

CERTIFICATE OF NEED TASK FORCE: FINAL REPORT DRAFT

Research and Recommendations of the
Certificate of Need Task Force Presented to
Governor Dannel P. Malloy

January 13, 2017

**FORMAL SUBMISSION LETTER TO GOVERNOR MALLOY SIGNED BY lieutenant GOVERNOR NANCY
WYMAN**

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Acknowledgements

This report was developed through the volunteer efforts of appointed members with areas of expertise in various segments of the health care field as mandated in Executive Order 51A (See **Appendix A**)

Member Per Executive Order	Designee	Title
<i>Chair</i>	<i>Lieutenant Governor Nancy Wyman</i>	
Secretary of Office of Policy and Management	Anne Foley	Undersecretary for Policy Development and Planning, Office of Policy and Management
Commissioner of Public Health	Raul Pino	Commissioner, Department of Public Health
Commissioner of Social Services	Roderick Bremby	Commissioner, Department of Social Services
Representing acute care hospitals in a city with greater than 80,000 residents	David Whitehead	Chief of Strategy & Transformation Office, Hartford Healthcare
Representing acute care hospitals in a city with less than 80,000 residents	Gary Havican April 12, 2016 – August 30, 2016	Vice President of Strategic Planning and Ambulatory Operations, Middlesex Hospital
Representing acute care hospitals in a city with less than 80,000 residents	Susan Martin September 1, 2016 – January 13, 2017	Vice President of Finance for Middlesex Hospital
Represents physician practice groups	Bob Patricelli	Founder and CEO, Women’s Health USA
Represents a nursing home	Mag Morelli	President, Leading Age
Represents a free-standing out-patient provider of health care services not currently affiliated with a hospital system or physician practice group	Dr. Gary Price	Medical Director and Owner, The Center for Aesthetic Surgery
Represents a qualified health plan sold through the health insurance exchange	Joseph Wankel	Vice President of Network Strategy & Operations, ConnectiCare
Represents the health care insurance industry	Keith Stover	Government Relations, Connecticut Association of Health Plans
Represents health care labor interests	John Canham-Clyne	Deputy Research Director, Unite Here International Union
Represents health care labor interests	Jennifer Smith	Political Director and Vice President, SEIU District 1199
With expertise and knowledge in the field of health economics	Dr. Fred Hyde	Clinical Professor of Health Policy & Management, Columbia University; Fordham University Fellow, Global Healthcare Innovation Management Center
Represents consumers interests	Tekisha Everette	Executive Director, Health Equity Solutions
Represents entities currently regulated by the CON process, appointed by Commissioner of Public Health	Jeff Walter	Former, Interim CEO, Connecticut Nonprofit Alliance
Represents entities currently regulated by the CON process, appointed by Commissioner of Public Health	Dr. Alan Kaye	President, Radiological Society of Connecticut

Acknowledgements (continued)

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I. Executive Summary

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II. Background

Executive Order 51 issued by Governor Malloy in February, 2016, established the CON Task Force to undertake a review and analysis of the state's CON process and programs and determine if changes are necessary to ensure quality of care and access for all state residents and the preservation of an open and competitive health care market. The examination is required to include, but is not limited to, the following:

- Perform a comprehensive review of the state's CON programs, including an analysis of the scope, existing authority, and structure of the current agencies having oversight, to determine if any changes should be made to improve efficiency, effectiveness, and alignment with state and federal health care reform efforts;
- Identify any challenges and gaps in the state's efforts to regulate health care services and facilities to promote affordability, equitable access, and high quality care, including the state's ability to maintain fair, open, and competitive health care market conditions; and
- Deliver recommendations on how to improve the existing CON programs and address any identified challenges or gaps in the state's regulation of health care services and facilities to the Governor no later than January 15, 2017.

The seventeen member Task Force (page ii) comprised of various stakeholders, met monthly April 12, 2016 – January 9, 2017 (excluding June). During this time Task Force members:

- a. Reviewed literature and research on the effectiveness of CON programs in enhancing health care quality, access and containing costs;
- b. Examined CON program structures and outcomes in other states;
- c. Participated in three CON Task Force member surveys to gather member opinion regarding:
 - Goals and purposes of a CON program;
 - Actions and facilities subject to CON and associated application review criteria; and
 - CON Decision-making process;
- d. Participated in 20 hours of presentations, discussion, and voting during CON Task Force meetings.

Meetings were open to the public and included opportunities for public comment at the beginning of each meeting. Meeting materials are posted on a dedicated [CON Task Force web page](#).

The CON Task Force was staffed by the Office of Policy and Management, Division of Policy Development and Planning.

III. History of CON Nationally and in Connecticut

Certificate of Need: Definition

National Definition: Certificate of Need (CON) programs are aimed at restraining health care facility costs and allowing coordinated planning of new services and construction. Laws authorizing such programs are one mechanism by which state governments seek to reduce overall health and medical costs¹.

Connecticut's Definition: "A Certificate of Need (CON) is a formal statement by a State agency (in the Department of Public Health's (DPH) Office of Health Care Access (OHCA) or the Department of Social Services (DSS)) that a health care facility, service or piece of equipment is needed or that a termination of a service will not have an adverse effect on access to health care services in the area of the state served by the health care facility. The CON program attempts to eliminate unnecessary duplication of services, preserve needed services and ensure access to quality care. Ongoing changes to the health care environment have emphasized the evolving role of CON as a planning tool. Overall, the aim of the CON program is to ensure access to quality health care services for the citizens of the State of Connecticut".²

Certificate of Need: History

The development of CON programs began in 1964 when New York became the first state in the nation to pass legislation that enabled state government to determine the need for new hospitals and nursing facilities before they were approved for construction. The American Hospital Association took interest in the concept of CON programs and urged states to develop similar laws³. In 1973 Connecticut established its CON program and became one of 15 states in the nation to implement this type of health care oversight. In the early 1970's the federal government began to seek ways to control rapidly rising health care costs, inequitable distribution of health care facilities and manpower and lack of effective methods of delivering health care. Congress viewed the CON process as an effective method of controlling these factors and passed Public Law 93-641, *The National Health Planning and Resources Development Act of 1974*.⁴ Public Law 93-641 required that all states seeking federal funding for health programs implement a CON program and specified (1) the facilities and services subject to the CON process; and (2) the procedures and criteria for conducting CON reviews. By 1978, thirty-six states had adopted CON laws.⁵ In 1987 Congress repealed the *National Health Planning and Resources Development Act of 1974* eliminating the requirement for states to administer a CON program and the funding tied to it. Upon repeal, 14 states terminated their CON programs⁶. As of April, 2016, thirty-five states and the District of Columbia continue to have CON programs with varying

As of April, 2016, thirty-five states and the District of Columbia have CON programs with varying oversight requirements. National Conference of State Legislatures

¹ National Conference of State Legislatures, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

² Quoted from the OHCA Certificate of Need Analyst Toolbox

³ National Conference of State Legislatures <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#Resources>

⁴ P.L. 93-641 – National Institutes of Health http://profiles.nlm.nih.gov/RM/A/A/I/Q/_/rmaaiq.pdf

⁵ Burt, Jessica C.; Williams, Kati V.; *Certificate of Need (CON) Law Series – Part I: A Controversial History*; Health Capitol, Volume 5, Issue 9; September 2012 http://www.healthcapital.com/hcc/newsletter/9_12/CERT.pdf

⁶ National Conference of State Legislatures; Table: Health Planning Agencies in States Without Current CON Programs. <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#Regulated>

oversight requirements⁷. Recent studies conducted on CON programs have yielded results that indicate states with CON programs have lower overall health care costs, reductions in duplicative services and better patient outcomes when compared to states without operational CON programs⁸. However, these studies rely on correlation and cannot claim that the existence of CON resulted in the lower costs.

Upon establishment in 1973 (Public Act 73-117), Connecticut's CON program was housed in the Commission on Hospitals and Health Care. In 1993, the state Legislature passed Public Act 93-262, *An Act Concerning the Establishment of the Department of Social Services (DSS)*, which carved out the CON program for nursing homes, residential care homes and intermediate care facilities for individuals with intellectual disabilities and moved oversight authority for these facilities to the newly formed DSS. All other CON program responsibilities remained with the Commission on Hospitals and Health Care. In 1994, Public Act 94-3, *An Act Concerning Health Care Access*, terminated the Commission on Hospitals and Health Care and established the Office of Health Care Access (OHCA), which was governed by a Board of Directors appointed by the Governor and Chaired by the Governor. Public Act 95-257, *An Act Concerning the Consolidation of State Operated Programs at Fairfield Hills, Norwich and Connecticut Valley Hospitals, Transfer of Addiction Services to The Former Department of Mental Health, Medicaid Waiver and The Office of Health Care Access*, officially transferred the responsibilities of overseeing the portion of the state's CON program not administered by DSS to OHCA. In 2009, OHCA was moved under the Department of Public Health (DPH) and oversight authority was given to the Commissioner of DPH. In 2010, in an effort to align with a changing health care system as a result of the federal Patient Protection and Affordable Care Act (Public Law 111-148), Connecticut's CON program underwent significant reform in an effort to: (1) simplify the CON process; (2) focus on oversight of "safety net" services and areas of potential overutilization; (3) develop CON criteria and standards to address the financial stability of the health care delivery system, and (4) improve the quality of patient care⁹. The result was Public Act 10-179, *An Act Making Adjustments to State Expenditures for the Fiscal Year Ending, June 30, 2011*¹⁰, which formed the CON process as it is implemented today.

Arguments in Support and Opposition of CON

In the decades since the federal government repealed the law requiring states to implement CON programs, a national debate over its benefits have continued. Supporters of CON believe in the general premise of CON regulation that excess capacity (service availability beyond actual need) results in higher health care costs. Additionally, [The American Health Planning Association](#) offers that CON can (1) Limit Health Care spending; (2) Improve Quality of Care; (3) Ensure access to care in otherwise underserved areas and (4) Be an effective health care system planning tool when used in conjunction with community-based planning efforts¹¹. While many opponents argue that there is no definitive evidence that CON programs control health care costs. They believe that an open market with less regulation that focuses on quality rather than price may be more effective and that implementing Diagnostic-Related

⁷ National Conference of State Legislatures; Table: Facilities and Services Regulated by CON <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#Regulated>

⁸ OHCA, *Independent Assessment of the Connecticut Department of Public Health Office of HealthCare Access Certificate of Need and Supporting Programs*; February 28, 2014. P. 71-74.

⁹ CT Department of Public Health, *Report to the Joint Standing Committee of the Connecticut General Assembly: Certificate of Need Requirements*. January 1, 2016.

¹⁰ P.A 10-179 *An Act Making Adjustments to State Expenditures for the Fiscal Year Ending, June 30, 2011*. <https://www.cga.ct.gov/2010/ACT/Pa/pdf/2010PA-00179-R00SB-00494-PA.pdf>

¹¹ *Improving Health Care: A Does of Competition*, AHPA Response; American health Planning Association, CON Article & Essays (updated 2014) <http://www.ahpanet.org/files/AHPAargfavorCON.pdf>

Groups would make regulation unnecessary.¹² The Federal Trade Commission (FTC) has been a critic of CON programs in recent years issuing statements that do not favor CON programs, such as the one to the Illinois Task Force on Health Planning and Reform wherein the FTC supported the repeal of the state's CON laws and stated that "the proposition that competition cannot work in health care is not supported by evidence or the law"¹³. In July 2004 the FTC issued a report that examines the role of competition in the health care market¹⁴. The FTC has maintained a position that competition in health care is necessary.

Areas of Health Care Subject to CON Review – National Perspective

Across the country, states with active CON programs vary in both what health care actions and facilities are subject to CON and the process used to conduct the associated regulatory functions. At the May 16, 2016 meeting of the CON Task Force, Thomas Piper, Chief Executive Officer of MacQuest Consulting and national CON expert, presented a detailed overview of CON Programs in other states, national results achieved by CON programs, and the landscape of health care systems with and without CON programs¹⁵. Mr. Piper identified 30 categories of health care services regulated nationally by CON programs to varying degrees. Connecticut currently regulates 12 out of the 30 categories. (See **Appendix B**) The only health care sector regulated by all CON states in some capacity is Long Term Care facilities. The majority of states, 32 out of 36, also use the CON process to regulate hospital activity.

IV. Other Health Care System Reform Efforts Underway in CT

The CON Task Force is only one of multiple health care system review and improvement initiatives occurring in Connecticut. It is important to have an awareness of the purpose and goals of concurrent health care reform efforts in order to understand the scope of the CON Task Force and its relation to more broad-based initiatives.

The Health Care Cabinet (HCC)

In 2011, [Public Act 11-58](#) established a Health Care Cabinet to advise Governor Dannel P. Malloy, Lt. Governor Nancy Wyman and the Office of Health Reform & Innovation on issues related to federal health reform implementation and development of an integrated health care system for Connecticut¹⁶. During the 2015 legislative session, the Connecticut legislature passed [Public Act 15-146](#) charging the HCC to study and report on the health care cost containment models in other states including, but not limited to, Massachusetts, Maryland, Oregon, Rhode Island, Washington and Vermont, to identify successful practices and programs that may be implemented in the state for the purposes of:

¹² National Council of State Legislatures, Chart: CON Supporter' Views vs. CON Opponents' views. <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

¹³ Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform; September, 15, 2008 https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-and-department-justice-written-testimony-illinois-task-force-health-planning-reform-concerning/v080018illconlaws.pdf

¹⁴ The Federal Trade Commission, Department of Justice, *Improving Health Care: A Dose of Competition* (Washington D.C.: FTC, DOJ, 2004) <https://www.justice.gov/sites/default/files/atr/legacy/2006/04/27/204694.pdf>

¹⁵ Piper, Thomas, Presentation, *National CON Perspectives: A Presentation to the Connecticut Certificate of Need Task Force, May 16, 2016* <http://portal.ct.gov/-/media/Office-of-the-Governor/Cert-of-need/CON-Doc-20160516-CT-Task-Force-pres-PIPER.pdf?la=en>

¹⁶ Health Care Cabinet Web Page <http://portal.ct.gov/en/Office-of-the-Lt-Governor/Health-Care-Cabinet/Health-Care-Cabinet>

(1) Monitoring and controlling health care costs; (2) Enhancing competition in the health care market; (3) Promoting the use of high-quality health care providers with low total medical expenses and prices; (4) Improving health care cost and quality transparency; (5) Increasing cost effectiveness in the health care market; and (6) Improving the quality of care and health outcomes.

The State Innovation Model (SIM)

In December, 2014 the State of Connecticut was awarded a \$45 million test grant by the federal Center for Medicare and Medicaid Innovation to *test state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries—and for all residents*¹⁷

Connecticut’s vision for the SIM program is to *establish a whole-person-centered health care system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and health care; and improves affordability by reducing healthcare costs*¹⁸. SIM has three major strategies for moving from a volume-centered healthcare system to one centered around accountable care and health enhancements communities: (1) transformation of the care delivery system through an advanced medical home glide path, a community and clinical integration program, reforming payment and insurance design through the launch of the Medicaid PCMH+ shared savings program; (2) quality measure alignment and development of value-based insurance designs, and; (3) building population health capabilities. All three strategies are supported by additional investments in consumer engagement, health information technology and evaluation and monitoring to achieve reform¹⁹.

The All Payer Claims Database (APCD)

[Public Act 13-247](#) enabled Connecticut’s Health Care Exchange, Access Health CT, to develop an All Payer Claims Database in order to achieve the state’s goals of improving healthcare quality and making healthcare more affordable and accessible. The APCD is a large-scale database that systematically collects and aggregates medical, dental, and pharmacy claims data from private payers (e.g. commercial insurers) and public payers such as Medicare and Medicaid. The purpose of the database is to provide information on health care cost and quality in order for users to make informed health care decisions. The APCD will make data available to consumers, payers, providers, state agencies, employers and researchers with the goal to improve quality, access and affordability of health care and the performance of the health care delivery system²⁰. Public Act 13-247 also established an APCD Advisory Group tasked with developing a plan to implement this multi-payer data initiative and enhance the outcomes and improve the understanding of health care expenditures in the public and private sectors.

¹⁷ Centers for Medicare and Medicaid Services, *State Innovation Models Initiative: General Information, November 18, 2016*. <https://innovation.cms.gov/initiatives/state-innovations/>

¹⁸ CT SIM; *SIM At A Glance, May 12, 2015* http://www.healthreform.ct.gov/ohri/lib/ohri/SIM_at_a_glance_05122015.pdf

¹⁹ Ibid.

²⁰ APCD Fact Sheet, March 16, 2012 http://www.healthreform.ct.gov/ohri/lib/ohri/APCD_Bill_Book_2012_On_Website.pdf

V. Current Goals, Purpose, Structure and Role of CON in Connecticut

CON Operating Premise

The underlying premise of CON in Connecticut and across the nation is that excess capacity (service availability beyond actual need) results in higher health care costs. Therefore, a regulatory process such as CON is needed to ensure that capacity (i.e. service expansions and number of available beds) does not exceed actual community need thus lowering health care costs by reducing the amount of fixed costs not generating revenue. Additionally, many CON supporters do not believe that health care is subject to traditional market forces that support competition, lower cost and higher quality.

