking about
11 the cost for purchasing the machine?
12 THE HEARING OFFICER: Not the cost for purchasing the
13 machine. We're talking about the patient-centered
14 costs. So --
15 ATTORNEY FELDMAN: What the patient's costs would be?
16 THE HEARING OFFICER: Yes.
17 ATTORNEY FELDMAN: Is that the question?
18 THE HEARING OFFICER: Yes.
19 ATTORNEY FELDMAN: Okay.
20 THE WITNESS (Williams): I believe that we have talked
21 to others -- right? To understand whether or not
22 they've been able to bill for the service. And
23 we've found that others have been able to bill the
24 service.
25 We do not have specific information on the

1 price that's applicable with other entities,
2 because we are not privy to their specific payer
3 arrangements. We would work with our payers to
4 establish a specific arrangement.
5 For patients that are commercially insured,
6 the impact to the patient is really whatever the
7 cost share is for that patient as defined by the
8 benefit plan that the patient has with the payer
9 with which they are insured.
10 For patients who are uninsured, we have a
11 generous financial assistance policy that would
12 apply to ensure that they are not impacted in a
13 negative way by the cost of this machine.
14 ATTORNEY FELDMAN: And we're just -- we'd like to
15 elaborate a little bit more.
16 Dr. Goodman, can you talk about this?
17 THE WITNESS (Goodman): Yeah. And again, it goes to us
18 ensuring that patients that are having this study
19 are suffering from a condition for which the study
20 would be indicated. And if we didn't have this
21 study, they would likely be having a PET scan and
22 an MRI scan separately, and being charged for
23 those two scans.
24 THE HEARING OFFICER: Now, how would billing for the
25 PET-MR study compare to the separate billing for

1 **the PET study and the MRI study?**
2 **THE WITNESS (Williams): So, a separate study for a PET**
3 **scan and MRI would have two separate bills,**
4 **potentially two different times, two different**
5 **codes, two different payments, and two different**
6 **cost shares applied for a patient.**
7 **For the combination procedure, it's going to**
8 **be one service, one bill, one code, and one cost**
9 **share for the patient. So, in many circumstances**
10 **it may be more beneficial to the patient from a**
11 **financial perspective than the two separate scans.**
12 **ATTORNEY FELDMAN: Just one further point here, Hearing**
13 **Officer Novi. Do you want to talk about that when**
14 **PET-CT originated this was a similar issue?**
15 **THE WITNESS (Alexa): I -- I don't have much to**
16 **elaborate on that, to be honest with you. I think**
17 **that that's true of any type of hybrid imaging**
18 **that comes along.**
19 **THE HEARING OFFICER: Okay. How would -- I know we --**
20 **I'm sorry. The woman at the back of the table,**
21 **Ms. Williams?**
22 **THE WITNESS (Williams): Yes.**
23 **THE HEARING OFFICER: How would the benefit, if there**
24 **was for this, compare to an increased cost that a**
25 **consumer might see?**

1 **THE WITNESS (Williams): So, the benefits are defined**
2 **by the payers.**
3 **THE HEARING OFFICER: Uh-huh.**
4 **THE WITNESS (Williams): And typically, payers have a**
5 **consistent benefit approach to a consistent set of**
6 **services. So, what I mean by that is for all**
7 **radiologic procedures the benefits that would be**
8 **applicable would typically be the same, whether**
9 **it's a $50 copay or a specified co-insurance, et**
10 **cetera.**
11 **So, radiology procedures are often**
12 **copay-based. It does depend on the payer. It is**
13 **payer-defined. I would expect the cost share to**
14 **be comparable for the combination versus the two**
15 **or better, either comparable or better, because**
16 **you're going from two separate scans to one.**
17 **THE WITNESS (Alexa): I think it's also important for**
18 **the community to understand that having a scan**
19 **like this, one of the goals of it is to help**
20 **diagnose more quickly for people to advance their**
21 **care so that the rest of their treatment can be**
22 **done more quickly. And, you know, I don't know**
23 **that we have measured this, but there's potential**
24 **to reduce downstream care as well.**
25 **So, you're talking about the cost of one**

1 little part of a patient journey. Somebody who
2 has this scan, this isn't the only thing they're
3 having. They're having many, many, many things
4 that -- that are going to face them.
5 This is just one of the tools that's actually
6 going to help them get to the diagnosis more
7 quickly and enable us to provide that patient with
8 better care, give the physician a better tool, and
9 in order for us to get to the end when they are
10 cured, faster, better, and hopefully cheaper.
11 THE HEARING OFFICER: Now, some of the other PET-MR
12 machines around our state are being used for
13 research. Will this machine be used for research?
14 THE WITNESS (Goodman): No, it will not.
15 THE HEARING OFFICER: I'm sorry. I could not hear that
16 answer.
17 THE WITNESS (Goodman): It will not be used for
18 research.
19 THE HEARING OFFICER: It will not. Oh, okay. If there
20 is downtime and the machine is open, will it be
21 used for either standalone MRI or PET scans?
22 THE WITNESS (Alexa): So, our intention is to utilize
23 this as a PET-MRI scanner, and that is how we are
24 looking at what we're doing, a scan itself on its
25 own. So, our intention is to use it as an MRI

1 scanner.
2 THE HEARING OFFICER: Okay. All right. That is it for
3 my PET-MRI questions. We'll now move over to the
4 CT scanners. We'll start with given -- let's see.
5 I just want to see where I feel like starting.
6 Hold on one second.
7 Actually, I got asked if we can meet quickly.
8 So I am going to ask for about a five-minute
9 break -- actually, we'll do a quick ten-minute
10 break. Also, you guys have just frozen on us
11 again. So, I might suggest checking your -- oh,
12 you've disappeared.
13 Oh, there you are again. Okay. So, let's
14 take a quick ten-minute break, and then we can get
15 to the questions for our last section for the two
16 CT scanners, and then we'll go into public
17 comment.
18 I do want to mention before we head to break
19 that public comment is open. If you would like to
20 sign up for our public comment, you can do so in
21 our chat function right now, or if you would like
22 to send an e-mailed public comment, you may do
23 that at any time within the next week to
24 CONcomment@ct.gov.
25 Again, you can e-mail comments to