Current Purpose and Structure of CON in Connecticut

Currently, Connecticut's CON program is intended to guide the establishment of health care facilities and services which best serve public needs, ensure that high quality health services are provided, prevent unnecessary duplication of health care facilities and services and promote cost containment²¹.

Nationally, CON application review and decision making authority rests in three main categories²²:

1. State health departments;
2. Joint administrative teams and appointed boards; and
3. Attorney General's Office.²³

States utilize different mechanisms to review and render decisions on CON applications with eighteen states conducting a joint administrative staff and appointed board review. Of the eighteen states that utilize this joint approach, nine states require consumer representation on the appointed board²⁴.

Connecticut is unique in that the responsibility of administering CON is divided between two state agencies essentially creating two independent CON programs: (1) The Office of Health Care Access within the Department of Public Health. OHCA staff review CON applications in the following categories: (a) acquiring equipment; (b) initiating services and increasing capacity; (c) terminating services; and (d) changes in ownership. Staff submit recommendations to the Deputy Commissioner of DPH who renders the final decision on the applications. (2) The Department of Social Services. DSS staff review CON applications related to: (a) nursing facilities; (b) residential care homes; and (c) intermediate care facilities for individuals with intellectual disabilities. The DSS Commissioner issues final decisions for applications reviewed by DSS staff.

Below is a summary of the actions subject to CON in Connecticut and the responsibilities of the designated oversight agencies:

²¹ Office of Health Care Access website <http://www.ct.gov/dph/cwp/view.asp?a=3902&q=564018&dphNav=|>

²² Khaikin, Christine; Uttley, Lois; & Winkler, Aubree; *When Hospitals Merge: Updating State Oversight to Protect Access to Care*; Merger Watch; March 2016.

²³ Only the state of California has CON application review and decision making authority solely administered by the Attorney General's Office. It should be noted that California does not operate a traditional CON program but has a regulatory oversight structure similar enough to CON that most CON studies include CON in their research findings.

²⁴ Khaikin, Christine; Uttley, Lois; & Winkler, Aubree; *When Hospitals Merge: Updating State Oversight to Protect Access to Care*; Merger Watch; March 2016.

Office of Health Care Access²⁵

Connecticut General Statutes (CGS) Section 19a-638 requires CON authorization for²⁶:

1. Acquiring Equipment

Applies to....	Acquiring
All health care entities ²⁷	CT, MRI, PET, and PET-CT scanners <i>Exceptions:</i> (1) equipment is used exclusively for scientific research not conducted on humans and (2) scanner is a replacement for one previously acquired through a CON or determination
All health care entities	Equipment utilizing technology that has not previously been used in the state

2. Initiating Services or Increasing Capacity

Applies to....	Planning to...
All health care entities	Establish a new health care facility
All health care entities	Establish cardiac services, including catheterization, interventional cardiology and cardiovascular surgery
All DPH-licensed facilities	Increase licensed bed capacity of a health care facility
All health care entities	Establish an outpatient surgical facility
Outpatient surgical facilities, short-term acute care general hospital	Increase of two or more operating rooms within any three-year period

3. Terminating Services

Applies to....	Planning to terminate...
Hospitals	Mental health or substance abuse services
Hospitals	Inpatient or outpatient services
Outpatient surgical facility	Surgical services <i>Exception:</i> Service is terminated due to insufficient patient volume or termination of a subspecialty, in which case notification to OHCA is required
Short-term acute care general hospital	An emergency department
Hospitals operated by the state that are eligible for reimbursement under the Social Security Act	Inpatient or outpatient services

4. Changes in Ownership

Applies to....	Planning to...
All health care entities	Transfer ownership of a large group practice, one which is comprised of eight or more full-time equivalent physicians, unless transfer is to a physician or a group of physicians
All health care entities	Transfer ownership of a health care facility
Not-for-profit hospitals	Transfer a material amount of its assets or change control of operations to a for-profit entity.

²⁵ CT Department of Public Health, *Report to the Joint Standing Committee of the Connecticut General Assembly: Certificate of Need Requirements*. January 1, 2016.

²⁶ These charts are for general overview purposes only, and do not include all exemptions or exceptions to CON review.

²⁷ Health care entities include hospitals licensed by DPH, specialty hospitals, freestanding EDs, outpatient surgical facilities, central service facilities, mental health facilities, substance abuse treatment facilities, mental health facilities, and other hospitals and facilities operated by the state that provide services eligible for reimbursement under the Social Security Act.

The entire CON process, from the time OHCA receives the application to the final decision, can take from 60 days to a year – depending on the complexity and completeness of the proposal and whether a public hearing is held. The following steps are required:

- Applicants publish notice (in newspaper for 3 consecutive days) of intent to file a CON. Must be published at least 20, but no more than 90, days before filing.
- Applicants submit required forms and \$500.
- OHCA has 30 days from receipt to review for completeness. If found incomplete, OHCA informs the applicant who has 60 days to respond. OHCA then has 30 days to inform applicant if application is complete or incomplete.
- Review criteria include consistency with DPH policies and regulations, clear public need including unmet need of the target population, impact on the strength of the health care system (including quality, accessibility, and cost), financial feasibility, past and proposed provision of services, use of existing facilities and services in the area, payer mix, documentation that it won't result in duplication of services in the area, and demonstration of no negative impact on diversity of providers and patient choice, costs or accessibility.
- OHCA has 90 days to render a decision and must wait at least 30 days to allow an opportunity for a public hearing to be requested. Review period is shorter (60 days) for transfer of ownership of group practices.

The Deputy Commissioner renders a decision. Forty eight (48) determinations were rendered in 2015, but only 14 were found to require a CON.

Department of Social Services

CGS Sections 17b-352 through 355 grants authority to DSS for the CON process for nursing facilities, residential care homes and intermediate care facilities for individuals with intellectual disabilities as described below.

Certificate of Need approval is required prior to undertaking any of the following activities:

Applies to....	Planning to ...
Nursing Homes Residential Care Homes Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IDD)	<ul style="list-style-type: none"> • Make a capital expenditure exceeding \$2 million. • Make a capital expenditure exceeding \$1 million, which increases facility square footage by five thousand square feet or five percent of existing square footage. • Make an acquisition of major medical equipment in excess of \$400,000 • Introduce or expand any new or additional function or service. • Terminate a health service including facility closure or a substantial decrease in total bed capacity by a facility or institution. • Transfer all or part of ownership or control prior to being initially licensed
Nursing Homes	<ul style="list-style-type: none"> • Build a new facility associated with a continuing care facility provided such beds do not participate in the Medicaid program. • Relocate Medicaid certified beds from one licensed nursing facility to another licensed nursing facility to meet a priority need identified in the strategic plan developed pursuant to subsection (c) of section 17b-369 of the Connecticut General Statutes. • Add nursing home beds restricted to use by patients with AIDS or requiring neurological rehabilitation • Add nursing home beds associated with a continuing care facility which guarantees life care • Relocate Medicaid beds from a licensed facility to a newly licensed facility, provided at least one currently licensed facility is closed in the transaction, and the new facility bed total is not less than 10% lower than total number of beds relocated
Residential Care Homes Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IDD)	Request a license for a new facility

The CON process begins with an applicant's submission of a letter of intent. DSS issues an application within 10 business days and the Applicant has up to 180 days to submit the CON application. DSS will issue a written decision generally within 120 days after receiving the application. CON decisions may be reviewed by the public during normal business hours²⁸.

²⁸ Department of Social Services Web Site <http://www.ct.gov/dss/cwp/view.asp?a=4771&q=570258>

VI. Revised Purpose and Goal of CON

A Word About Process

The recommendations presented in this report by the CON Task Force represent several months of examination, research and discussion using the following six-steps:

1. Education: The Task Force spent initial meetings being educated on the current purpose, goals and best practices of CON programs nationally and in Connecticut. Members were provided existing state legislation and regulation, research studies, literature reviews, and presentations by OHCA and DSS staff and national subject matter experts. (See **Appendix C** for a list of presenters and to view copies of their presentations) Task Force members had the opportunity to discuss research and ask questions of all presenters and state agency staff.
2. Surveys: Due to the amount of material requiring discussion, Task Force members responded to a series of three surveys between monthly meetings as a mechanism for obtaining member opinions in advance of meetings. This procedure allowed the Chair to make the most efficient use of meeting time. Survey results were compiled by Task Force staff, posted-online, and presented and discussed at the public meetings. The following surveys were conducted: (See **Appendix D** for copies of the survey results)

Survey 1: Purpose and Goal of Connecticut's CON: designed to gather views on the basic premise and functions of the CON program. Members were asked questions in two categories: (a) Should Connecticut have a CON program or other regulatory process in place to shape the state's health care system? And (b) What factors (access, quality, cost, planning, need and competition) should Connecticut regulate based on the state's health care system, market forces and available data?

Survey 2: Actions and Facilities Subject to CON: designed to obtain Task Force member opinions on two major categories of CON: (a) What services and actions should be subject to a CON review? And (b) What guidelines and principles should the decision-making entity consider when reviewing applications?

Survey 3: Decision-Making Authority: designed to gather Task Force member opinion on the current CON decision-making process and recommended changes. The survey focused on the four components of the decision-making process: (a) Organization – who reviews applications and renders decisions; (b) Public Input – opportunities for consumer participation in the CON process; (c) Transparency – methods of informing the public about pending applications and consumer access to information; and (d) Appeals Process – mechanism through which the public can appeal a CON decision.

3. Discussion: Members examined whether Connecticut's program, as currently defined in statute and regulation, is designed to address the needs of state residents in a rapidly changing health care landscape. They debated the questions: (a) Does the current goal of Connecticut's CON program

need to be revised to better meet the needs of the state? And (b) Is Connecticut reviewing the “correct” actions and services with the most appropriate criteria to achieve the health care goals of the state? Members with varying opinions engaged in robust discussions about what the revised goals of the CON program should be and what actions should be regulated through the CON process in order to meet the stated goals.

4. **Development of Draft Recommendation Options:** After months of discussion it became clear that Task Force members would not achieve consensus opinion regarding revisions to the state’s CON program. Therefore, Task Force staff developed a set of recommendations reflecting the varying options shared by members. The Task Force agreed to vote on the presented options in order to gauge levels of support for each. (See Appendix E to view draft recommendation options presented for vote)
5. **Public Comment and Transparency:** All CON Task Force materials were made available to the public on a dedicated CON web page²⁹ and meetings were recorded and made available online by the CT-N media network. Each meeting began with a public comment period and draft recommendations were posted for public review and comment from December 5, 2016 - December 15, 2016. (See **Appendix F** to view public comment).
6. **Voting:** All recommendation options presented by members were brought to the full Task Force for final discussion and roll-call vote. The recommendations presented in this report reflect any recommendation that received at least one member vote. Options with no support were eliminated. Recommendation options garnering majority support (over 50%) are highlighted. (See **Appendix G** to view the record of votes)

Setting the Context

Rationale: The underlying premise of the CON process when implemented nationally in the early 1970s revolved around the idea that overbuilding, expanding, or purchasing capital equipment would drive up health care costs if it resulted in excess capacity. CON programs were designed to restrict new or additional health care facility construction or equipment to only those entities that could demonstrate a genuine need. However, recent changes in health service reimbursement that move away from pure “cost-based” systems to payments based on quality or diagnosis have diminished incentives for health care providers to expand regardless of demand. As a result, the original purpose of CON - the limiting of expansions or added capacity to the health care system – no longer seems to be applicable in holding down health care costs. There is also a lack of evidence³⁰ to show that CON programs, as they are currently implemented, improve quality or access to health care services. While

Conclusion: To fulfill the goals of improving access, improving quality, and containing cost, CON review should be targeted to those actions that reduce competition – primarily mergers and acquisitions in the health care system.

²⁹ The web page was housed on Governor Malloy’s Official Web Site <http://portal.ct.gov/en/Office-of-the-Governor/Working-Groups/Certificate-of-Need-Taskforce>

³⁰ See Appendix H for list of sources.

some studies³¹ have shown that CON states, in comparison to non-CON states, have decreased health care costs, these studies rely on correlation only and cannot claim that the existence of CON resulted in the lower costs. Other studies³² have shown that CON programs have actually increased costs.

Research³³ has shown that limiting capacity in this way can give preference to incumbents in the system and actually impede access to services, especially new technologies. Consolidation and merging of health care facilities and services, by limiting competition, is shown to be a primary driver in increasing health care costs³⁴. In addition, research indicates that competition in the health care market can enhance quality³⁵

Conclusion: To fulfill the goals of improving access, improving quality, and containing cost, CON review should be targeted to those actions that reduce competition – primarily mergers and acquisitions in the health care system. In addition, CON review should focus on implementing statewide health care planning efforts that identify underserved populations and unmet need, in order to promote health equity and improve access to services.

Proposed Revised Goals of Connecticut’s CON Program

Based on meeting discussions and research the Task Force proposes the following revised goals of the CON program. The proposed goals move Connecticut away from need-based review criteria and toward an application review process focused on alignment with state health planning efforts and actions that have the potential to reduce competition and negatively impact access, quality and cost.

Proposed Goals of the CON Program: *To improve access to and quality of health care services and contain costs by fostering a competitive environment in the health care market and implementing statewide planning efforts aimed at promoting health equity and fulfilling unmet needs.* See Figure 1.

³¹ (a) Gendregske, M. J. (March 19, 2002). DaimlerChrysler Corporation. [Certificate of Need: Endorsement by DaimlerChrysler Corporation](#); and (b) Hellinger, Fred. (2009). [The Effect of CON Laws on Hospital Beds and Healthcare Expenditures: An Empirical Analysis](#); The American Journal of Managed Care, Vol. 15(10).

³² Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). [The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured](#).

³³ (a) Ohlhausen, Maureen K. (Fall 2015). [Certificate of Need Laws: A Prescription for Higher Costs](#); American Bar Association. [Antitrust](#), Vol. 30, No. 1; and (b) The Federal Trade Commission, Department of Justice. (2004). [Improving Health Care: A Dose of Competition](#).

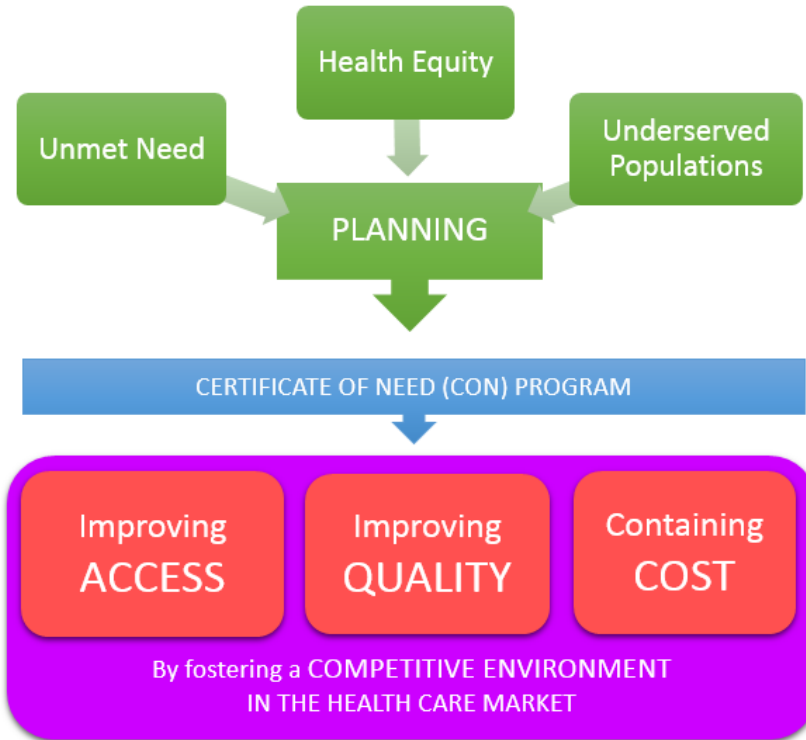
³⁴ (a) Gaynor, M. and Town, R. (June 2012). [The Impact of Hospital Consolidation-Update](#). The Robert Wood Johnson Synthesis Project; and (b) Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). [The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured](#).

³⁵ Gaynor, M. and Town, R. (June 2012). [The Impact of Hospital Consolidation-Update](#). The Robert Wood Johnson Synthesis Project

Figure 1 Revised Goal of CON

PROPOSED GOALS OF CERTIFICATE OF NEED (CON) PROGRAM

To improve access to and quality of health care services and contain costs by fostering a competitive environment in the health care market and implementing statewide planning efforts aimed at promoting health equity and fulfilling unmet needs.



VII. Recommendations

As a result of eight months of meetings, presentations by subject matter experts, and literature reviews the CON Task Force has finalized a series of recommendations to improve Connecticut's existing CON program. The following recommendations were developed to align with the revised goals of CON as stated in Section VI. **Revised Purpose and Goal of CON** and are categorized as follows:

- CON Application Review Criteria
- CON Decision-Making Process
- CON Application Process
- CON Post-Approval Compliance Mechanisms
- CON Evaluation Methods

Recommendations included in the body of the report reflect options that received the majority (greater than 50%) of votes from Task Force members. Recommendations receiving minority support (a vote

from at least one Task Force member) are included in **Appendix I**. A complete record of votes by category and member can be found in **Appendix G**. Additionally, some members were not present at for the final vote on recommendations but submitted their positions in writing to Task Force staff. These opinions could not be counted in the official vote tally but are included in **Appendix J**.

A. Actions Subject to CON Review

Recommendations for *Actions Subject to CON* are categorized as follows:

- Acquiring Equipment
- Initiating Services/Increasing Capacity
- Terminating Services
- Reduction of Services
- Relocation of Services
- Transfers of Ownership
- Conversions
- Actions Subject to DSS CON Review

Acquiring Equipment

ACQUIRING EQUIPMENT - Members Could Only Choose One Option	Votes
<i>Status Quo: CON review of scanners, new technology, and non-hospital based linear accelerators</i>	
A. <i>Eliminate CON review of equipment acquisitions*</i>	<i>6 out of 15</i>
B. <i>Statutorily restrict the process of self-referral³⁶ for scanners</i>	<i>9 out of 15</i>
C. <i>Restrict the practice of self-referral of scanners through application review criteria</i>	<i>9 out of 15</i>

* Seven options for revising the CON Process as it relates to the acquisition of equipment were proposed and voted on by Task Force members. No one category received a majority vote (exceeding greater than 50% member support). Therefore, the recommendation reflected here, seeking to eliminate the CON process for the acquisition of equipment, represents the singular category to receive the most votes. The remaining nine votes were scattered across four alternate recommendations that all support maintaining some form of CON review for the acquisitions of equipment through varying mechanisms. Therefore, it could be argued that a majority of members favor maintaining the CON process for equipment in some manner. (See **Appendix I** for a description of these categories)

³⁶ Self-referral in this context is defined as Physician self-referral is the practice of a physician referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation arrangement Source: (a) Stark Law: Information on Penalties, Legal Practices and Latest News and Advice, <http://starklaw.org/default.htm>; (b) Sunshine, Jonathan and Bhargavan, Mythreyo; The Practice of Imaging Self-Referral Doesn't Produce Much One-Stop Service; Health Affairs 29, no.12 (2010).

Initiating Services/Increasing Capacity

Terminating Services

[INSERT AFTER JANUARY VOTE]

Reduction of Services

[INSERT AFTER JANUARY VOTE]

Relocation of Services

[INSERT AFTER JANUARY VOTE]

Transfer of Ownership

1. TRANSFERS OF OWNERSHIP	Votes
<i>Status Quo:</i> CON review of transfers of ownership of all health care facilities and certain transfers of large group practices and expanded CON review (cost and market impact review, mandatory public hearing, stronger application criteria, post-transfer compliance monitoring) of certain hospital transfers of ownership	
A. <i>Strengthen CON review of hospital mergers and consolidations by: Applying expanded CON review to hospital acquisitions of health care facilities and large group practices (cost and market impact review, mandatory public hearing, stronger application criteria, post-transfer compliance monitoring)</i>	11 out of 14
B. <i>Strengthen CON review of hospital mergers and consolidations by: Applying expanded CON review to all hospital mergers and acquisitions (not only those involving for-profit entities and larger hospital systems, as under current law)</i>	10 out of 14
C. <i>Strengthen CON review of hospital mergers and consolidations by: Imposing consequences for non-compliance with post-transfer conditions</i>	12 out of 14
D. <i>Ensure all health care providers are treated equally by requiring review of transfer of ownership of health care facilities and large group practices by any acquirer including a hospital, a hospital system, an insurer, investor and any other entity seeking to acquire such facility or large group practice</i>	8 out of 14

Conversions

2. CONVERSIONS – Members Could Only Choose One Option	Votes
<i>Status Quo:</i> Expanded CON review and enhanced role of Attorney General in protecting charitable assets	
A. <i>Maintain status quo</i>	11 out of 14

[INSERT AFTER JANUARY VOTE]

B. CON Application Review Criteria

[INSERT AFTER JANUARY VOTE]

C. CON Decision-Making Process

Nationally, the CON decision-making authority and process varies among the states currently operating CON programs. (See **Appendix D** for a summary of CON decision-making processes by state) The 2016 Merger Watch Report, *When Hospitals Merge*³⁷, focuses on the 32 states and the District of Columbia that utilize the CON process to regulate hospital care³⁸ and focuses on four major areas of decision-making:

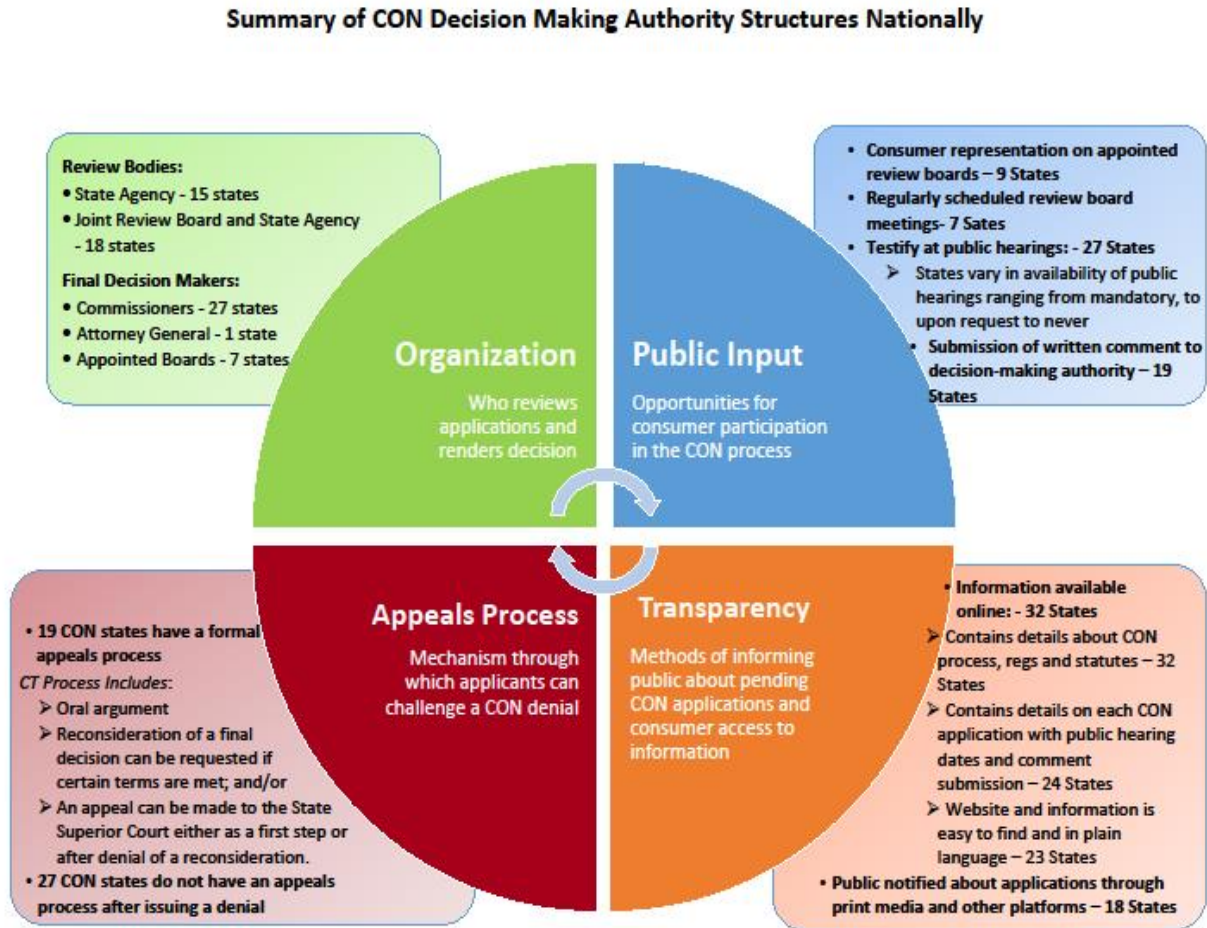
- Organization: Who reviews applications and renders decisions
- Public Input: Opportunities for consumer participation in the CON process
- Transparency: Methods of informing the public about pending applications and consumer access to information
- Appeals Process: Mechanism through which the public can appeal a CON decision

The Task Force utilized this method of categorization to structure the recommendations for the CON decision-making process.

³⁷ Khaikin, Christine; Uttley, Lois; & Winkler, Aubree; *When Hospitals Merge: Updating State Oversight to Protect Access to Care*; Merger Watch; March 2016.

³⁸ Three states (Arkansas, Ohio, and Oklahoma) do not review hospitals as part of their CON process. Therefore the questions posed by the Merger Watch study were not applicable to those states and they are not included in the data tables.

Figure 2: Summary of CON Decision-making Authority Structure Nationally



[INSERT AFTER JANUARY VOTE]

D. Application process

[INSERT AFTER JANUARY VOTE]

E. CON Post-Approval Compliance Mechanisms

[INSERT AFTER JANUARY VOTE]

F. CON Evaluation Methods

[INSERT AFTER JANUARY VOTE]

VIII Identified Challenges and Gaps

Physician Self-Referral

The practice of physician self-referral was a topic raised frequently during Task Force discussions regarding the role of CON in regulating the acquisition of equipment. Physician self-referral is the practice of a physician referring a patient to a medical facility in which s/he has a financial interest, be it ownership, investment, or a structured compensation arrangement³⁹. Opponents of physician self-referral argue that the practice leads to increased health care costs, reduced access to services for underserved areas and low-income populations, and with no demonstrated proof of improved quality of care for patients⁴⁰. A 2012 study from the U.S. Government Accountability Office tracked MRI and CT Scan usage and expenditures for Medicare beneficiaries from 2004-2010. The study examined the referral behaviors of physicians who switched from a non-self-referral model to a self-referral model and found that referrals for MRIs and CT scans substantially increased by providers after they switched to a self-referral model⁴¹. However, proponents of the practice purport that it improves quality of care and efficiency for patients.

In 1989 Congress passed the physician self-referral law (Section 1877 of the Social Security Act) often referred to as the “Stark Law”, to address the practice of self-referral for clinical laboratory services reimbursed by Medicare. Since that time, Stark Laws have been expanded twice to do the following⁴²:

³⁹(a) Stark Law: Information on Penalties, Legal Practices and Latest News and Advice, <http://starklaw.org/default.htm>; (b) Sunshine, Jonathan and Bhargavan, Mythreyo; The Practice of Imaging Self-Referral Doesn't Produce Much One-Stop Service; Health Affairs 29, no.12 (2010).

⁴⁰ (a) Sunshine, Jonathan and Bhargavan, Mythreyo; The Practice of Imaging Self-Referral Doesn't Produce Much One-Stop Service; Health Affairs 29, no.12 (2010).; (b) Hillan, Bruce J. et al.; *Frequency and Costs of Diagnostic Imaging in Office Practice – A Comparison Self-Referring and Radiologist-Referring Physicians*; The New England Journal of Medicine; 1990. (c) Hillman, Bruce, J. et al., *Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population*; Journal of the American Medical Association; Vol. 268, No.15; October 21, 1992.

⁴¹ Stark Law: Information on Penalties, Legal Practices and Latest News and Advice, <http://starklaw.org/default.htm>

⁴² Centers for Medicare and Medicaid Services, *Physician Self-Referral Information Web Page*; <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/>

1. Prohibit a physician from making referrals for certain designated health services⁴³ payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies.
2. Prohibit the entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third party payer) for those referred services.
3. Establish a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

However, the practice of self-referral continues due to a loophole in the law that exempts actions that fall under “in-office ancillary services”.⁴⁴ The U.S. Government Accountability Office recommended in 2012 that the Centers for Medicare and Medicaid Services (CMS) improve its ability to identify self-referral of advanced imaging and take steps to address increases in use of these services. CMS agreed it should continue monitoring self-referral of these services to ensure appropriate utilization⁴⁵. On April 28, 2016, Representative Jackie Seier, a Democrat from California, introduced a bill, H.R. 5088, to close the self-referral loophole in the Stark Laws. It was referred to the Subcommittee on Health on May 17, 2016. There has been no action since its referral.

In the meantime, states have considered taking action to close the exemption as a method of curbing overutilization of testing. The state of Maryland passed the *Maryland Patient Referral Law* which closes the loophole in federal Stark Laws by specifying the services qualifying for the “ancillary imaging exemption,” radiography and sonography, and exempting MRIs, CT and radiation therapy services⁴⁶.

Members of the Connecticut CON Task Force debated the pros and cons of self-referral at length and expressed differing opinions as to whether CON is an appropriate mechanism to protect against such a practice or curb cost and overutilization in the absence of a Maryland-like law. Some members shared concern about eliminating CON for the acquisition of equipment without self-referral legislation being enacted in the state. Although consensus could not be reached regarding the role of CON for the acquisition of equipment, 60 percent of Task Force members voted in favor of Connecticut statutorily restricting the process of self-referral for scanners or restricting the practice of self-referral of scanners through CON application review criteria (See Section VII Acquiring Equipment).

Price and Cost

The need for state government to take steps to control health care prices and rising costs was raised numerous times over the nine months of Task Force meetings. Some members felt that CON, if

⁴³ Designated Health Services include: Clinical laboratory services, Physical therapy services, Occupational therapy services, Outpatient speech-language pathology services, Radiology and certain other imaging services, Radiation therapy services and supplies, Durable medical equipment and supplies, Parenteral and enteral nutrients, equipment, and supplies, Prosthetics, orthotics, and prosthetic devices and supplies, Home health services, Outpatient prescription drugs, Inpatient and outpatient hospital services.

⁴⁴ Carreyrou, John; *The Short Answer: What to Know About the Stark law and Self-Referral*, The Wall Street Journal; October 22, 2014 <http://blogs.wsj.com/briefly/2014/10/22/what-to-know-about-the-stark-law-and-self-referral-the-short-answer/>

⁴⁵ U.S. Government Accountability Office, *Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions*, GAO Highlights; September, 2012.

⁴⁶ Proval, Cheryl; *Maryland Versus Stark: Different Exceptions, Different Results*, Radiology Business; August 28, 2014. <http://www.radiologybusiness.com/topics/policy/md-versus-stark-different-exceptions-different-results>

structured properly, can be utilized in a manner that would control both, such as implementing post approval compliance penalties for not adhering to price projections set forth in a CON application. However, others expressed the opinion that CON is not the appropriate mechanism to control either and noted that the state's Health Care Cabinet is charged with conducting a cost containment study and presenting recommendations. OHCA staff noted that the CON program is not intended to nor does it have the necessary resources to control health care costs. Additionally, research does not support the utilization of CON to achieve cost containment. As stated previously, there is a lack of evidence⁴⁷ to show that CON programs, as they are currently implemented, improve quality or access to health care services. While some studies⁴⁸ have shown that CON states, in comparison to non-CON states, have decreased health care costs, these studies rely on correlation only and cannot claim that the existence of CON resulted in the lower costs. Other studies⁴⁹ have shown that CON programs have actually increased costs.

Though there was some disagreement regarding whether cost containment falls within the scope of CON, members are in agreement that rising health care costs in the state need to be addressed. However, there is no consensus on the best mechanism to achieve this end.

IX Conclusion

CON, across the country and in Connecticut, has its supporters and detractors. The topic of government regulation of the health care system is broad and controversial. As is demonstrated by the lack of consensus achieved on the majority of recommendations put forward in this report, there are numerous opinions on appropriate levels of government intervention, what should be regulated and the appropriate mechanism to administer regulation. However, the recommendations contained herein, provide options for paths the state of Connecticut can take to improve access to and quality of health care services and contain costs by fostering a competitive environment in the health care market and implementing statewide planning efforts aimed at promoting health equity and fulfilling unmet needs. All to ensure that Connecticut residents can obtain the best possible health care.

⁴⁷ See Appendix H for list of sources.

⁴⁸ (a) Gendregske, M. J. (March 19, 2002). DaimlerChrysler Corporation. [Certificate of Need: Endorsement by DaimlerChrysler Corporation](#); and (b) Hellinger, Fred. (2009). [The Effect of CON Laws on Hospital Beds and Healthcare Expenditures: An Empirical Analysis](#); The American Journal of Managed Care, Vol. 15(10).

⁴⁹ Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). [The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured](#).

Appendices A - J

Appendix A – Executive Order 51A

DRAFT

STATE OF CONNECTICUT

BY HIS EXCELLENCY

DANNEL P. MALLOY

EXECUTIVE ORDER NO. 51A

CONNECTICUT
SECRETARY OF THE STATE
CAPITOL OFFICE
2016 SEP -7 P 1:45

WHEREAS, it is a priority goal of the State of Connecticut to provide affordable, accessible, high quality health care across the state;

WHEREAS, a financially stable health care system – that includes both hospitals and freestanding medical service providers – requires thorough state health care planning and regulation to achieve this goal;

WHEREAS, Connecticut currently has twenty-eight acute care hospitals located in the state, including one exclusively for children, that annually provide services for almost two million patient days and over 400,000 discharges;

WHEREAS, Connecticut currently has nineteen corporate hospital systems in the state, and four of these corporate systems have affiliations with twelve of our state's acute care hospitals, while another four of our acute care hospitals have affiliations with corporate systems outside of the state;

WHEREAS, Connecticut has two long established Certificate of Need (CON) processes – one such process is completed through the Office of Health Care Access within the Department of Public Health and the other process is done through the Department of Social Services;

WHEREAS, the CON process currently is intended to regulate the ability of hospitals, nursing homes, certain physician groups, and other healthcare facilities seeking to establish new facilities or provide new services, change ownership, purchase and acquire certain equipment, and terminate certain services;

WHEREAS, Connecticut's hospitals increasingly are applying for regulatory approval through the CON process to become members of these larger umbrella corporate health care systems for reasons other than significant financial distress;

WHEREAS, in light of the evolving health care industry and changing market conditions, it is crucial that Connecticut's CON programs align with state and federal health care reform efforts, encourage transparency and competition, protect consumers, provide accessible and affordable health care delivery, contribute to economic development, and promote community benefits;

WHEREAS, I am committed to ensuring that we coordinate the state's regulatory oversight of its health care delivery systems with the broader goals of maintaining open, transparent, and competitive health care markets in the state that enhance access and quality of care and improve affordability without losing sight of the economic development impact of the hospital systems;

WHEREAS, Executive Order 51 was originally issued on February 25, 2016 and it has become apparent that certain modifications and revisions to the original text of the Executive Order to provide additional flexibility in the analysis are deemed appropriate.