1 **CONcomment@ct.gov any time between now and next**
2 **Wednesday.**
3 **We'll go on break until about 10:55. Okay?**
4 **Thank you, everybody. We'll see you in a few**
5 **minutes.**
6
7 **(Pause: 10:46 a.m. to 10:56 a.m.)**
8
9 **THE HEARING OFFICER: All right. Good morning. It's**
10 **10:56. I do apologize for being a minute late.**
11 **All right. As the Zoom voice has just**
12 **notified you, we are -- well, just let me get**
13 **through this. As the Zoom voice has just notified**
14 **you, we are recording this hearing, and your**
15 **remaining in this hearing is your consent to being**
16 **recorded. If you would like to revoke your**
17 **consent, please leave the Zoom hearing at this**
18 **time.**
19 **ATTORNEY FELDMAN: I need one more minute, please.**
20 **THE HEARING OFFICER: That's fine. You guys can go**
21 **off, and we'll just -- we'll wait for you, too.**
22
23 **(Pause: 10:57 a.m. to 10:58 a.m.)**
24
25 **ATTORNEY FELDMAN: Hi, Hearing Officer Novi.**

1 THE HEARING OFFICER: Okay.
2 ATTORNEY FELDMAN: I do ask you if I could ask some
3 rebuttal questions to our witnesses here?
4 THE HEARING OFFICER: Sure. Do you want me to finish
5 up with all of our questions, and then you can go
6 on to all of yours?
7 Or do you want to do it as we go?
8 ATTORNEY FELDMAN: I would just at this point like to
9 do some questions about PET-MRI right now.
10 THE HEARING OFFICER: No problem.
11 ATTORNEY FELDMAN: Just to clarify what I view as --
12 THE HEARING OFFICER: No problem. Go ahead.
13 ATTORNEY FELDMAN: Okay. I'm going to start by asking
14 Dr. Goodman a question. Can you please explain to
15 me when a PET-MRI would be indicated versus
16 performing two separate studies?
17 THE WITNESS (Goodman): Yeah. So, with the advent of
18 PET-MRI, there are certain conditions where one
19 would need to have that study done on one piece of
20 equipment, for example, the heart.
21 To do a PET-MRI on a heart to see if it's got
22 myocarditis is something you cannot do separately
23 on a PET scan or an MRI, because you have to have
24 that image at the same time, same place, on the
25 same patient.

1 **ATTORNEY FELDMAN: So, are you basically saying that if**
2 **you performed two separate studies where the**
3 **patient had to go maybe even two separate days, or**
4 **go through two separate studies, that you would**
5 **not have the same information available to you for**
6 **diagnostic purposes that you would with an**
7 **integrated study?**
8 **Are you going to have equal information?**
9 **THE WITNESS (Goodman): No. We need that integrated**
10 **study.**
11 **ATTORNEY FELDMAN: And why? Can you explain why?**
12 **THE WITNESS (Goodman): Because MRI has far more soft**
13 **tissue delineation than a PET. If I did a PET-CT**
14 **on a heart, I would just see a blob. If I do a**
15 **PET-MRI on a heart -- a PET-MRI on a heart, I can**
16 **see exactly where that activity is because the MRI**
17 **scan delineates the heart better than a CT.**
18 **ATTORNEY FELDMAN: So -- and I welcome Dr. Laurans,**
19 **too. With respect to the Neurosciences Center**
20 **where this is going to be primarily -- it will be**
21 **hospital-based situated.**
22 **In the case of patients who are suffering**
23 **from some sort of neurological disease, the**
24 **information that you're going to get from PET-MR,**
25 **how is that different from any information you**

1 currently acquire from a diagnostic imaging
2 perspective?
3 THE WITNESS (Goodman): Well, let's go to the epilepsy
4 case again. Epilepsy, we can see where the
5 metabolic activity of the seizures locus is, and
6 we can see at the same time where that activity is
7 correlated to a portion of the brain in an MRI
8 scan. You can't do that on an MRI scan separately
9 and a PET scan separately.
10 ATTORNEY FELDMAN: So how does that impact diagnosis
11 and outcomes?
12 THE WITNESS (Goodman): There would be changes if the
13 medicine improves.
14 THE WITNESS (Laurans): Yeah, I -- this is Max Laurans.
15 I would -- I would only add that currently
16 patients undergoing a workup for epilepsy and a
17 potential surgery undergo several phases, which
18 includes a combination of imaging modalities.
19 And this would potentially replace several of
20 them in order to get both a more accurate
21 diagnosis, and correct.
22 ATTORNEY FELDMAN: And from a cost-effectiveness
23 perspective, you're saying it's one study versus
24 several?
25 THE WITNESS (Laurans): Yes.

1 **ATTORNEY FELDMAN: I have another question for Deremius**
2 **Williams. Can you comment for me with respect to**
3 **what the impact would be for patients from a**
4 **financial standpoint who undergo this very**
5 **medically necessary diagnostic exam?**
6 **THE WITNESS (Williams): Sure. Based on the**
7 **indications of this exam, the fact that it**
8 **replaces potentially several exams and how**
9 **patients' health insurance benefits work, I would**
10 **expect there to either be no impact or potentially**
11 **improved benefit to patients because they will**
12 **have less cost-share liability or application with**
13 **a single test versus multiple tests.**
14 **For patients who are uninsured, we have a**
15 **very generous financial assistance policy that**
16 **would be applied, and we would not expect there to**
17 **be any increase or impact on medical debt.**
18 **ATTORNEY FELDMAN: So you're saying that by offering**
19 **this type of imaging modality, it does not present**
20 **a situation where it will result in patients**
21 **experiencing medical debt?**
22 **Is that what you're saying?**
23 **THE WITNESS (Williams): I am saying that. We would**
24 **not have such an expectation. If anything, we**
25 **actually expect the financial experience for the**

1 patient to improve.
2 ATTORNEY FELDMAN: Okay. And just for clarification
3 with respect to Medicaid patients, do they
4 currently cover these exams separately?
5 THE WITNESS (Williams): It is. Separately, yes.
6 Separately, PETs and MRI are covered today.
7 ATTORNEY FELDMAN: And if Medicaid does cover this
8 exam, which we assume they will on some level like
9 we have learned from other states, is there going
10 to be any financial impact on the patient?
11 THE WITNESS (Williams): I would not expect there to be
12 any financial impact on the patient, similar to
13 how there's no financial burden on the patient
14 from the separate scans today.
15 ATTORNEY FELDMAN: Correct. So there's no cost sharing
16 for Medicaid patients?
17 THE WITNESS (Williams): That is correct.
18 ATTORNEY FELDMAN: Okay. Thank you. I'm done.
19 THE HEARING OFFICER: Okay. So I do see that there are
20 certain things like heart studies and epilepsy,
21 which would benefit from that. We don't have that
22 technology available in the state.
23 How is that different than the current
24 diagnostic procedures that exist and that they're
25 using?