NOW, THEREFORE, I, DANNEL P. MALLOY, Governor of the State of Connecticut, by virtue of the power and authority vested in me by the Constitution and by the Statutes of the State of Connecticut do hereby **ORDER AND DIRECT**:

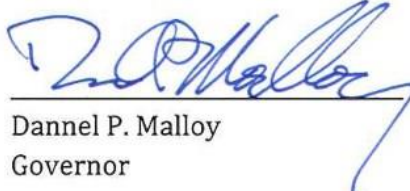
1. There is established a Certificate of Need Taskforce (the Taskforce) to review and analyze the CON programs and process. The Taskforce shall be composed of the following members:
 - i. The Lieutenant Governor, who shall serve as Chair;
 - ii. The Secretary of the Office of Policy and Management, or the Secretary's designee, ex-officio;
 - iii. The Commissioner of Public Health, or the Commissioner's designee, ex-officio;
 - iv. The Commissioner of Social Services, or the Commissioner's designee, ex-officio;
 - v. Two members representing acute care hospitals, one in a city with greater than 80,000 residents and one in municipality with less than 80,000 residents, currently regulated by the CON process;
 - vi. One member that represents physician practice groups;
 - vii. One member that represents a nursing home;
 - viii. One member that represents a free standing out-patient provider of health care services not currently affiliated with a hospital system or physician practice group;
 - ix. One member that represents a qualified health plan sold through the Connecticut Health Insurance Exchange;
 - x. One member that represents the health care insurance industry;
 - xi. Two members that represent health care labor interests;
 - xii. One member with expertise and knowledge in the field of health economics;
 - xiii. One member that represents consumer interests; and
 - xiv. Two members that represent entities currently regulated by the CON process, to be appointed by the Commissioner of Public Health.
2. The Office of Policy and Management and the Department of Public Health will administer and provide staffing support for the Taskforce.
3. The Taskforce shall undertake a review and analysis of the state's CON process and programs and determine if changes are necessary to ensure quality of care and access for all state residents and the preservation of an open and competitive health care market. Such examination shall include, but not be limited to the following:
 - a. Perform a comprehensive review of the state's CON programs, including an analysis of the scope, existing authority, and structure of the current agencies having oversight, to determine if any changes should be made to improve efficiency, effectiveness, and alignment with state and federal health care reform efforts;
 - b. Identify any challenges and gaps in the state's efforts to regulate health care services and facilities to promote affordability, equitable access, and high quality care, including the state's ability to maintain fair, open, and competitive health care market conditions;
 - c. Deliver recommendations on how to improve the existing CON programs and address any identified challenges or gaps in the state's regulation of health care services and facilities to the Governor no later than January 15, 2017.
4. The Department of Public Health shall provide the Task Force with a briefing of the pending applications currently before it on or before April 1, 2016.
5. To provide the necessary time for a fair and thorough evaluation of the CON process, the Department of Public Health and the Department of Social Services are directed not to make any final decisions on any CON application – including those previously received and currently under review – until June 30, 2017, insofar as permitted by law, if the application meets the following conditions:
 - a. It involves (1) a nonprofit hospital transferring a material amount of its assets or operations to a for-profit entity or a change of control of its operation to a for-profit entity filed pursuant to section 19a-486a of the Connecticut General Statutes, or (2) the acquisition of a nonprofit hospital by another entity in which the hospital will remain a nonprofit pursuant to section 19a-638 of the general statutes; and
 - b. Such proposed transfer of assets, change in control of operations, or acquisition will result, when combining the total hospital health system operating revenue in the most recent annual short term acute care hospital financial status report from the Office of

Health Care Access of the hospital systems in the application, in an amount greater than twenty percent of Connecticut's total hospital health system operating revenue.

6. The Commissioner of Public Health may make a final decision on an application that otherwise meets the criteria set forth in paragraph 5a and 5b of this Executive Order if the nonprofit hospital transferring a material amount of its assets, changing control of its operations, or proposing to be acquired has had a negative total margin in each of the three prior fiscal years, as indicated in the most recent Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals, prepared by the Office of Health Care Access.
7. In so far as it becomes necessary for the Department of Public Health to act on an application that meets the criteria set forth in paragraph 5 of this Order prior to the completion of the work of the Task Force, the Department of Public Health may:
 - a. for the purposes of subdivision (5) subsection (a) of section 19a-639 of the Connecticut General Statutes, find that accessibility and cost effectiveness of health care delivery in the region will not be improved if the total hospital health system operating revenue of the hospital systems in the application, when combined, result in an amount greater than twenty percent of Connecticut's total hospital health system operating revenue, as stated in the most recent annual short term acute care hospital financial status report from the Office of Health Care Access;
 - b. for the purposes of subdivision (11) of subsection (a) of section 19a-639 of the Connecticut General Statutes, find the diversity of health care providers and patient choice in the geographic region will be negatively impacted if the total hospital health system operating revenue of the hospital systems in the application, when combined, result in an amount greater than twenty percent of Connecticut's total hospital health system operating revenue, as stated in the most recent annual short term acute care hospital financial status report from the Office of Health Care Access; and
 - c. for the purposes of subdivision (12) subsection (a) of section 19a-639 of the Connecticut General Statutes, find that health care costs or accessibility to care will be adversely affected due to the consolidation included in the application if the total hospital health system operating revenue of the hospital systems in the application, when combined, result in an amount greater than twenty percent of Connecticut's total hospital health system operating revenue, as stated in the most recent annual short term acute care hospital financial status report from the Office of Health Care Access.
8. The Taskforce shall terminate January 15, 2017 or upon the submission of its recommendations, whichever is later.

This Order shall take effect immediately.

Dated at Hartford, Connecticut this 7th day of September, 2016.


Dannel P. Malloy
Governor

By His Excellency's Order



Denise W. Merrill
Secretary of the State



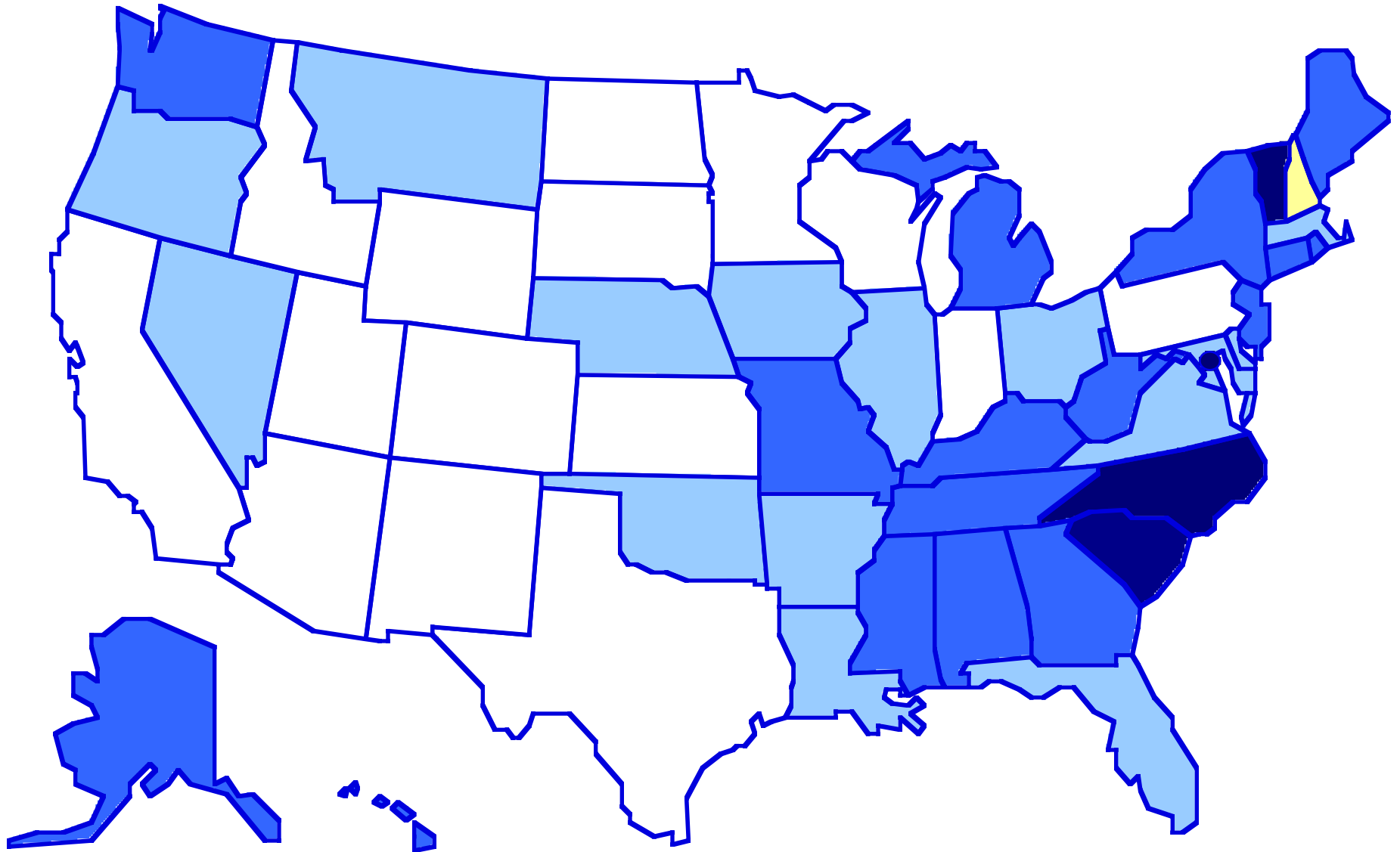
Appendix B - National CON Matrix

DRAFT

2016 Map of Certificate of Need Regulation by State

Relative Scope and Review Thresholds

(a geographic illustration of the CON matrix)



Weighted Range of Services Reviewed (see left side of matrix)

no CON sunseted 0-9.9 10.0-19.9 20.0-44.0

revised May 13, 2016

2016 CON Matrix by State rated by Regulated Services, Review Thresholds and Relative Scope

(summarized from 2016 information collected by email directly from Certificate of Need directors -- see related map depicting relative regulation across the United States)

Rank (no. of svcs. x weight) <small>recent chgs in yellow</small>	Categories	Acute Care (hosp)	Air Ambulance	Amb Surg Ctrs	Burn Care	Cardiac Cath.	CT Scanners	Gamma Knives	Home Hlth	Hospice	ICF/MR	LTC Hospital	Lithotripsy	LTC (nursing home)	Med Office Bldg	Mobile Hi Tech	MRI Scanners	Neo-ntl Int Care	Obstetric Svcs	Open Heart Svcs	Organ Transplant	PET Scnr (incl CT)	Psychiatric Svcs	Rad Therapy (linac)	Rehabilitation	Renal Dialysis	RCF/Asst Living	Subacute	Substance Abuse	Swing Beds	Ultra-sound	Other (items not otherwise covered)	Tally (no. of svcs.)	compiled by Thomas R. Piper MacQuest Consulting, LLC Jefferson City, MO macquest@mac.com 573-230-5350			
																																		Reviewability Thresholds			
																																		Capital	Med Eqpt	New Svc	Weight
30.0	Vermont																															30					
25.2	Dist. of Columbia																															28	inpat only for subs abuse & MH svcs	3,000,000 hosp 1,500,000 other	1,000,000	500,000	1.0
24.0	North Carolina																														24	Bone mrv, diag ctrs, ORs, Endo inpatient hospice	1,500,000 fac 250,000 phys	750,000	any amt	1.0	
20.0	South Carolina																														20		2,000,000	600,000	1,000,000	1.0	
19.8	West Virginia**																														22	Diagnostic ctrs	5,000,000	5,000,000	any amt	0.9	
18.9	Hawaii																														27		4,000,000	1,000,000	any amt	0.7	
17.1	Alaska																														19	asstd lvg to LTC; res psych trtm fac	1,500,000	1,500,000	1,500,000 hth fac any LTC	0.9	
16.8	Maine																														24	nursg hm cap exp 5,629,068	11,058,137	3,538,604	3,317,441	0.7	
16.8	Rhode Island																														21	Bone Marrow Transplant Prog	5,720,877	2,451,805	1,634,536	0.8	
15.3	Mississippi																														17		2,000,000 5,000,000 non-clinical	1,500,000	any amt	0.9	
15.3	Georgia																														17	Stereotactic radiosurgery	2,878,487	1,206,799	any amt	0.9	
15.2	New York																														19		6,000,000	6,000,000	any amt	0.8	
14.4	Kentucky																														18		3,023,673	3,023,673	n/a	0.8	
14.4	Michigan																														18	Clinical projects	3,180,000	any amt	any clinical	0.8	
14.4	Tennessee																														18	Non-res meth, res hospice	any amt	any amt	any amt w/ bed chg	0.8	
14.0	New Jersey																														14		1,000,000	1,000,000	any amt	1.0	
13.2	Connecticut																														12		any amt	any amt	n/a	1.1	
13.0	New Hampshire*																														13	Robotic Surgery	3,083,974	400,000	any amt	1.0	
12.6	Missouri																														14	New hospital	600,000 LTC 1,000,000 other	400,000 LTC 1,000,000	1,000,000	0.9	
12.0	Alabama																														20	dementia asstd lvg & freestdg emerg depts	5,709,099	2,854,550	any amt	0.6	
11.9	Washington																														17	sale/purch/lease hospitals	varied by type of service	n/a	any amt	0.7	
9.0	Virginia																														18	Gen. surg. misc.	18,608,519	any amt	any amt	0.5	
9.0	Massachusetts																														15	ECMO	17,826,988	950,935	any amt	0.6	
9.0	Iowa																														9	brth ctrs, optp hlth & community MH fac	1,500,000	1,500,000	500,000	1.0	
7.5	Illinois																														15	Posturg ctrs, brth ctrs, res rehab ctrs	12,797,313	7,233,262 LTC 3,338,430 other	any amt	0.5	
6.0	Arkansas																														6	child & adolescent res psych facilities	1,000,000 LTC	n/a	n/a	1.0	
6.4	Maryland																														16	Acute CCF swing beds crt acc hosp	11,900,000 hosp 5,900,000 other	n/a	any amt	0.4	
5.4	Montana																														6		1,500,000	n/a	150,000	0.9	
5.0	Florida																														10	Ped cardiac svcs only (not adult)	n/a	n/a	n/a	0.5	
4.0	Oklahoma																														4	psych, chemdep	1,000,000	n/a	any beds	1.0	
4.0	Delaware																														8	Freestanding emerg & birthing centers	5,800,000	5,800,000	n/a	0.5	
2.0	Nevada																														4		2,000,000	n/a	n/a	0.5	
1.6	Oregon																														4		any LTC/hosp	n/a	any LTC/hosp	0.4	
0.5	Ohio																														1	quality stds for other services	2,000,000	n/a	n/a	0.5	
0.4	Nebraska																														2	moratorium	any LTC	n/a	n/a	0.2	
0.4	Louisiana																														4		n/a	n/a	any LTC/MR	0.1	

*scheduled to sunset on 06/30/16

**06/10/16 exemption process for hospital renovation/replacement, ESRD, nursing homes, assisted living, ambulatory care facilities, CT scanners

Because this is a brief summary comparison, some information does not fully describe items reviewed or threshold distinctions. Weights are based on judgements about financial parameters. In no case does this matrix reflect program severity. Updated May 13, 2016, using the most recent information available.