1 THE WITNESS (Goodman): It's -- it's better than the
2 current diagnostic tests that we're using because
3 they're being done at the same time. So we can
4 see where metabolic activity is at the same time
5 as -- as the patient is being scanned for the MRI
6 and the PET.
7 So in many situations, we don't have the
8 ability to do that with separate tests.
9 THE HEARING OFFICER: All right. That was my only --
10 THE WITNESS (Alexa): I might provide one last bit of
11 information here. So for example, some patients
12 have a CT scan, some patients have an MRI scan.
13 They're not equivalent scans. They have them for
14 different reasons. So the same thing would be
15 true for the PET-MRI.
16 We're still going to have PET-CTs out there
17 that are still going to be done. And now we have
18 another modality that does not -- had not existed
19 before for us that we can do that is PET-MR.
20 So prior to MR being in existence, we had to
21 rely on CT. When MRI came along, it didn't get
22 rid of CT. It just provided more information that
23 we had at our hands to help diagnose our patients
24 more quickly, more effectively, with better
25 accuracy and provide improved guidance.

1 THE HEARING OFFICER: All right. Thank you. Let's
2 shift to the two CT scanners under -- oh, opened
3 the wrong one again -- under 32744.
4 All right. On Bates page 60, under table
5 A -- let me just get down to my Bates page 60.
6 This is sometimes harder than it looks.
7 I do apologize.
8 All right. Under table A, YNHH states that
9 two CT scanners are located at the SRC campus on
10 1450 Chapel Street; should be hospital-based, not
11 satellite, as shown on the OHS inventory.
12 Explain this rationale.
13 THE WITNESS (Alexa): Okay. So we have three satellite
14 sites that we consider for our imaging. There's
15 the Hamden location and the Guilford location.
16 But for some reason, the SRC or the Saint Raphael
17 Hospital CT scanners were categorized as
18 outpatient when they're actually a hospital, part
19 of a hospital license. So those should be looked
20 at as hospital scanners, not as satellite
21 scanners. That's what was said.
22 Because they serve an ED, they serve
23 inpatient cases, they still have to do procedures
24 on them, and they do some operations.
25 THE HEARING OFFICER: Okay. Now we are going to go to

1 Bates page 172 -- and give us all a chance to get
2 there.
3 And it says that YNHH does not list Griffin
4 Imaging & Diagnostics Center at Ivy Brook, 2 Ivy
5 Brook Road in Shelton as a hospital and satellite
6 CT scanner. Can you explain that?
7 THE WITNESS (Alexa): So, which one again? I
8 apologize. I was fumbling through this.
9 THE HEARING OFFICER: On page 172 of the application,
10 YNHH does not list Griffin Imaging & Diagnostics
11 Center at Ivy Brook, which is on 2 Ivy Brook Road
12 in Shelton, as a hospital-owned satellite CT
13 scanner. Can you explain that?
14 THE WITNESS (Alexa): Yeah, I -- I don't believe those
15 are in our service area.
16 THE HEARING OFFICER: Well, you do have a non-hospital
17 ambulatory scanner in Shelton listed. You don't
18 have yours listed, though, or the Griffin Imaging
19 one listed. We have Advanced Radiology, but not
20 the other one.
21 ATTORNEY FELDMAN: So these -- you're asking about
22 ambulatory scanners, and these -- this application
23 is about hospital-based scanners?
24 THE HEARING OFFICER: Well, as a hospital-based
25 satellite scanner. So, you do have things in the

1 area listed, but you're not listing -- would you
2 like the opportunity to recheck your satellite
3 scanners in the service area and the non-hospital
4 satellite scanners, and refile?
5 Because you do have Advanced Radiology
6 Consultants in Shelton, which is part of the PSA,
7 but you don't have the satellite one of Griffin
8 Imaging as a hospital-based satellite, because
9 from this one it looks like there's only two Yale
10 satellite scanners.
11 THE WITNESS (Alexa): Wait. So --
12 ATTORNEY FELDMAN: Yeah. We'll need a minute, please
13 to go off?
14 THE HEARING OFFICER: Okay.
15
16 (Pause: 11:11 a.m. to 11:13 a.m.)
17
18 THE WITNESS (Alexa): Okay. Sorry about that.
19 THE HEARING OFFICER: No, problem.
20 THE WITNESS (Alexa): Okay. Yeah, I mean, I think with
21 the late file, if that is considered to be in the
22 service area, we will add that back in and include
23 it.
24 But I do want to just clarify that the
25 application that we're putting in today is for two

1 additional hospital-based scanners in the service
2 area.
3 THE HEARING OFFICER: I understand, but we do expect
4 accuracy in all -- if you are including it in your
5 application, you know we may question things that
6 are not -- even if it's not directly related. But
7 if you're including it as you're relying on that,
8 that's in there, and you want to make sure it's as
9 accurate as possible.
10 All right. So, on a similar vein, Bates page
11 27. We'll all head back up to the top.
12 All right. Table C, YNHH hospital-based and
13 satellite does not list Milford Hospital as a
14 hospital-based nor a hospital satellite location.
15 Can you explain that?
16 THE WITNESS (Alexa): It is listed in table B. We're
17 just focusing on -- in table C we're focusing
18 on -- on the Yale New Haven campus area. It is
19 included in the table before.
20 THE HEARING OFFICER: Okay. So, maybe --
21 ATTORNEY FELDMAN: There's two different -- the tables
22 are entitled, table B above, which includes
23 Milford states, hospital-based CTs in the service
24 area. And then table C is Yale New Haven
25 hospital-based and satellite CTs. That's why

1 Milford is on top of table B and not in table C.
2 THE HEARING OFFICER: It's a little confusing, but
3 we -- okay. Again, I would just maybe -- careful
4 with the naming in further, because hospital-based
5 and satellite without further explanation might
6 lead people to wonder why it's not included.
7 All right. So, on table number -- let's go
8 to Bates page 50.
9 Okay. And now, here you'll see why it does
10 get a little confusing as it doesn't show -- on
11 Bates page 50, table C, it does not list Milford
12 Hospital as a hospital-based.
13 Or actually -- well, it does, but hold on.
14 Do you want to revisit that table? Because
15 it is slightly confusing as to whether --
16 THE WITNESS (Alexa): So, I think I -- maybe I can help
17 clear that up in a second.
18 THE HEARING OFFICER: Yes.
19 THE WITNESS (Alexa): So, Milford Hospital is what
20 the -- it is a hospital-based CT, but Milford
21 Hospital is not part of Yale New Haven Hospital.
22 It's part of Bridgeport Hospital.
23 So, it is in the service area. So, Milford
24 is considered in our service area, but it's not
25 one of the Yale New Haven Hospital units. It is

1 part of Milford -- or Bridgeport.
2 ATTORNEY FELDMAN: Bridgeport.
3 THE WITNESS (Alexa): And we can -- we include it
4 because it is a hospital-based CT in our service
5 area.
6 THE HEARING OFFICER: Okay. All right.
7 THE REPORTER: Just a friendly reminder from the
8 Reporter, if the witnesses could keep their voices
9 up. I am hearing them, but I am straining
10 sometimes. Thank you.
11 THE HEARING OFFICER: Yeah.
12 THE REPORTER: Sorry for the interruption.
13 THE HEARING OFFICER: I'm actually going to second that
14 from the Court Reporter. The people at the back
15 of the room, it is harder to hear you. So, if you
16 could speak a little louder, that would actually
17 be really helpful because sometimes if you see me
18 going like this, I'm trying to hear what you're
19 saying.
20 So, at the back of the room, if you could
21 speak a little louder than you think is necessary,
22 that would be appreciated.
23 All right. I have a question from one of our
24 analysts who would like to see -- that you
25 initially responded that you are willing to do a

1 late file for a hospital-based versus
2 hospital-based satellite scanners. Are you
3 willing to provide that as Late-File 5?
4 ATTORNEY FELDMAN: A clarification, please?
5 THE HEARING OFFICER: Uh-huh.
6 ATTORNEY FELDMAN: So, when you talk about
7 hospital-based scanners, are you talking about
8 Yale New Haven Hospital only?
9 THE HEARING OFFICER: Let's take everybody in your PSA.
10 ATTORNEY FELDMAN: Well, we are the only hospital in
11 our PSA.
12 THE HEARING OFFICER: Except for Milford.
13 ATTORNEY FELDMAN: Yeah. We gave you that information
14 already. It's in table B.
15 THE HEARING OFFICER: Well, it was given, but it was
16 given in a confusing manner, because you gave us a
17 table where you did the whole PSA and then you
18 gave us a table where it says all hospital
19 scanners, but it didn't say just at the Yale New
20 Haven Hospital.
21 So, why don't we get a clarified chart?
22 Because the two charts that were on page --
23 ATTORNEY FELDMAN: Okay.
24 THE HEARING OFFICER: Let's do a clarified chart with
25 titles --

1 **ATTORNEY FELDMAN: Yeah.**
2 **THE HEARING OFFICER: With better titles.**
3 **ATTORNEY FELDMAN: We're happy to do that. So, are you**
4 **asking -- our current table C, which lists Yale**
5 **New Haven hospital-based and satellite CTs, do you**
6 **want one table that includes all hospital-based**
7 **CTs in our service area?**
8 **Is that what you're asking for?**
9 **THE HEARING OFFICER: Yes.**
10 **ATTORNEY FELDMAN: Okay. I am being told that table A1**
11 **in our response, our completeness responses -- oh,**
12 **response to issues already provides what you're**
13 **looking for, including fiscal year '24.**
14 **THE HEARING OFFICER: Okay.**
15 **ATTORNEY FELDMAN: That is on page 1. It's called**
16 **table A1, Yale New Haven Hospital CT scanner**
17 **utilization updated, and it includes Milford.**
18 **It's all the hospital-based equipment in the**
19 **service area. So, you have it.**
20 **THE HEARING OFFICER: Okay.**
21 **ATTORNEY FELDMAN: So, we're going to --**
22 **THE HEARING OFFICER: Does this include the approved**
23 **but not in-use devices --**
24 **ATTORNEY FELDMAN: Yeah, because we submitted this**
25 **before we completed -- are those the CTs you're**

1 referring to, or the MRI?
2 THE HEARING OFFICER: I'm referring to the CTs that
3 were previously issued in 22-32586.
4 ATTORNEY FELDMAN: They are --
5 THE HEARING OFFICER: The multiple devices that were
6 given to the satellite locations.
7 ATTORNEY FELDMAN: Yeah, they were not included.
8 THE HEARING OFFICER: Oh, okay. But you did include, I
9 believe, two CT scanners, two PET-CT scanners, and
10 two MRIs.
11 ATTORNEY FELDMAN: Yeah. So, if you look at table B1,
12 you can see these two CT scanners have yet to
13 be -- become operational.
14 THE HEARING OFFICER: Uh-huh.
15 ATTORNEY FELDMAN: You know, for planning and budgetary
16 reasons. They are listed in table B1 based on
17 projections. That's the best we could do.
18 THE HEARING OFFICER: Okay. And when are those --
19 ATTORNEY FELDMAN: I just want to make sure you see
20 page 2 of the issues responses.
21 THE HEARING OFFICER: Uh-huh.
22 ATTORNEY FELDMAN: Okay?
23 THE HEARING OFFICER: Yeah, I'm there. And when are
24 those going to -- are you estimating those to come
25 online?