Appendix C – List of Presenters and Link to Presentations

DRAFT

Certificate of Need Task Force Presenters

Copies of all Presentations can be found on the [CON Task Force Web Page](#)⁵⁰

Presenter Name	Title	Organization	Topic	Date of Presentation
Kimberly Martone	Director	OHCA	Review of Current CON Process and Status Update on Pending CON Applications	April 12, 2016
Christopher Lavigne	Director	Division of Rate Setting and Certificate of Need, DSS	Review of Current DSS CON process and Status Update on Pending CON Applications	April 12, 2016
Thomas Piper	CEO	MacQuest Consulting	National CON Perspectives	May 16, 2016
Victoria Veltri	Chief Health Care Policy Advisor	Office of the Lieutenant Governor	Related State Initiatives	May 16, 2016
Zack Cooper		Yale University, Health Care Pricing Project	Markets and Competition in Health Care	July 18, 2016
Jessica Schaeffer-Helmecki and Hillary Style	Planning Analyst and Consultant	OHCA	An Overview of Select States' CON Programs	July 18, 2016
Victoria Veltri	Chief Health Care Policy Advisor	Office of the Lieutenant Governor	Connecticut Reform Activities Relevant to CON	September 19, 2016
Robert Clark and Gary Haws	Special Counsel to the AG Assistant AG	Attorney General's Office	Role of the Attorney General's Office in the CON Process	September 19, 2016
Kimberly Martone	Director	OHCA	DPH Task Force Refresher on OHCA CON Process and PDH Licensure Overview	November 21, 2016

⁵⁰ CON Task Force Web Page <http://portal.ct.gov/en/Office-of-the-Governor/Working-Groups/Certificate-of-Need-Taskforce>

Appendix D – Survey Results

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FINAL RESULTS – CON TASK FORCE SURVEY

Key Survey Findings: Survey findings show that CON Task Force members believe that Connecticut should have a CON program or some other regulatory process in place in order to shape the state's health care landscape. Results are mixed as to the individual factors that should be the goal of such regulation (i.e. access, quality, cost, planning, need, and competition).

Key Research Findings: Task force staff have reviewed numerous studies and articles regarding the effectiveness of CON programs. While research findings are mixed, with arguments being found both in support and opposition of the value of CON laws, the following key findings are:

- Limiting excess capacity does not result in lowered health care costs. In addition, limiting capacity through CON programs can give preference to incumbents in the system and actually impede access to services, especially new technologies.
- Other trends in the health care landscape such as limited competition due to mergers, acquisitions, vertical integration, and consolidations are increasing health care costs.
- In general, competition, particularly between hospitals, improves quality of care. Research regarding the ability of CON to affect quality are mixed, with studies often reporting evidence of success as being inconclusive or needing further study.

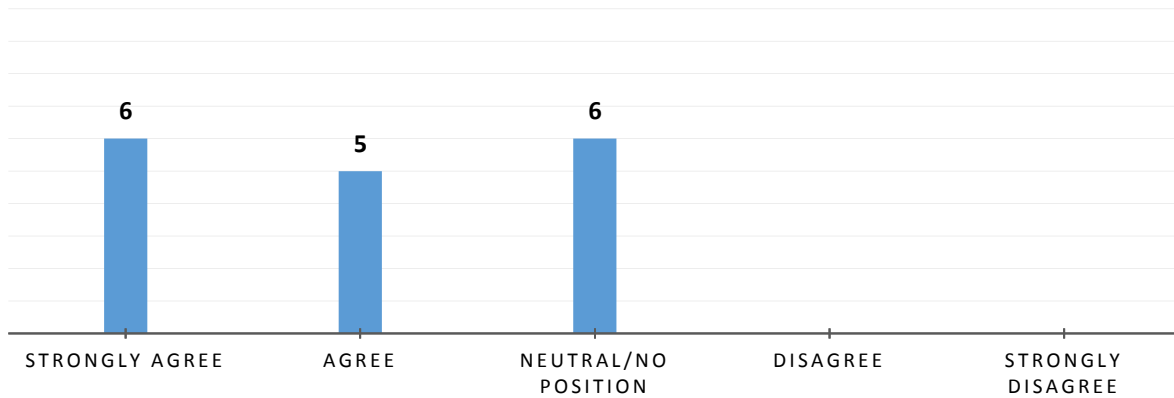
Key Task Force Questions for July 18th Meeting:

- Is a CON program or other regulation needed to achieve all desired outcomes or can free market forces achieve some ends?
- What goals should regulation achieve?
- What factors does regulation need to focus on in order to achieve the established goals?

Next Steps:

- Evaluate whether the following is aligned with determined purposes and goals:
 - Services subject to CON or actions that trigger CON
 - Criteria or standards used to determine whether a CON is approved
 - Review process including organizational structure of the decision-makers, transparency, ability for public input
 - Evaluation methods to ensure purpose and goals are being met
- Identify any remaining challenges or gaps in state efforts to regulate health care services
- Draft and finalize recommendations

Connecticut should have a CON program or some other regulatory process in place in order to shape the state's health care landscape.



No task force member indicated that Connecticut should not have a CON program or some other regulatory process in place to shape the state’s health care landscape. Although members’ views differ on the purpose and goals of this process, the existence of some form of regulatory oversight is a potential area of consensus.

KEY COMMENTS FROM TASK FORCE MEMBERS:

“I am concerned that these questions [...] presuppose a need for an overarching regulatory structure, and I'm not sure I agree.”

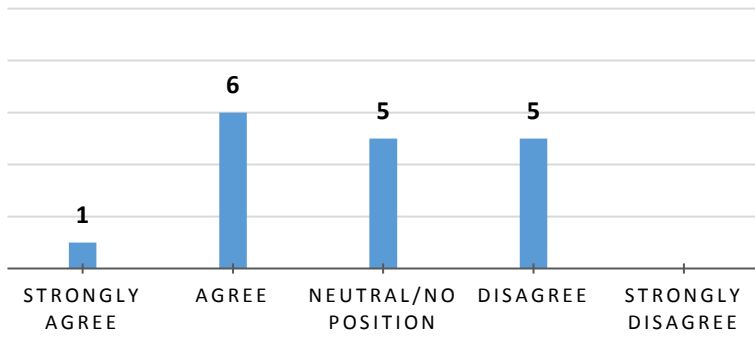
“[T]he CON question is part of the broader regulatory effort to cope with the rapid transformation of the health care system. It can't be viewed in isolation from the work of the Cabinet or other bodies.”

RESEARCH FINDINGS: Currently, 35 states and the District of Columbia have a CON program, and California has a similar process of review through its Office of the Attorney General. These programs vary widely in the type of services requires CON review, the designated agency charged with the review, the criteria of review, the public participation in the review, and the existence of post-approval mechanisms and enforcement.

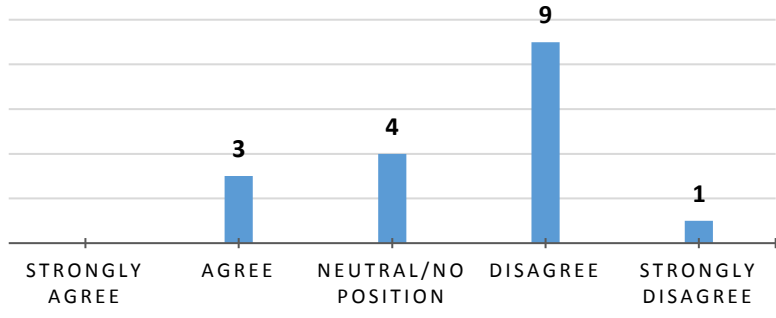
33 states, including D.C., have a CON program that applies to hospitals and their various transactions¹.

- **Actions that Trigger CON:** Of these states, a CON review is triggered for various hospital actions: 33 require CON for new hospital construction; 5 states require CON for hospital closures; 8 states require CON for hospital transfer of control; and 8 states require CON for loss of health care services.
- **CON Application Review:** 18 states have a joint administrative team and appointed board make final CON decisions and 9 states require consumer representation on this board.
- **CON Application Considerations:** 22 states consider whether the project is compatible with state health planning goals; 25 states consider whether the project is financially feasible; 17 states consider whether the project impacts underserved populations; and 11 states consider whether the project impacts health care access within a geographic region.
- **Public Communication:** Almost all of the CON states have a public website with details about the CON process, regulations, and statutes, with 23 of those websites being considered “easy” for the consumer to find information. 24 states post each CON application with public hearing dates and guidance on comment submission and 18 states notify the public about CON applications via newspaper or another platform.
- **Public Input:** 7 of the states have public input into the review process by allowing them to testify at regularly scheduled review board meetings. 19 states allow public participation in the review process through written comments. In 22 states, public hearings on CON applications are held by public request, and 5 states have mandatory public hearings for CON applications.
- **Post-Approval:** In 19 states, after a CON is denied, there is a post-approval challenge process. In 27 states, after a CON is approved, there is some sort of mechanism for enforcing compliance.

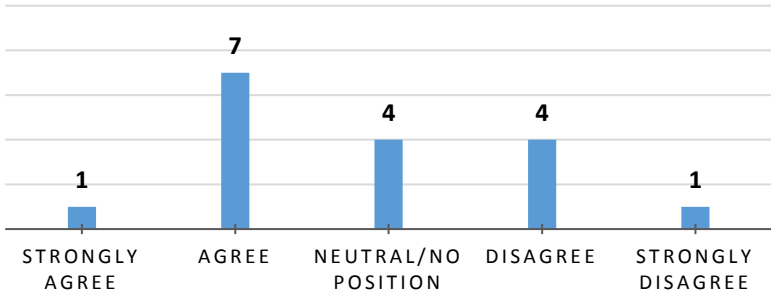
Excess capacity or duplication in a health care system is a primary driver of increased health care costs.



Limiting the capacity in a health care system based on meeting only the demonstrated need is an effective strategy to control health care costs.



Restricting new health care facility construction or the addition of services reduces price competition, and could lead to increased health care costs.



KEY COMMENTS FROM TASK FORCE MEMBERS:

“At the level of acute care hospitals, the notion that new market entrants will provide competition seems far-fetched, Below that level, competition can be beneficial for outpatient and ambulatory services, but creating incentives for over prescription (which is the real driver in parts of the system where overutilization is a problem), is hard to avoid.”

“Induced demand is a major factor in health care. Self-referral of procedures and tests is a major driver of health care costs.”

“Our current system has not controlled costs. The segments of health care which currently operate in a “market environment” with price transparency and competition have seen relative costs actually decrease. Current regulatory, reimbursement, and “health care reform” are clearly driving more and more care into the hospital environment which is unquestionably more expensive.”

RESEARCH FINDINGS:

The underlying premise of the CON process when implemented nationally in the early 1970s revolved around the idea that overbuilding, expanding, or purchasing capital equipment would drive up health care costs if it resulted in excess capacity. CON programs were designed to restrict new or additional health care facility construction or equipment to only those entities that could demonstrate a genuine need.

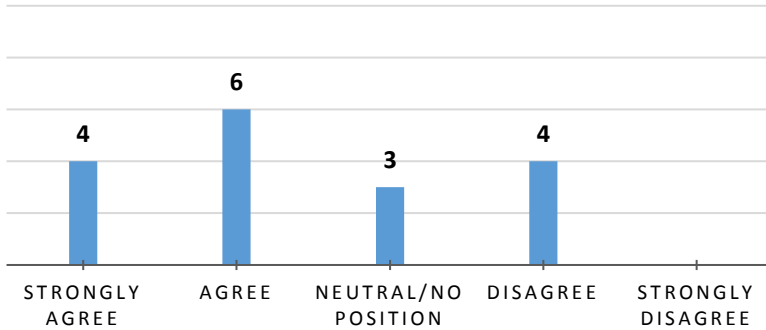
However, recent changes in health service reimbursement that move away from pure “cost-based” systems to payments based on quality or diagnosis have diminished incentives for health care providers to expand regardless of demand.ⁱⁱ As a result, the original purpose of CON - the limiting of expansions or added capacity to the health care system – no longer seems to be applicable in holding down health care costs.

It has been shownⁱⁱⁱ that the consolidation and merging of health care facilities and services, through limiting competition is a primary driver in increasing health care costs.

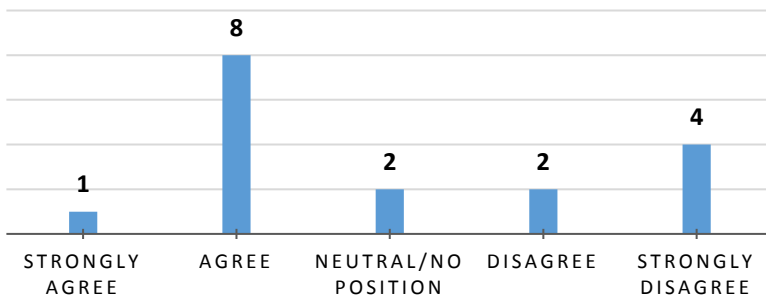
While some studies^{iv} have shown that CON states, in comparison to non-CON states, have decreased health care costs, these studies rely on correlation only and cannot claim that the existence of CON resulted in the lower costs. Other studies^v have shown that CON programs have actually increased costs.

Research has shown that limiting capacity in this way can give preference to incumbents in the system and actually impede access to services, especially new technologies.^{vi}

Health care services are not subject to the same market forces as a "typical" economic product.



Health care prices would be more effectively controlled by market pressures than an externally regulated process.



RESEARCH FINDINGS:

There is significant debate around whether health care services operate under the same market pressures as other service industries where competition reduces price and improves quality.

In general, opponents of CON programs argue that free-market forces apply to the health care industry^{vii} while proponents assert that market forces alone do not control service growth spending cost, quality, or access^{viii}.

There are many other factors that influence patient choice other than price – patients are often insulated from actual costs due to third party payment. Proximity, availability of subspecialty services, relationships with providers, and convenience (such as extended hours) are all factors that come into play when a patient selects services^{ix}.

In addition, most health services, such as labs, x-rays, or other tests, are ordered by providers; patients do not “shop” for these services like other commodities^x.

The non-profit status of a hospital does not play as large a role in curtailing costs as once thought. Studies^{xi} show that non-profits are affected by the same market pressures as for-profit hospitals and are just as likely to have prices rise based on market pressures.

KEY COMMENTS FROM TASK FORCE MEMBERS:

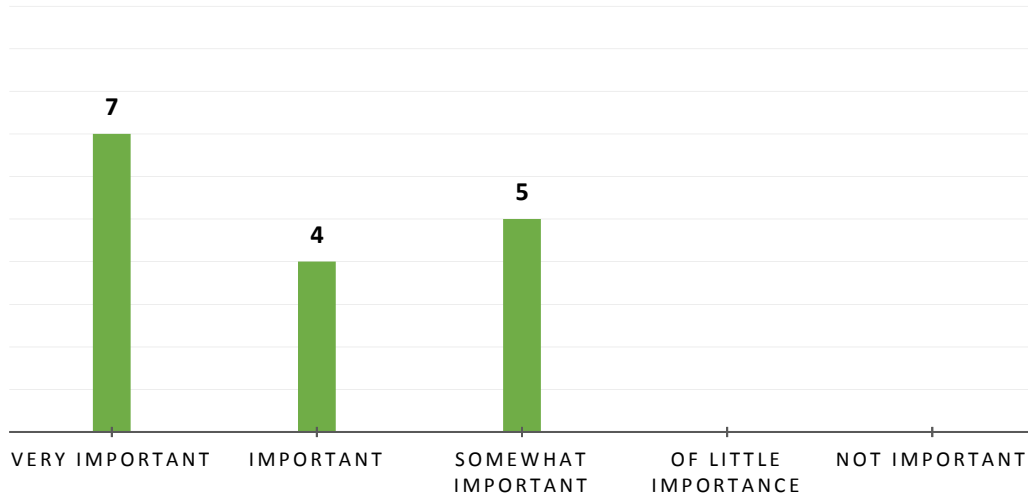
“To me, [the] vision of competition based on quality and access is really a vision of using robust regulation to establish the terms of practice. The idea that individual consumers will use data to make choices to maximize price and outcomes is a dangerous mirage. The overwhelming majority of decision-making on health care services is driven by forces exogenous to the patient. Market forces don't apply in health care transactions for two reasons. The minor reason is the extreme imbalance of technical knowledge, which won't be overcome by websites. But the major reason is that patients who are suffering have diminished moral agency. Rational choice theory, the basis for all market model construction cannot apply.”

“Carefully regulated, competition can provide some level of price control. But competition has been the primary cost control strategy in the US for 50 years, and US health care costs have mushroomed at two or more times the rate of inflation the whole time [...] Regardless of the efficacy of competition, the FTC has allowed providers to consolidate so deeply that “unscrambling the egg” of large systems would be the only way to restore competition. That seems legally, administratively and financially impossible. We should nurture competition where possible, but recognize its severe limitations as an overall strategy.”

“While I don't see that CON controls costs, there are other reasons to regulation the health care system through CON.”

WHAT GOALS SHOULD REGULATION ACHIEVE?

PLANNING Aligns with state-wide health planning goals



KEY COMMENTS FROM TASK FORCE MEMBERS:

In response to the question asking if other factors not listed in the survey should be considered, a task force member said *“age and condition of the existing infrastructure”*.

“‘Planning,’ in my view does not belong on this list. A system dedicated to cost-effective, access to quality healthcare would naturally include a robust cross-cutting planning process to meet public health needs.”

“CON should be a process that allows the regulatory body to assess whether a proposed new or expanded service will enhance or harm the community's, or the state's, overall health care delivery system.”

“CON should be a process that allows the regulatory body to assess whether a proposed new or expanded service will enhance or harm the community's, or the state's, overall health care delivery system.”