1 **ATTORNEY FELDMAN: They're in the queue and there**
2 **they're being -- going through a budgetary review**
3 **process. So, probably at least one in 2025 or**
4 **2026. They're in the works.**
5 **THE WITNESS (Alexa): Yeah, projects like this take**
6 **time and they are a priority and they are in the**
7 **queue, and they will be implemented as quickly as**
8 **we possibly can.**
9 **THE HEARING OFFICER: All right. You guys have frozen**
10 **again. So, whoever just spoke, if you could say**
11 **your name?**
12 **THE WITNESS (Alexa): Yes, this is Daniel Alexa.**
13 **THE HEARING OFFICER: All right. So, I'm going to**
14 **add -- I'm going to institute the names while**
15 **speaking until you unfreeze again -- oh, you've**
16 **unfrozen again. All right.**
17 **Okay. So, let me go back to my questions.**
18 **All right. Given the capacity of other**
19 **non-hospital based CT scanners, does YNHH send**
20 **patients to these other available locations?**
21 **And if not, please explain.**
22 **THE WITNESS (Alexa): This is Dan Alexa talking again.**
23 **You know, since we operate over capacity in**
24 **our outpatient locations it would be reasonable to**
25 **argue/assume that any patients that did not want**

1 to wait or who preferred to have their scan done
2 someplace else at a non-ambulatory site have
3 already kind of done so. I think that data is
4 kind of normalized into it.
5 So, patients have a choice when they have a
6 scan that is ordered for them, and they can decide
7 to come to one of our locations to have their
8 services done, or they can choose a different
9 hospital or a non-hospital ambulatory location.
10 So, if they were waiting longer than they
11 wanted to at one of our sites or if there wasn't a
12 location, they already have that, that ability to
13 do that. So, I -- I make the assumption that that
14 is already kind of normalized out, that those
15 patients are already making that choice. And so,
16 you know, that's -- that's how their utilization
17 is currently set up. It's based off of that.
18 THE HEARING OFFICER: Okay. All right. That's it for
19 our questions on the CT scanners.
20 I will turn it over to Attorney Feldman, if
21 you have any follow-up questions?
22 ATTORNEY FELDMAN: If you would just give us a minute
23 to go on mute, we would --
24 THE HEARING OFFICER: Sure.
25 ATTORNEY FELDMAN: -- just need to have a short

1 **discussion.**

2

3 **(Pause: 11:26 a.m. to 11:31 a.m.)**

4

5 **THE WITNESS (Alexa): All right. We're back.**

6 **ATTORNEY FELDMAN: All right. Hearing Officer Novi, I**

7 **do have a rebuttal question for Mr. Alexa.**

8 **THE HEARING OFFICER: Definitely.**

9 **ATTORNEY FELDMAN: Several, in fact.**

10 **THE HEARING OFFICER: Okay.**

11 **ATTORNEY FELDMAN: Mr. Alexa, Hearing Officer Novi was**

12 **referring to the two CT ambulatory scanners that**

13 **are in the queue to become operational for Yale**

14 **New Haven Hospital. Can you explain to me how**

15 **those two CT scanners have any relevance or**

16 **relation to what we're asking to do off of Saint**

17 **Raphael's campus for those two proton-scanning CT**

18 **scanners?**

19 **A VOICE: (Unintelligible.)**

20 **ATTORNEY FELDMAN: Or -- what I said?**

21 **THE WITNESS (Alexa): Proton counting.**

22 **ATTORNEY FELDMAN: Proton counting, yes. I need**

23 **coffee.**

24 **THE WITNESS (Alexa): I think we all could.**

25 **So, what I want to make sure we understand is**

1 that what we're really looking for here is to take
2 care of our acute-care patients in the hospital
3 setting. And what -- we look at the site for
4 Saint Raphael's Hospital right now, they've got
5 the two CT scanners that service ED patients,
6 inpatients, they service procedure patients, and a
7 small portion of outpatients. Roughly 53 percent
8 or half that business is ED patients, and another
9 25 percent of those are inpatient.
10 What is happening now with the expansion of
11 the ED and the development of the neuroscience
12 tower is if we don't add these CT scanners in that
13 campus, we're going to basically have no ability
14 to perform any inpatient scans or any outpatient
15 scans for any procedures because of the ED volume,
16 which is currently over half of our volume, is
17 going to expand.
18 So, the current scanners that we have are
19 essentially going to be dedicated to servicing the
20 acute needs of ED patients that come into the
21 hospital. So, we still have inpatients that we
22 have to service. We still have outpatients -- I
23 mean, procedures that have to be done, inter --
24 interventional radiology procedures done on those
25 scanners, and also the -- the current outpatient

1 base that goes there.
2 Saint Raphael is a really good lo -- pardon
3 me, location for a lot of our patients that need
4 to take a bus there, or they have no other means
5 of transportation. It's a good location for them
6 to go to, to serve those patients there.
7 So, I guess -- well, I guess what I'm really
8 saying is, it's like if I use an analogy of, like,
9 a balloon. Right now we've shown that our
10 capacity at Saint Raphael's Hospital is currently
11 at, like, 158-plus percent. That balloon should
12 be full at 100. It's up to 150 percent. If we
13 try to put more into it, it's going to explode.
14 So, we need to make the balloon bigger at that
15 site.
16 And then, the next point I want to make is
17 what you asked about with how it relates to the
18 other two scanners that we have approval for.
19 Even when you add those scanners in to our
20 outpatient volume capacity and you include these,
21 it still has us over the 85th percentile, even
22 over the 100th percentile for -- for capacity.
23 So, despite having these units to support our
24 hospital inpatient acute needs and provide another
25 location for our patients that have transportation

1 issues, it also -- it only slightly impacts our
2 overall ambulatory availability. So, the other
3 scanners are definitely needed. We've already
4 demonstrated the need at those locations. This is
5 an entirely separate need to support a hospital.
6 ATTORNEY FELDMAN: So, referring to those two scanners
7 when we came before OHS, we presented to them 2021
8 data. Right? And based on your experience in
9 your role, have you seen the utilization of CT
10 grow?
11 THE WITNESS (Alexa): So, we've, you know, whenever you
12 went to -- you know, I've been in radiology
13 imaging now at academic medical centers for 26
14 years. And one of the things that's most
15 important to us is providing the appropriate
16 access to patients. And so, you know, and we've
17 also learned that imaging touches every service
18 line across the board, you know. So, every
19 patient that comes through a hospital is somehow
20 going to be impacted by imaging.
21 So, any improvements in imaging access are
22 going to directly result in improvements in the
23 service that they get overall. And, to the --
24 converse to that, any detriment impact in access
25 is going to make care more difficult. So, by

1 having all of these, by having the right access to
2 patients, by implementing the ambulatory
3 locations, it's going to enable us to provide a
4 higher level of care.
5 ATTORNEY FELDMAN: But, in terms of the information
6 that we had, we took a snapshot in 2021 with
7 respect to utilization. If we take a snapshot now
8 in 2024, what's going to look different in terms
9 of utilization of CT?
10 THE WITNESS (Alexa): Yeah, so we underwent in
11 between -- right in fiscal year '23, we underwent
12 a process improvement plan. So, we tried to
13 optimize the current standards that we have, and
14 that's how you've seen the growth where we are
15 now.
16 Now, we're at a point where we can no longer
17 improve the operational efficiencies in our
18 location. So, without adding these it's going to
19 lead to more backlogs and more delays, and it's
20 going to lead to, you know, patients having a more
21 difficult time to get the results of their
22 diagnosis done.
23 ATTORNEY FELDMAN: So, utilization now is higher than
24 it was in 2021?
25 THE WITNESS (Alexa): Yes.

1 **ATTORNEY FELDMAN: So, you're basically -- are you**
2 **basically say that with the two additional CTs**
3 **that we're requesting OHS to approve to be located**
4 **on the Saint Raphael's campus, and the two CTs**
5 **that will be ambulatory satellite sites, will we**
6 **be over capacity with respect to utilization as it**
7 **relates to CT?**
8 **THE WITNESS (Alexa): So, we are still going to be over**
9 **capacity, but it is going to reduce it and make it**
10 **more -- it will help, but it -- but it will not --**
11 **we're still going to be well over capacity.**
12 **ATTORNEY FELDMAN: And, with respect to those two sites**
13 **that are ambulatory and in the queue, do you --**
14 **well, tell me a little bit about the population**
15 **you hope to serve at that location from the New**
16 **Haven-centric area, the underserved population.**
17 **THE WITNESS (Alexa): Yeah. So, our -- like I've**
18 **mentioned before, our patients have a choice on**
19 **where they can go. And so, when they have an**
20 **opportunity, when they're scheduling they can**
21 **choose either by location or by first available**
22 **appointment. So, it gives them more options and**
23 **more opportunity to have their scan.**
24 **So, patients that need a bus or that need to**
25 **be on a route or something, they can choose a site**

1 like Saint Raphael's or another hospital, you
2 know, or the main hospital to have their scan
3 done. So, the goal is to improve access to
4 everybody and enable us to provide, you know, care
5 more efficiently.
6 ATTORNEY FELDMAN: Mr. Alexa, you mentioned that you
7 have -- your entire professional experience has
8 been at academic medical centers. Can you tell me
9 the academic medical centers you've worked at?
10 THE WITNESS (Alexa): I've worked at Cleveland Clinic
11 and I've worked at NYU.
12 ATTORNEY FELDMAN: And, in terms of your -- I mean,
13 obviously, we're comparing different academic
14 medical centers, so it's not an exact science.
15 But does the amount of imaging equipment that Yale
16 New Haven Hospital has compared to NYU and
17 Cleveland Clinic pale at all to the --
18 THE WITNESS (Alexa): Yeah, I think every academic
19 medical center and every hospital faces different
20 challenges and we have to address them as they
21 are. I think that -- so the answer is, yes, that
22 those institutions have more access to more
23 imaging equipment.
24 I think -- and to be honest, I think that our
25 plans really got halted a lot, you know, during

1 the pandemic. I think it made it really hard to
2 continue to look at how we're going to invest in
3 advancing, you know, applying for CONs to get the
4 right amount of patients.
5 My goal at all of the locations that I've
6 ever worked is to try to have the right amount of
7 capacity for the patients that we need to serve.
8 That's my goal here as well. And in order to get
9 to that point, you know, we need to be able to
10 start to expand our portfolio to handle the
11 current patient volume that we have, you know,
12 based on our optimization and based on the
13 patients that want to come to us.
14 So, you know, that's our challenge here is --
15 I'm always looking at first, how do we optimize
16 within our current structure; two, how can we
17 expand hours by hiring more people.
18 Next is to then say, okay. Do we need to
19 increase the number of locations we have to make
20 that a little -- a little bit better/bigger, so
21 that we can serve our patients and get them
22 through the care continuum more quickly and
23 efficiently.
24 ATTORNEY FELDMAN: Thank you. I have no further
25 questions for Mr. Alexa.

1 **THE HEARING OFFICER: Okay. With that, we will go**
2 **ahead and -- actually, let me ask. I'm just going**
3 **to wait for Faye to let me know if we've had any**
4 **signups.**
5 **While I do that, I will go ahead and read the**
6 **public portion. This is the public portion of**
7 **today's hearing for two CON applications filed by**
8 **Yale New Haven Hospital's SRC location, Docket**
9 **Numbers 24-32705-CON and 24-32744-CON.**
10 **We had the technical portion this morning,**
11 **and we have not had any signups for today. So, I**
12 **will not read through the instructions for**
13 **public -- actually, I will make now a brief**
14 **announcement.**
15 **Is there anybody on this call who would like**
16 **to make a public comment? Please sign up in the**
17 **chat function if you would like to make one at**
18 **this time. Otherwise, anyone who would like to go**
19 **ahead and submit written comments, we will be open**
20 **on submitting written comments for one week from**
21 **today up until 11/6. And those written comments**
22 **can be e-mailed or mailed.**
23 **Although, be careful with mail because you're**
24 **never quite sure it will get there by 11/6 --**
25 **seven calendar days from today. And the e-mail**