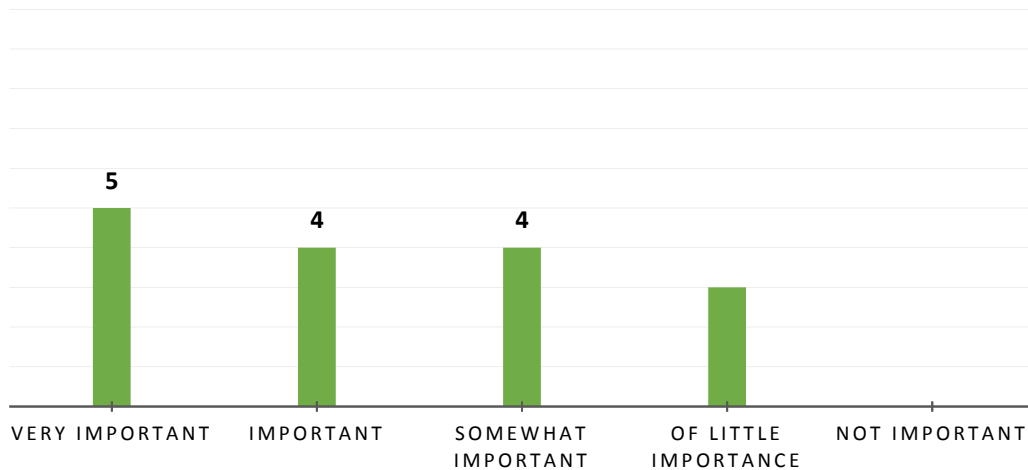
NOTES:

- OHCA is tasked with establishing and maintaining a state-wide health care facilities and services plan and conducting a state-wide health care facility utilization study^{xii}.
 - Blueprint for health care delivery in the state and include an inventory of all facilities, services, and equipment.
 - Examines unmet need and identifies possible gaps in services and at-risk and vulnerable populations, as well as containing standards and guidelines for best practices for specific services
- Almost half of the states (43%) that review various hospital transactions in their CON programs include compatibility with state health planning goals as review factor.^{xiii}

DISCUSSION:

- Does Connecticut have adequate and clear state-wide health planning goals?
- Which entity should be responsible for developing and implementing state-wide health planning goals?
- Should the CON review process include criteria on the alignment of the application with state-wide health planning goals?

NEED
Demonstrates a clear need or
avoids duplication of services



KEY COMMENTS FROM TASK FORCE MEMBERS:

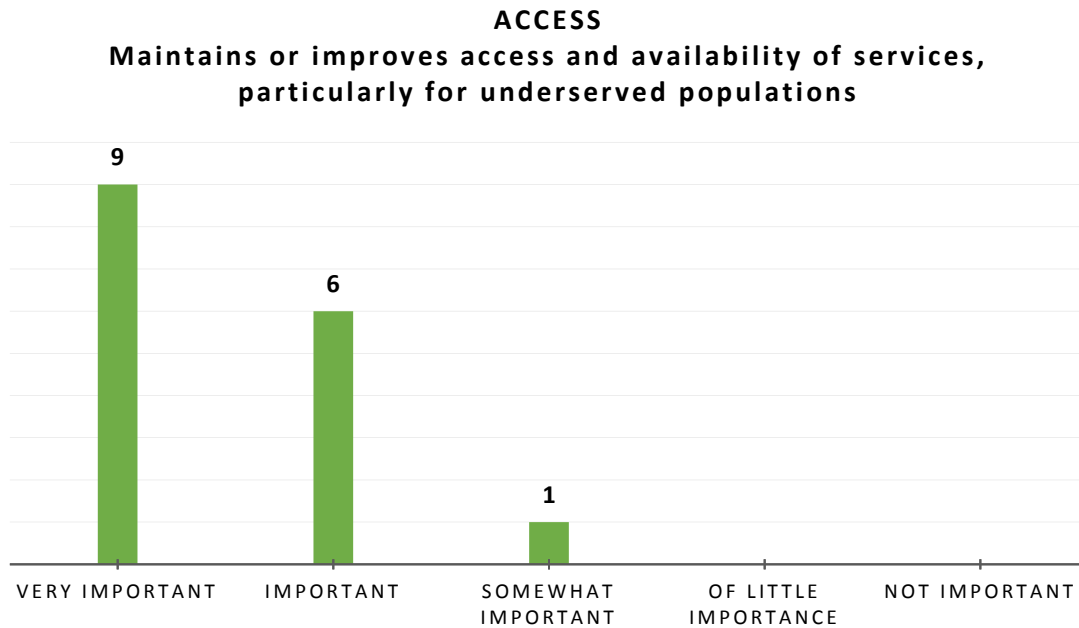
“Need’ and ‘Quality’ are obviously important but are not manageable, in my view, through a CON process.”

NOTES:

- The underlying premise of the CON process when implemented nationally in the early 1970s revolved around the idea that restricting new health care facility construction or the addition of health care equipment or beds to only those entities that could demonstrate a genuine need.
- Most studies^{xiv} demonstrate that there is no evidence that CON programs are successful in containing health care costs. Instead of relating costs to whether or not capacity is limited, studies shows that it is actually the consolidation and merging of health care facilities and services is a primary driver in increasing health care costs^{xv}.

DISCUSSION:

- Should the state limit the addition of health care services and equipment? If so, is a CON program to most effective vehicle in which to accomplish this?
- Are there other ways that excess capacity will be naturally limited without the state’s regulation?
- Does limiting “excess capacity” or “duplication” have an inadvertent effect on access?
- Should the CON review process include criteria on demonstrating a clear need or avoiding duplication of services?



KEY COMMENTS FROM TASK FORCE MEMBERS:

“I would like to underscore the importance of improved access and quality of care from a health equity viewpoint. This is critical to the CON process. Not only for racial and ethnic minority populations but also for women.”

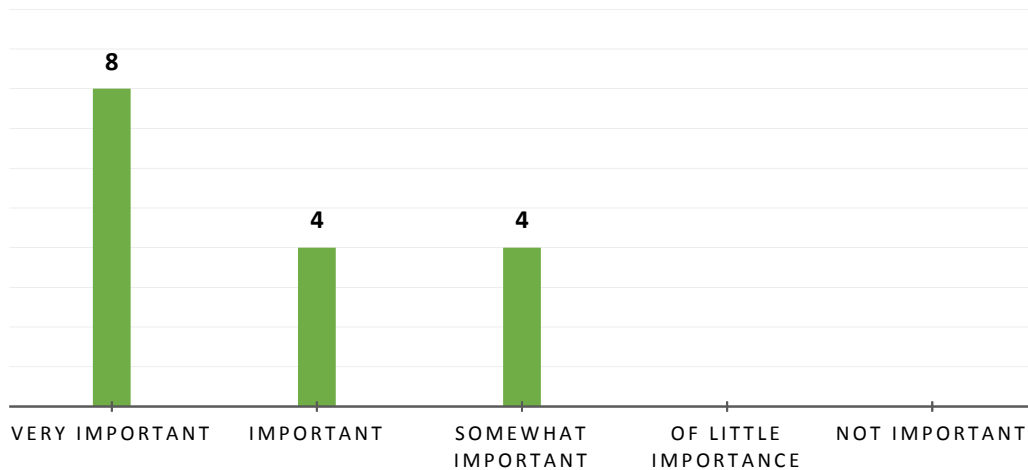
NOTES:

- Research indicating that CON programs have improved access to care for the underserved or increased uncompensated care is limited, with mixed results.^{xvi}
- By limiting capacity in the health care market, CON programs give preference to incumbents in the system which can impede access to services, especially new technologies.^{xvii}
- Better access to primary care lead to fewer hospitalizations^{xviii}.

DISCUSSION:

- Does improving or increasing access to services lead to “excess capacity”?
- Should the state regulate the reduction or termination of services, as it relates to access?
- Should the CON review process include criteria on maintaining or improving access and availability of services, particularly for underserved populations?
- Since better access to primary care leads to fewer hospitalizations, should focus on access be more on physician networks than hospitals?
- Does Connecticut’s current CON process adequately measure access when reviewing applications?
- How can we measure access in a CON application? How is access defined – is it a certain distance, market share, or just the mere presence or lack of certain types of services?

COST
Maintains or improves cost-effectiveness or
affordability of services



KEY COMMENTS FROM TASK FORCE MEMBERS:

“As noted, the CON question is part of the broader regulatory effort to cope with the rapid transformation of the health care system. It can't be viewed in isolation from the work of the Cabinet or other bodies.”

“While I don't see that CON controls costs, there are other reasons to regulate the health care system through CON.”

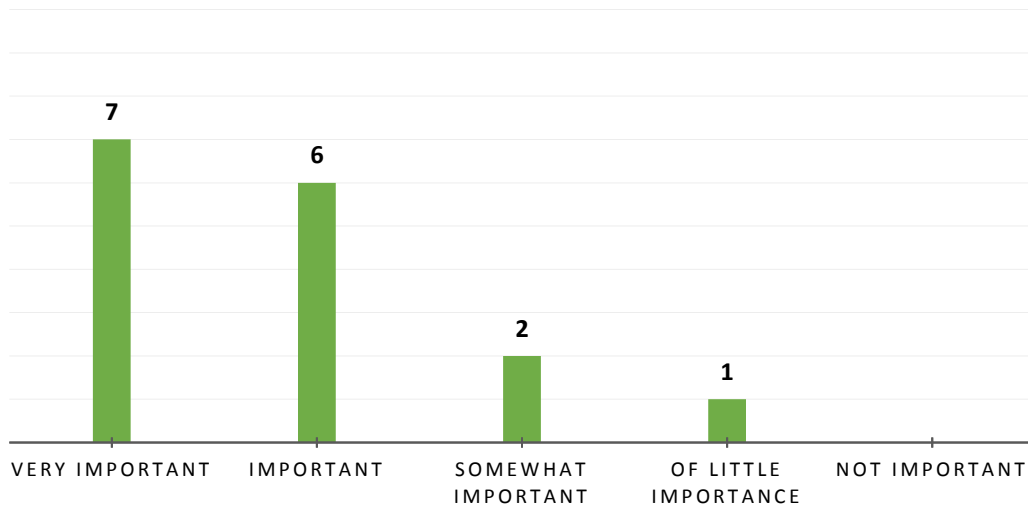
NOTES:

- While some studies^{xix} have shown that CON states, in comparison to non-CON states, have decreased health care costs, these studies rely on correlation only and cannot claim that the existence of CON resulted in the lower costs.
- It has been shown^{xx} that the consolidation and merging of health care facilities and services, not an excess of capacity or duplication, is a primary driver in increasing health care costs.

DISCUSSION:

- Can CON be an effective tool for managing health care costs? Would the addition of more stringent post-approval review and monitoring help?
- What role does competition play in managing health care costs? Should CON program goals relating to cost containment be focused on maintaining competition rather than limiting supply?
- Should the CON review process include criteria on maintaining or improving cost-effectiveness or affordability of services?

QUALITY
Maintains or improves quality of health care services



KEY COMMENTS FROM TASK FORCE MEMBERS:

“I would like to underscore the importance of improved access and quality of care from a health equity viewpoint. This is critical to the CON process. Not only for racial and ethnic minority populations but also for women.”

“For quality more interested in improve rather than maintain.”

“ ‘Need’ and ‘Quality’ are obviously important but are not manageable, in my view, through a CON process.”

“I rated quality low, not because it is relatively unimportant, but because it is very difficult to evaluate in the CON or any other regulatory process.”

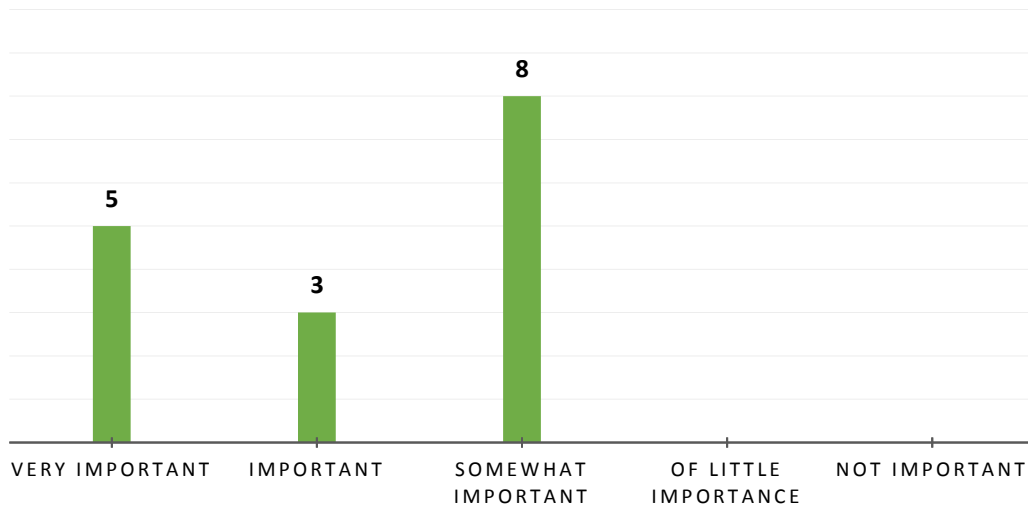
NOTES:

- Research regarding the ability of CON to affect quality are mixed with studies often reporting evidence of success being inconclusive or needing further study. In some cases, CON impact on improved quality may be present in certain areas (such as cardiac services) but not in others (such as delaying the acquisition of needed equipment)^{xxi}.
- While evidence is mixed, there is a growing body of research that supports that, in the US healthcare system, hospital competition improves quality.^{xxii} In addition, studies show that physician-hospital consolidation has not led to either improved quality or reduced costs.
- There is not a universally accepted set of metrics for measuring hospital quality. However, available data provides no evidence that Connecticut’s high health care costs are correlated to high quality.^{xxiii}

DISCUSSION:

- Should the state regulate the quality of health care services? If so, is a CON program the most effective vehicle to accomplish this?
- Should the CON review process include criteria on maintaining or improving quality of health care services?
- Quality is a relative term that can have many measures (e.g. whether a diagnosis is correct; whether the “right” treatment is selected to treat a diagnosis; whether the treatment is performed in a technically competent manner; or whether consumers can access the care they desire). How can quality be weighed and defined in a CON review process?

COMPETITION
Preserves an open and competitive health care market



KEY COMMENTS FROM TASK FORCE MEMBERS:

“Competition is a tool for a regulatory system, not an end in itself. Note also that these answers apply to the full spectrum of regulatory activity, not CON by itself.”

“It is unclear to me how the current system preserves competition. Materials submitted, and comments made by the DPH clearly state that the intent of the current system is not to foster competition.”

“CON's could be used to actually promote competition, if administered with that in mind.”

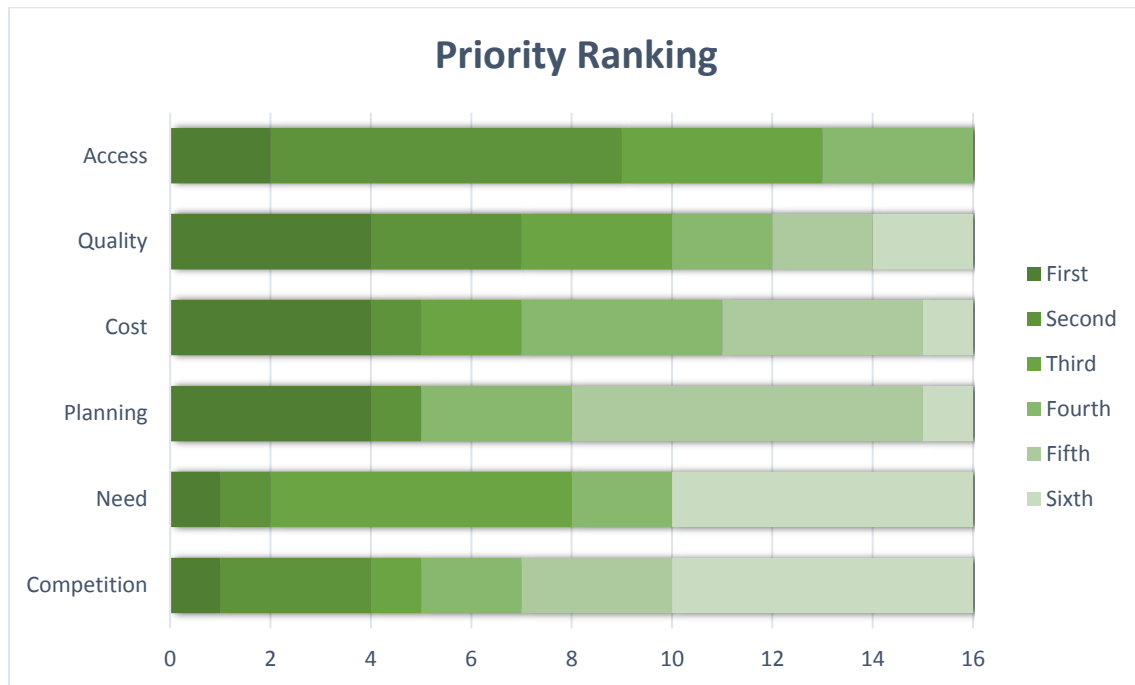
“Competition can be harmful in health care vs. other industries, particularly if new entrants can cherry pick patients.”

NOTES:

- In general, research indicates that competition in the health care market enhances quality and lowers costs.^{xxiv}
- No studies were found regarding CON programs’ effectiveness at promoting or protecting competition. However, research has shown that limiting capacity through CON programs can give preference to incumbents in the system and actually impede access to services, especially new technologies.^{xxv}
- Research shows^{xxvi} that the consolidation and merging of health care facilities and services, not an excess of capacity or duplication, is a primary driver in increasing health care costs.
- Beginning December 1, 2015, OHCA is required to conduct a cost and market impact review for certain^{xxvii} hospital transactions. This cost and market impact review will include a determination of whether a hospital current has or, as a result of the application, is likely to have a dominant market share or materially higher prices^{xxviii}. OHCA may deny an application based on the cost and market impact review if it is found that the affected community will not be assured of continued access to high quality and affordable health care or any likely increases in the prices for health care services or total health care spending in the state may negatively impact the affordability of care^{xxix}.