1 address at which you can send e-mail comments is
2 CONcomment@ct.gov.
3 Again, that is CONcomment@ct.gov.
4 And our physical mailing address is 450
5 Capitol Ave, MS Number 51, OHS, PO BOX 340308,
6 Hartford, Connecticut, 06134.
7 All right. So I do not have anybody for a
8 public comment. So, at this time, I would like to
9 thank Ms. Fentis for keeping that open and looking
10 for public comments.
11 We will move to -- wait. Before I list the
12 late files -- actually, I'll list them first, and
13 then we will ask how long you think you'll need,
14 Attorney Feldman, to grab those together and go
15 ahead and get those back to us.
16 We have Late-File 1 is a slide deck that was
17 displayed during the testimony.
18 Late-File 2 is to calculate the projected
19 hospital-based MRI utilization in the PSA
20 indicated on CON Application 24-32705, ensuring
21 all recent Yale New Haven CON approved units are
22 included. This will also come as a letter to you
23 later -- or as an order later.
24 Late-File Number 3 was to develop a visual
25 representation comparing the PET-MRI scanning

1 process to conducting a separate PET and a
2 separate MRI scan, including in the charts
3 detailed information on the three types of imaging
4 modalities and advantages -- or, well, that was
5 not quite exactly what I was looking for.
6 No, sorry, I had that written out for me from
7 somebody else.
8 It was a timeline of the PET-MR scans and the
9 MRI/PET-CT scans; indicate what additional people
10 and appointments and times are needed, and that I
11 would like a visual representation of that as well
12 so that the public can see, again, where they
13 might be saving time, where they might be saving
14 where the timeline might be less on one, more on
15 another, and where they might save also on less
16 appointments.
17 ATTORNEY FELDMAN: I just need some clarification.
18 THE HEARING OFFICER: Yes?
19 ATTORNEY FELDMAN: Sorry.
20 THE HEARING OFFICER: That's okay.
21 ATTORNEY FELDMAN: I understand what you're looking
22 for, but for what type of imaging?
23 THE HEARING OFFICER: Just the PET-MR versus -- the one
24 machine versus the two, you know, going with a PET
25 scan and a separate MRI scan. This is just for

1 the PET-MR machine. It's to show the public what
2 the savings or what the benefits might be.
3 ATTORNEY FELDMAN: Okay.
4 THE HEARING OFFICER: In a visual representation.
5 Also, you guys have frozen again, so I do want to
6 say anybody who talks, we're going to institute
7 the name roll again because it is very frozen.
8 And now you're back. Every time I say it,
9 you come back -- so I do appreciate that.
10 All right. And then Late-File Number 4 is
11 for PET-MR scanners in the New England states and
12 New York. Please provide information that you
13 might have on the costs that patients could face
14 for the PET-MR scans conducted at the surrounding
15 facilities, if you have any.
16 ATTORNEY FELDMAN: I don't think we have access to that
17 information.
18 THE HEARING OFFICER: Okay.
19 ATTORNEY FELDMAN: That is not information that is
20 publicly available or that providers can share.
21 THE HEARING OFFICER: Okay. Hold on one second. Let
22 me go back down.
23 Late-File 4. Okay. We'll strike Late-File
24 4. So it will be through Late-File 3. With those
25 in mind, Attorney Feldman, what do you think would

1 be a reasonable timeline for submission?
2 ATTORNEY FELDMAN: Oh, okay. With respect to the
3 Griffin Ivy -- whatever it's called, CT, are you
4 looking for us to include that in a new chart?
5 THE HEARING OFFICER: I did ask the --
6 ATTORNEY FELDMAN: I mean --
7 THE HEARING OFFICER: I did ask the analyst if she
8 still wanted that, and she indicated that we did
9 not necessarily need late files on that one.
10 ATTORNEY FELDMAN: I would agree.
11 THE HEARING OFFICER: So it will just be the three late
12 files.
13 ATTORNEY FELDMAN: Great. How much time do you think?
14 Let's say ten days we will do it. We'll ask for
15 ten days. We might get it to you on a rolling
16 basis, or altogether sooner.
17 THE HEARING OFFICER: How about we give you a little
18 more, because there is a holiday on the 11th, and
19 tomorrow is Halloween.
20 And how about we have them due by the end of
21 the day, November 12th?
22 ATTORNEY FELDMAN: That's fine.
23 THE HEARING OFFICER: I always err on the side of
24 caution, and then when there's a holiday involved
25 I know things get a little crazy, so.

1 ATTORNEY FELDMAN: Thank you.
2 THE HEARING OFFICER: All right. So we will have those
3 due November 12th. That is a Tuesday -- by 4:30
4 p.m., please? You've also frozen again. I'm
5 going to say it, and you will unfreeze magically.
6 All right. So -- and now you've unfrozen.
7 Thank you again.
8 So at this point, we will have those due by
9 the close of business on November 12th. And we
10 will move to closing arguments and statements from
11 the Applicant's attorney at this time, Attorney
12 Feldman.
13 ATTORNEY FELDMAN: Thank you. I don't have a whole
14 lot, but I do have something to say, and I'm going
15 to just try to summarize what we are basically
16 trying to present under today. Some of these
17 statements are personal, my opinion, and I believe
18 that we are truly fortunate to have an academic
19 medical center like Yale New Haven Hospital, which
20 commits to these very innovative and important
21 projects in our state.
22 In this specific application, more
23 specifically, we're talking about a much needed
24 expanded ED. As you probably have heard, there's
25 a lot of ED crowding, a lot of ED utilization, and

1 **we need to respond to that by increasing the size,**
2 **more than doubling the size of the ED on the Saint**
3 **Raphael's campus.**
4 **And as you saw in Dr. Laurans' pre-filed**
5 **testimony, those two neurosciences towers are just**
6 **remarkable. And it's very exciting that we will**
7 **have the level of service that they will bring in,**
8 **the innovation that will continue to develop new**
9 **treatments for people that are suffering from**
10 **neurological and neurodegenerative diseases.**
11 **And more of that -- I mean, some of the**
12 **things that I heard today regarding autism, PTSD,**
13 **depression, OCD, it's just truly amazing. And I**
14 **believe that the Neurosciences Center will become**
15 **a destination, not only for residents in**
16 **Connecticut, but I think from all over the country**
17 **and all over the world.**
18 **We're so lucky to have Dr. Laurans, who**
19 **talked about the importance of iMRI and the uses**
20 **for it in the OR, in the Neurosciences Center, and**
21 **how not having iMRI will truly be a disadvantage**
22 **to patients.**
23 **We're also so fortunate to hear from**
24 **Dr. Goodman about the proposal to acquire a**
25 **PET-MRI, which will provide our physicians at Yale**

1 with information that they don't currently have.
2 What are they going to do with this information?
3 They're going to be able to diagnose more
4 accurately and treat people more precisely.
5 We've seen through the research studies that,
6 you know, with this information, staging and
7 treatment radically changes. So instead of
8 working in a dark room, we're going to have light
9 shining on the diagnostic process, and that is
10 truly amazing.
11 You also heard about the addition of these
12 two CT scanners on the SRC campus. They are
13 needed, because if we don't have them we're going
14 to have problems. We're going to have very
15 limited access to CT. And these very
16 next-generation CT scanners are the first in the
17 state, but they will provide more accurate
18 information also, and we're likely to see more
19 proton scanners in the state.
20 But even with those two incremental CTs,
21 which will be fully utilized by the Saint
22 Raphael's campus, we do have two new CTs online.
23 And even with the addition of those two CTs, we
24 believe, strongly believe that the demand for CT
25 will not decrease. It will continue to increase,

1 and that we will be over capacity at the point in
2 time when all these CTs are operational.
3 And why are we asking for it now? Because
4 you saw the pictures; we are building, and this is
5 not something we just bring in on a dolly and plop
6 it down and we're ready to go plug it in and we're
7 good to go. This requires very specific
8 construction and planning and budgeting to get
9 this all ready for the date of 2027.
10 I want to end with a few, what I believe to
11 be, salient and important points. As I said
12 earlier, I really think that the amount of imaging
13 equipment here that Yale New Haven Hospital has is
14 really insignificant compared to other neighboring
15 academic medical centers, whether you look at
16 Columbia or NYU or Cornell or Mass General. We
17 are really not even close. But to continue to
18 attract the best and the brightest physicians to
19 Yale New Haven Hospital, we have to have available
20 to us the available -- the necessary technology so
21 that they could do cutting-edge treatments and
22 progressive innovative care.
23 We believe that looking at some of the
24 capacity issues with other non-Yale-based
25 ambulatory radiology centers is truly irrelevant

1 in that we don't have control over the quality.
2 We don't have control of the protocols. And I
3 think we demonstrated in last year's imaging CON
4 that physicians want the imaging to be done by
5 Yale physicians and read by Yale physicians. We
6 want to avoid duplication. We don't want people
7 to have a scan in some community location and then
8 come to Yale New Haven Hospital and have to have
9 it repeated.
10 So I guess the point is, is that not all
11 providers are equal, and patients just cannot be
12 shunted around because it leads to delays. It
13 leads to duplication, and it negatively impacts
14 quality.
15 Finally, I just want to ask OHS and OHS staff
16 to think about from your perspective and the
17 perspective of patients what it's like to have a
18 neurodegenerative diagnosis, or think you have
19 one, or to have a stroke or have a loved one have
20 a stroke. We all want the first thing -- if
21 you've experienced this, and I have experienced
22 this -- is we want access as quickly as possible.
23 We don't want to wait twelve days before
24 we're scanned or imaged, and we want to make sure
25 that the imaging we have doesn't miss anything

1 because I've had that happen, too. So that's
2 really what I want to leave you with.
3 It's truly amazing here that Yale as a
4 safety-net hospital will be able to offer all
5 patients that come to it with the most innovative
6 and exciting and precision-based medicine in the
7 state.
8 And I thank you for your time, and I have no
9 further comments.
10 THE HEARING OFFICER: All right. Thank you Joan. I
11 did want to let you know that you did freeze
12 actually quite quickly in, but because we could
13 hear you we let it go.
14 ATTORNEY FELDMAN: That's fine with me.
15 THE HEARING OFFICER: We could hear you so I didn't
16 want to interrupt your closing. You are frozen at
17 the moment. So I'm going to institute the name
18 rule again -- oh, and now you're back. Every time
19 I say it, it comes back -- so I do apologize.
20 But I want to thank you all for attending
21 today. We have the late files due on November
22 12th, and the record of this hearing will remain
23 open until closed by OHS at a later date.
24 Thank you to everybody, and again thank you
25 to our Court Reporter, and we will see you later.

1 ATTORNEY FELDMAN: Thank you.

2 THE HEARING OFFICER: This hearing is now adjourned for

3 today.

4 ATTORNEY FELDMAN: Thank you.

5 THE WITNESS (Alexa): Thank you.

6 THE WITNESS (Goodman): Thank you.

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8 (End: 11:57 a.m.)

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1 STATE OF CONNECTICUT

2 I, ROBERT G. DIXON, a Certified Verbatim Reporter within and for the State of Connecticut, do
3 hereby certify that I took the above 104 pages of proceedings in the STATE OF CONNECTICUT, DEPARTMENT OF
4 PUBLIC HEALTH, OFFICE OF HEALTH STRATEGY, APPLICATION & PUBLIC HEARING In Re: YALE NEW HAVEN HOSPITAL
5 ACQUIRING A NEW MRI SCANNER (24-32705-CON) & ACQUIRING A NEW CT SCANNER (24-32744-CON) CERTIFICATE OF NEED
6 APPLICATIONS, held before: ALICIA NOVI, ESQ., THE HEARING OFFICER, on October 30, 2024, (via
7 teleconference).

I further certify that the within testimony
8 was taken by me stenographically and reduced to typewritten form under my direction by means of
9 computer assisted transcription; and I further certify that said deposition is a true record of the testimony
10 given in these proceedings.

I further certify that I am neither counsel
11 for, related to, nor employed by any of the parties to the action in which this proceeding was taken; and
12 further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor
13 financially or otherwise interested in the outcome of the action.

14

WITNESS my hand and seal the 14th day of
15 November, 2024.

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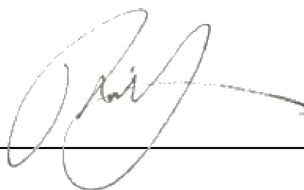

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Robert G. Dixon, N.P., CVR-M No. 857

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My Commission Expires 6/30/2025

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