DISCUSSION:

- Is the goal of CON to preserve competition? Or is competition a means to an end – better quality, access, cost, etc?
- How does the current cost and market impact review evaluate the impact of a hospital CON application on competition?
- Should the CON review process include criteria on preserving an open and competitive health care market?



ⁱ This data is updated as of April 2016 and taken from the MergerWatch report [“When Hospitals Merge: Updating State Oversight to Protect Access to Care”](#). This data was considered only when researching how CON programs review hospitals and hospital actions.

ⁱⁱ (a) Kenen, Joanne. [“Getting the Facts on Hospital Mergers and Acquisitions.”](#) Association of Health Care Journalists; and (b) The Federal Trade Commission, Department of Justice. (2004). [Improving Health Care: A Dose of Competition.](#)

ⁱⁱⁱ (a) Gaynor, M. and Town, R. (June 2012). [The Impact of Hospital Consolidation-Update.](#) The Robert Wood Johnson Synthesis Project; and (b) Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). [The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured.](#)

^{iv} (a) Gendregske, M. J. (March 19, 2002). DaimlerChrysler Corporation. [Certificate of Need: Endorsement by DaimlerChrysler Corporation](#); and (b) Hellinger, Fred. (2009). [The Effect of CON Laws on Hospital Beds and Healthcare Expenditures: An Empirical Analysis](#); The American Journal of Managed Care, Vol. 15(10).

^v Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). [The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured.](#)

^{vi} (a) Ohlhausen, Maureen K. (Fall 2015). [Certificate of Need Laws: A Prescription for Higher Costs](#); American Bar Association. [Antitrust](#), Vol. 30, No. 1.; and (b) The Federal Trade Commission, Department of Justice. (2004). [Improving Health Care: A Dose of Competition.](#)

^{vii} (a) Ohlhausen, Maureen K. (Fall 2015). [Certificate of Need Laws: A Prescription for Higher Costs](#); American Bar Association. [Antitrust](#), Vol. 30, No. 1.; and (b) The Federal Trade Commission, Department of Justice. (2004). [Improving Health Care: A Dose of Competition.](#); and (c) Yee, T., Stark, L.B., Bond, A. M., and Carrier, E. (May 2011). [Health Care Certificate of Need Laws: Policy or Politics?](#); National Institute of Health Care Reform Research Brief, No. 4.

^{viii} (a) Yee, T., Stark, L.B., Bond, A. M., and Carrier, E. (May 2011). [Health Care Certificate of Need Laws: Policy or Politics?](#); National Institute of Health Care Reform Research Brief, No. 4.; (b) Steen, John. [Certificate of Need: A Review](#), American Health Planning Association Articles and Essays; (c) American Health Planning Association. [Improving Health Care: A Dose of Competition, AHPA Response.](#) American Health Planning Association Articles and Essays; and (d) Piper, Thomas. (July 2014). [Certificate of Need: Protecting the Public Interest, PowerPoint Slides](#); National Conference of State Legislatures Website.

^{ix} (a) Steen, John. [Certificate of Need: A Review](#), American Health Planning Association Articles and Essays. (b) American Health Planning Association. [Improving Health Care: A Dose of Competition, AHPA Response.](#) American Health Planning Association Articles

FINAL RESULTS – CON TASK FORCE SURVEY

and Essays; and (c) Piper, Thomas. (July 2014). *Certificate of Need: Protecting the Public Interest, PowerPoint Slides*; National Conference of State Legislatures Website.

^x Piper, Thomas. (July 2014). *Certificate of Need: Protecting the Public Interest, PowerPoint Slides*; National Conference of State Legislatures Website.

^{xi} (a) Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). [The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured.](#); and (b) Young, G. J. and Desai, K. R. (1999). [Non-Profit Hospital Conversion and Community Benefits: New Evidence from Three States](#); Health Affairs, Vol. 18(5).

^{xii} §19a-634 of the Connecticut General Statutes

^{xiii} Khaikin, C. Uttley, L., and Winkler, A. (2016) [When Hospitals Merge: Updating State Oversight to Protect Access to Care](#): The Merger Watch Project.

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^{xvii} (a) Ohlhausen, Maureen K. (Fall 2015). [Certificate of Need Laws: A Prescription for Higher Costs](#); American Bar Association. [Antitrust](#), Vol. 30, No. 1.; (b) The Federal Trade Commission, Department of Justice. (2004). [Improving Health Care: A Dose of Competition](#).

^{xviii} Conover, C.J. and Sloan, F. A. (June 1998). [Does Removing Certificate of Need Regulations Lead to A Surge in Health Care Spending?](#), Journal of Health Politics, Policy and Law, Vol. 23(3)

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^{xxiii} [Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion](#).

^{xxiv} (a) Gaynor, M. and Town, R. (June 2012). [The Impact of Hospital Consolidation-Update](#). The Robert Wood Johnson Synthesis Project; and (b) Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). [The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured](#); (c) [Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion](#); and (d) Yee, T., Stark, L.B., Bond, A. M., and Carrier, E. (May 2011). [Health Care Certificate of Need Laws: Policy or Politics?](#): National Institute of Health Care Reform Research Brief, No. 4.

^{xxv} (a) Ohlhausen, Maureen K. (Fall 2015). [Certificate of Need Laws: A Prescription for Higher Costs](#); American Bar Association. [Antitrust](#), Vol. 30, No. 1.; and (b) The Federal Trade Commission, Department of Justice. (2004). [Improving Health Care: A Dose of Competition](#).

^{xxvi} (a) Gaynor, M. and Town, R. (June 2012). [*The Impact of Hospital Consolidation-Update*](#). The Robert Wood Johnson Synthesis Project; and (b) Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). [*The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*](#).

^{xxvii} These applications include cases where (1) an application for a certificate of need filed pursuant to section 19a-638 involves the transfer of ownership of a hospital, as defined in section 19a-639, and (2) the purchaser is a hospital, as defined in section 19a-490, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars, or a hospital system, as defined in section 19a-486i, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars or any person that is organized or operated for profit.

^{xxviii} §19a-639f of the Connecticut General Statutes

^{xxix} §19a-639(d)(4) of the Connecticut General Statutes

Results of Survey #2

CERTIFICATE OF NEED (CON) TASK FORCE

SEPTEMBER 19, 2016

Acquiring Equipment: Scanners

MAJORITY RESPONSE: ELIMINATE

1	5	7
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

1	Maintain – no changes
1	Notification only to OHCA
	Expedited process for ALL applications
2	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
	All applications conditioned on the provision of services to Medicaid or underserved populations
7	Eliminate
2	Other

Other Respondent Considerations:

- For applications that propose to not serve Medicaid/underserve populations, justification should be required in the application.
- There should be an ability to incentivize the relocation of equipment and services to areas of need.

Acquiring Equipment: New Technology

MAJORITY RESPONSE: ELIMINATE

3	3	7
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

3	Maintain – no changes
	Notification only to OHCA
1	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
1	All applications conditioned on the provision of services to Medicaid or underserved populations
7	Eliminate
1	Other

Other Respondent Considerations:

- Create a streamlined process for applicants who are willing to commit to full public transparency on cost/price, utilization and outcomes and who accept conditions on the provision of service to Medicaid or underserved populations
- Be aware of “new” or experimental technology being applied in underserved communities in an exploitive fashion

Acquiring Equipment: Linear Accelerators

MAJORITY RESPONSE: ELIMINATE

2	3	8
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

2	Maintain – no changes
	Notification only to OHCA
1	Expedited process for ALL applications
1	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
	All applications conditioned on the provision of services to Medicaid or underserved populations
8	Eliminate
1	Other

Other Respondent Considerations:

- Lack of knowledge about this piece of equipment was noted by one respondent.

Initiating Services and Increasing Capacity: New Hospitals

MAJORITY RESPONSE: MODIFY

2	7	4
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

2	Maintain – no changes
	Notification only to OHCA
1	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
3	All applications conditioned on the provision of services to Medicaid or underserved populations
4	Eliminate
3	Other

Other Respondent Considerations:

- Two respondents suggested combining or considering both the expedited process for applications to serve populations in designated “high-need” areas and making all applications conditioned on the provision of services to Medicaid or underserved populations.
- Require applicant to show it can build a vertical network infrastructure to compete effectively

Initiating Services and Increasing Capacity: New Specialty Hospitals

MAJORITY RESPONSE: PRESERVE

5	3	5
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

5	Maintain – no changes
	Notification only to OHCA
1	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
1	All applications conditioned on the provision of services to Medicaid or underserved populations
5	Eliminate
1	Other

Other Respondent Considerations:

- Require applicant to show it can build a vertical network infrastructure to compete effectively

Initiating Services and Increasing Capacity: New Freestanding Emergency Departments

MAJORITY RESPONSE: MODIFY

Options Presented:

2	Maintain – no changes
	Notification only to OHCA
1	Expedited process for ALL applications
2	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
1	All applications conditioned on the provision of services to Medicaid or underserved populations
4	Eliminate
3	Other

2	7	4
MAINTAIN	MODIFY	ELIMINATE

Other Respondent Considerations:

- CON should be conditioned on the provision of services to Medicaid and underserved populations while ensuring that freestanding ER services are 100% consistent with services rendered within hospital environment.
- Combine or consider both the expedited process for applications to serve populations in designated “high-need” areas and making all applications conditioned on the provision of services to Medicaid or underserved populations.
- Review the value of freestanding EDs and the degree to which patient use them when they should be utilizing urgent care or primary care physicians; consider a moratorium

Initiating Services and Increasing Capacity: New Outpatient Surgical Facilities

MAJORITY RESPONSE: **MIXED**

1	6	6
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

1	Maintain – no changes
	Notification only to OHCA
3	Expedited process for ALL applications
1	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
1	All applications conditioned on the provision of services to Medicaid or underserved populations
6	Eliminate
1	Other

Other Respondent Considerations:

- Create a streamlined process of applications serving high need areas and condition approvals on provision to Medicaid or underserved populations

Initiating Services and Increasing Capacity: New Central Service Facilities

MAJORITY RESPONSE: ELIMINATE

4	2	7
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

4	Maintain – no changes
	Notification only to OHCA
	Expedited process for ALL applications
1	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
	All applications conditioned on the provision of services to Medicaid or underserved populations
7	Eliminate
1	Other

Other Respondent Considerations:

- Lack of knowledge about this type of facility was noted by one respondent.

Initiating Services and Increasing Capacity: New Mental Health Facilities

MAJORITY RESPONSE: **MIXED**

1	6	6
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

1	Maintain – no changes
	Notification only to OHCA
3	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
1	All applications conditioned on the provision of services to Medicaid or underserved populations
6	Eliminate
2	Other

Other Respondent Considerations:

- Combine or consider both the expedited process for applications to serve populations in designated “high-need” areas and making all applications conditioned on the provision of services to Medicaid or underserved populations.

Initiating Services and Increasing Capacity: New Substance Abuse Treatment Facilities

MAJORITY RESPONSE: **MIXED**

1	6	6
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

1	Maintain – no changes
	Notification only to OHCA
2	Expedited process for ALL applications
1	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
2	All applications conditioned on the provision of services to Medicaid or underserved populations
6	Eliminate
1	Other

Other Respondent Considerations:

- Combine or consider both the expedited process for applications to serve populations in designated “high-need” areas and making all applications conditioned on the provision of services to Medicaid or underserved populations.
- Expand CON process or other type of licensure to sub-acute SA treatment facilities such as sober homes or halfway houses

Initiating Services and Increasing Capacity: New Cardiac Services

MAJORITY RESPONSE: PRESERVE

3	4	6
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

3	Maintain – no changes
	Notification only to OHCA
1	Expedited process for ALL applications
1	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
1	All applications conditioned on the provision of services to Medicaid or underserved populations
6	Eliminate
1	Other

Other Respondent Considerations:

- Combine or consider both the expedited process for applications to serve populations in designated “high-need” areas and making all applications conditioned on the provision of services to Medicaid or underserved populations.

Initiating Services and Increasing Capacity: Licensed Bed Capacity

MAJORITY RESPONSE: ELIMINATE

2	3	8
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

2	Maintain – no changes
	Notification only to OHCA
1	Expedited process for ALL applications
1	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
	All applications conditioned on the provision of services to Medicaid or underserved populations
8	Eliminate
1	Other

Other Respondent Considerations:

- Combine or consider both the expedited process for applications to serve populations in designated “high-need” areas and making all applications conditioned on the provision of services to Medicaid or underserved populations.

Initiating Services and Increasing Capacity: Increase in Operating Rooms (2 or more in 3 year period)

MAJORITY RESPONSE: ELIMINATE

2	2	9
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

2	Maintain – no changes
	Notification only to OHCA
1	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
1	All applications conditioned on the provision of services to Medicaid or underserved populations
9	Eliminate
	Other

Terminating Services: Hospital Mental Health/Substance Abuse Services

MAJORITY RESPONSE: MODIFY

Options Presented:

4	7	2
MAINTAIN	MODIFY	ELIMINATE

4	Maintain – no changes
2	Require a CON application only when the service is being terminated in a designated “high-need” area
1	Require notification when termination due to insufficient patient volume or a certain threshold of financial loss; all other terminations must go through the full application process
2	Create an expedited application process for when termination due to insufficient patient volume or a certain threshold of financial loss; all other terminations must go through the full application process
2	Eliminate
2	Other

Other Respondent Considerations:

- Require CON application only when the service being terminated is in a “high need” area-make it an expedited process that recognizes concern for terminations proposed due to the financial loss in providing services
- Require a hospital to develop a specific plan on how hospital will ensure community MH and SUD needs will be met after the termination of services

Terminating Services: Hospital Inpatient/Outpatient Services

MAJORITY RESPONSE: MODIFY

3	9	1
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

3	Maintain – no changes
2	Require a CON application only when the service is being terminated in a designated “high-need” area
1	Require notification when termination due to insufficient patient volume or a certain threshold of financial loss; all other terminations must go through the full application process
3	Create an expedited application process for when termination due to insufficient patient volume or a certain threshold of financial loss; all other terminations must go through the full application process
1	Eliminate
3	Other

Other Respondent Considerations:

- Require notification when the service is proposed to be terminated due to insufficient patient volume or a certain threshold of financial loss **unless in a high need area**; all other terminated services should be subject to expedited CON process
- CON application should be required if there is a proposed **reduction** of services

Terminating Services: Hospital Emergency Departments

MAJORITY RESPONSE: MODIFY

4	6	3
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

4	Maintain – no changes
1	Require a CON application only when the service is being terminated in a designated “high-need” area
1	Require notification when termination due to insufficient patient volume or a certain threshold of financial loss; all other terminations must go through the full application process
2	Create an expedited application process for when termination due to insufficient patient volume or a certain threshold of financial loss; all other terminations must go through the full application process
3	Eliminate
2	Other

Other Respondent Considerations:

- Create an expedited application process
- CON should be required if there is a proposed reduction in emergency services/beds

Terminating Services: Surgical Services

MAJORITY RESPONSE: ELIMINATE

0	6	7
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

0	Maintain – no changes
3	Require a CON application only when the service is being terminated in a designated “high-need” area
1	Require notification when termination due to insufficient patient volume or a certain threshold of financial loss; all other terminations must go through the full application process
1	Create an expedited application process for when termination due to insufficient patient volume or a certain threshold of financial loss; all other terminations must go through the full application process
7	Eliminate
1	Other

- Other Respondent Considerations:
- If the outpatient facility is part about of the larger local hospital system, proposed terminated and/or reduction of surgical services should be evaluated as part of that entity's services.

Transfer of Ownership: Large Group Practices

MAJORITY RESPONSE: MODIFY

3	8	2
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

3	Maintain – no changes
	Notification only to OHCA
1	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
2	All applications conditioned on the provision of services to Medicaid or underserved populations
2	Eliminate
5	Other

Other Respondent Considerations:

- Require CON only if transfer is to a hospital
- Approvals should be conditioned on the provision of services to underserved populations but should also include a deeper financial impact assessment, and post approval sanction opportunity should actual cost impacts vary materially from the representations made.
- Acquire consultants to create a report regarding market and pricing impact of increased concentration of ownership.
- Streamline, expedited application, but process should include review of services to Medicaid and underserved populations. Application should be able to be denied if discriminatory practices are discerned.
- Condition approval on serving Medicaid/underserved and abolish presumption of passage

Transfer of Ownership: Specialty Hospitals

MAJORITY RESPONSE: MAINTAIN

6	5	2
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

6	Maintain – no changes
1	Notification only to OHCA
	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
2	All applications conditioned on the provision of services to Medicaid or underserved populations
2	Eliminate
1	Other

Other Respondent Considerations:

- Combine or consider both the expedited process for applications to serve populations in designated “high-need” areas and making all applications conditioned on the provision of services to Medicaid or underserved populations.

Transfer of Ownership: Freestanding Emergency Departments

MAJORITY RESPONSE: MODIFY

4	5	4
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

4	Maintain – no changes
1	Notification only to OHCA
	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
2	All applications conditioned on the provision of services to Medicaid or underserved populations
4	Eliminate
2	Other

Other Respondent Considerations:

- Ensure that any free standing ER operations provide 100% of services offered within the hospital environment
- Combine or consider both the expedited process for applications to serve populations in designated “high-need” areas and making all applications conditioned on the provision of services to Medicaid or underserved populations.

Transfer of Ownership: Outpatient Surgical Facilities

MAJORITY RESPONSE: **MIXED**

3	5	5
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

3	Maintain – no changes
1	Notification only to OHCA
	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
2	All applications conditioned on the provision of services to Medicaid or underserved populations
5	Eliminate
2	Other

Other Respondent Considerations:

- Require CON if transfer of ownership is to/will create a larger health care system and possibility eliminate the ability for competition.
- Combine or consider both the expedited process for applications to serve populations in designated “high-need” areas and making all applications conditioned on the provision of services to Medicaid or underserved populations.

Transfer of Ownership: Central Service Facilities

MAJORITY RESPONSE: ELIMINATE

2	3	8
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

2	Maintain – no changes
2	Notification only to OHCA
1	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
	All applications conditioned on the provision of services to Medicaid or underserved populations
8	Eliminate
	Other

Transfer of Ownership: Mental Health Facilities

MAJORITY RESPONSE: MODIFY

3	7	3
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

3	Maintain – no changes
1	Notification only to OHCA
2	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
3	All applications conditioned on the provision of services to Medicaid or underserved populations
3	Eliminate
1	Other

Other Respondent Considerations:

- Combine or consider both the expedited process for applications to serve populations in designated “high-need” areas and making all applications conditioned on the provision of services to Medicaid or underserved populations.

Transfer of Ownership: Substance Abuse Treatment Facilities

MAJORITY RESPONSE: MODIFY

3	6	4
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

3	Maintain – no changes
1	Notification only to OHCA
1	Expedited process for ALL applications
0	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
3	All applications conditioned on the provision of services to Medicaid or underserved populations
4	Eliminate
1	Other

Other Respondent Considerations:

- Combine or consider both the expedited process for applications to serve populations in designated “high-need” areas and making all applications conditioned on the provision of services to Medicaid or underserved populations.

Expanded Reviews: Hospital Transfer of Ownership

MAJORITY RESPONSE: **MAINTAIN**

8	4	0
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

2	Maintain – no changes
	Notification only to OHCA
	Expedited process for approval for ALL applications
2	All applications conditioned on the provision of services to Medicaid or underserved populations
0	Eliminate
2	Other

Other Respondent Considerations:

- Add emphasis to issues that have a negative impact to the competitive market place
- Needs to viewed as a means of nudging the CT delivery system in the direction of a high quality, efficient and competitive set of consumer and payer choices; as a regulatory support and constraint to channel competitive forces toward positive outcomes; and to function in conjunction with antitrust and insurance regulation.

Conversions

MAJORITY RESPONSE: **MAINTAIN**

7	2	3
MAINTAIN	MODIFY	ELIMINATE

Options Presented:

7	Maintain – no changes
	Notification only to OHCA
	Expedited process for ALL applications
	Expedited process ONLY for applications that propose to serve populations in designated "high-need" areas
	All applications conditioned on the provision of services to Medicaid or underserved populations
3	Eliminate
2	Other

Other Respondent Considerations:

- Ensure these reviews are not influenced by factors beyond those outlined in regulations or needlessly prolonged.
- Large scale reductions to services, job cuts, and cuts to employees wages/benefits should not be allowed to make the conversion "financially feasible"

CON Proposed Recommendations

Office of Policy and Management

November 21, 2016

CON Proposed Recommendations

- Today we will focus on recommendations for:
 - CON Decision-Making Process
 - CON Application Process
 - CON Post Approval Compliance Mechanisms
 - Relocating Services
 - CON Evaluation Methods

CON Proposed Recommendations

- Recommendations were formulated based on:
 - Research
 - Task Force Discussions
 - OHCA suggestions
 - Survey Responses
- Relevance of some recommendations will depend upon the alternatives put forth by the Task Force regarding actions and services subject to CON.
- Task Force member feedback is important!

Results & Recommendations from
Survey #3:
CON Decision-Making Authority

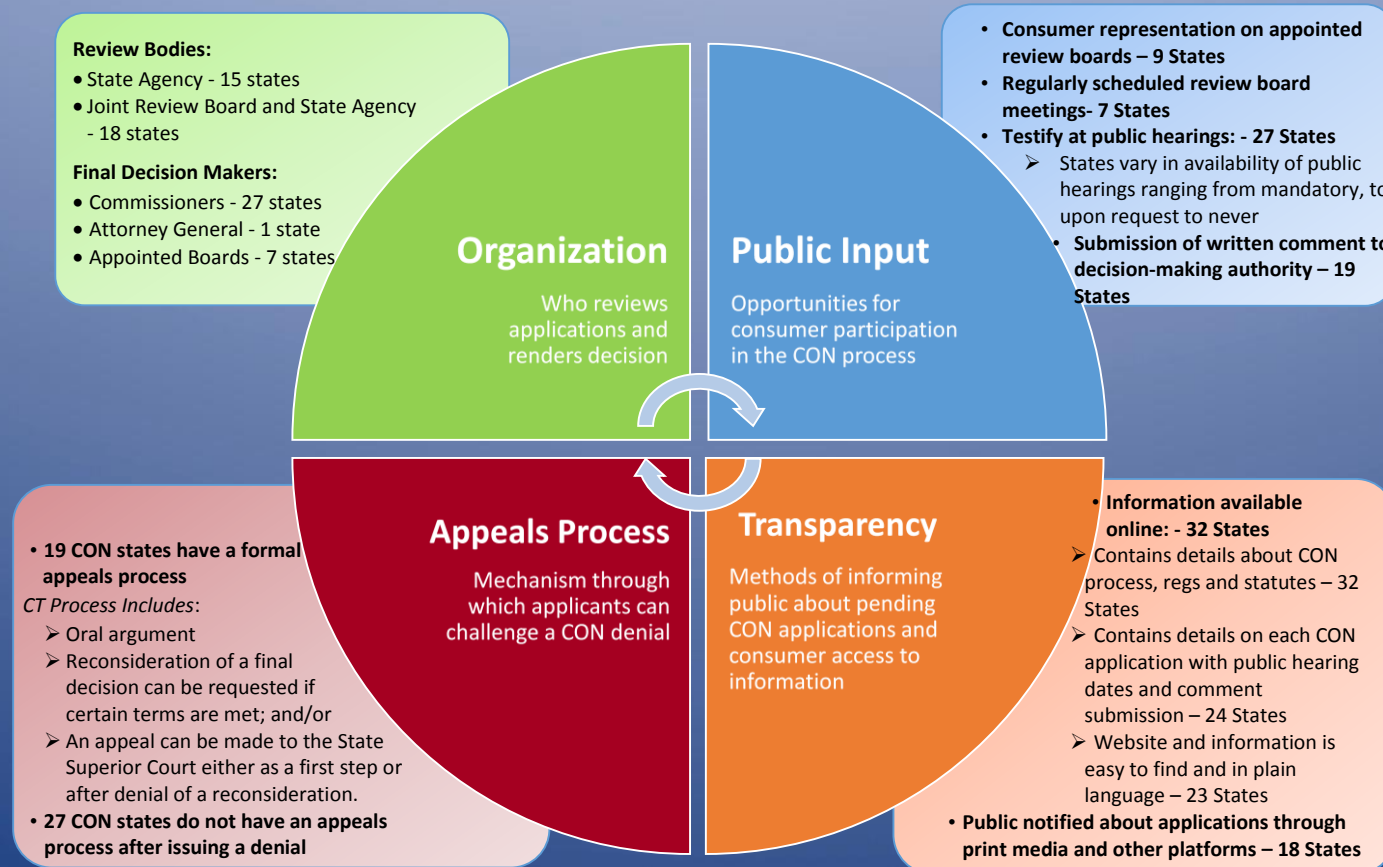
CON Decision-Making: National Perspective

- CON decision-making authority and process varies among states.
- 32 states and the District of Columbia utilize CON to regulate hospitals.
- The 2016 Merger Watch Report, *When Hospitals Merge*, presented information on decision-making processes in relevant states.

Four Categories of CON Decision-Making

- **Organization:** Who reviews applications and renders decisions
- **Public Input:** Opportunities for consumer participation in the CON process
- **Transparency:** Methods of informing the public about pending applications and consumer access to information
- **Appeals Process:** Mechanisms through which the public can appeal a CON decision

Highlights of CON Decision-Making Across the Country



CON Decision-Making: Organization

- Nationally, CON application review and decision - making authority rests in three main categories:
- State Health Departments;
 - ❖ CT falls into this category
- Joint Administrative Teams and Appointed Boards; and
- Attorney General's Office.

CON Decision-Making Survey Results: Organization

Survey Question

- Should Connecticut consider changing the decision-making structure for CON applications to a joint review process involving both administrative staff and an appointed board?
- Member Responses:
 - 2 – Yes, CT should have Joint Review Board
 - ✓ 7 – NO, CT should not have a Joint Review Board

Comments

- *“Do not think [an appointed board] is necessary if the decision making process is objective and based on data and an approved state plan.”*
- *“Not in favor of a Board. Having a Board will complicate the process and not necessarily add value.”*
- *“We currently have input from all above mentioned”*
- *“If the approval process is based on objective data and an approved statewide plan, then the makeup of the decision making body is less relevant.”*
- *“I would limit the board to the Commissioners of DPH, DOI, and OPM, and the AG”*
- *“My initial response is no, but depends on who appoints if we were to consider a board. This needs to be an independent process. What would make sense is a panel of subject matter experts that could make recommendations.”*

CON Decision-Making Survey Results: Organization

Task Force Recommendation: Maintain Current Structure

- Maintain the organizational structure of the CON process as it currently exists with OHCA staff responsible for reviewing health care facility CON applications and DSS staff responsible for reviewing long-term care facility applications.
- Final decisions on CON applications should continue to be rendered by the Deputy Commissioner of the Department of Public Health (DPH) and the Commissioner of the Department of Social Services (DSS), respectively.
- The Attorney Generals' Office should continue its limited role in the CON process consisting of the review of charitable assets in hospital conversion applications and providing legal guidance to OHCA as needed.

CON Decision-Making Survey Results: Organization

- Proposed Recommendation:
- For All OHCA Applications: Establish a panel of Subject Matter Experts to assist OHCA in application review.
 - Cost of retaining experts covered by applicants
 - Include representatives from specific fields (i.e. behavioral health, cardiac, radiology etc.)
 - Include consumer representatives

CON Decision-Making: Public Input

- Nationally, states offer several opportunities for public input:

Allow public to participate in review process through:	Number of States	
	Yes	No
Conducting regularly scheduled review meetings (“batched” applications)	7	26*
Allowing written comments	20*	13
Conducting mandatory public hearings	5	28*
Conducting public hearings upon request	22*	11

*CT is represented in this category

CON Decision-Making: Public Input – Batching

Question

- Should applications be "batched" and reviewed at regularly scheduled times throughout the year, with some exceptions?
- Member Responses:
 - 3 – Yes, CT should batch with certain exceptions
 - ✓ 6 – NO, CT should not batch applications

Comments

- An exception should be made for the acquisition of “new technology”

CON Decision-Making: Public Input – Mechanisms

Survey Question

- Are there any other changes you would like to see to the current public hearing process, including the ability for public input and the timing of notifications?
- Member Responses:
5 members submitted a response to this open-ended question

Comments

- *"I believe the current mechanism allows for public input"*
- *"Public hearing should be mandatory; written public comment submission should be an option"*
- *"No. Current process works well."*
- *"Schedule public hearings within 30 days of CON application deemed complete. Limit Intervener status to those cases where a significant financial impact can be demonstrated within the defined service area."*
- *"Public should be able to submit written comments."*

CON Decision-Making: Public Input

Task Force Recommendations:

- Maintain and expand current methods of soliciting and accepting public input on pending CON applications.
 - Establish a panel of subject matter experts that can include consumer representation
- Require that transfers of ownership of health care facilities other than hospitals (freestanding emergency departments, outpatient surgical facilities, mental health facilities, and substance abuse treatment facilities) to hospitals or hospital systems also receive mandatory public hearings.

CON Decision-Making: Transparency

- Transparency = how accessible information on the CON is to the general public.
- Nationally, the level of transparency varies:

Public communication includes:	Number of States	
	Yes	No
Details about CON process, regulations and statutes on a website	32*	1
Details about each CON application with public hearing dates and comment submission on a website	24*	9
“Easy to find” information on the website for the consumer	23*	10
Notifications about CON applications via newspaper or other platform	18*	15

*CT is represented in this category

CON Decision-Making: Transparency

Survey Question

- Are there any changes you would like to see in the way OHCA notifies the public about the CON process?
- Member Response:
5 responses were received

Comments

- *“In the digital age within which we live, I am curious about the role social media could/can play in this. For now, I don't have any suggested changes.”*
- *“No. Current process works well.”*
- *“Is there any assessment of the effectiveness of the various modes of noticing the public?”*
- *“Use of electronic postings exclusively.”*
- *“Press releases”*

CON Decision-Making: Transparency

- **Task Force Recommendations:**
- Expand current methods of informing the public about the status of CON applications, public hearings, decisions and appeals.
 - Require applicants to provide a physical copy of the application/determination/appeals at local sites within the affected community (libraries, community centers, Town Halls) and on additional web sites (local health departments, municipal web sites)
 - Continually research and implement new innovative ways to reach the public and solicit participation in the CON process

CON Decision-Making: Appeals Process

- Nationally, 19 of the 33 CON states allow members of the public to appeal CON decisions

State post-approval process includes:	Number of States	
	Yes	No
Ability for public to contest a CON decision	19	14*

* Connecticut is represented in this category

CON Decision-Making: Appeals Process

Question

Should there be a mechanism in which members of the public can have an opportunity to challenge or request the reexamination of a CON decision?

- Member Responses:
 - 2 – Yes, the public should be allowed to challenge a decision
 - ✓ 7 – NO, the public should not be allowed to challenge a decision.

Comments

- *"I would suggest streamlining the functions and having all CON applications reviewed in place. This is probably evident from my vote to have a joint commission but I want to be explicit and say it does not make sense to have two offices with duplicating functions."*
- *"Limit the CON approval process to 90-120 days, and there should be an expedited review process, i.e. within 30 days for service relocations, change in ownership, service additions and terminations, outpatient operating room capacity. Distinguishing between substantive and non-substantive review, defined."*

Decision-Making Recommendations

- Respondents indicated that, in general, no significant changes are needed to the current CON decision-making process.
- Suggested changes for consideration include:
 - Establish a Panel of Experts that includes consumer representation (OHCA suggestion)
 - Continually research and implement new innovative ways to reach the public and solicit participation in the CON process
 - Expand criteria for when a public hearing is required

Proposed Recommendations:

CON Application Process and Post
Approval Compliance Mechanisms

Recommendations: CON

Application Process

- Streamline the application process.
 - What specific efficiencies can be made to the application process?

Recommendations: CON Application Process

For Select Applications

- Create an expedited CON application process for:
 - Initiating services & increasing capacity if service/facility is located in a “high need” area; &
 - Terminating services due to the loss of physicians.
- Require a single CON and CMIR for the sale of all assets for:
 - Hospital conversions and acquisitions

Recommendations: CON Post - Approval Compliance Mechanisms

Current Post-Approval Compliance Mechanisms

- OHCA CON post-approval compliance authority defined in CGS § 19a-639 and § 19a-653(a)

Recommendations: CON Post Approval Compliance Mechanisms

Proposed Revisions to Post-Approval Compliance Mechanisms

- Remove the term “willful” from statute CGS § 19a-653(a) regarding penalties to allow OHCA greater flexibility.
- Increase enforcement authority by adding language to CGS § 19a-653(a) to impose civil penalties on any person or health care facility or institution which fails to comply with any provision or condition of a certificate of need decision or agreed settlement pursuant to CGS § 19a-639a.
- Align OHCA and DPH licensing division inspection and monitoring activities

Proposed Recommendations: Actions Subject to CON

Relocation of Services

Actions Subject to CON: Relocation of Services

Question For CON Task Force:

After hearing OHCA's presentation regarding the current CON Process for the relocation of services, are any changes needed?

Proposed Recommendations:

CON Evaluation Methods

Recommendations: CON Evaluation Methods

- Key Question: What methods can OHCA and DSS employ to allow the agencies to ascertain whether the revised CON process is achieving the established program goal to ***improve access to and quality of health care services and contain costs by preserving competition in the health care market and implementing statewide planning efforts aimed at promoting health equity and fulfilling unmet needs.***

Recommendations: CON Evaluation Methods

- Proposed Evaluation Mechanisms
 - Expand OHCA's role in quality monitoring to ensure alignment with clinical best practices and guidelines for quality & efficiency.
 - Align OHCA quality monitoring to requirements for licensure when possible.
 - Ensure that the Statewide Health Care Plan tracks access to and cost of services across the state.
 - Implement evaluation mechanisms beyond a point in time snapshot when an entity enters and exits the market to include factors that allow the state to determine CON impact on quality, access and cost

Appendix E – Recommendation Options Presented for Vote

DRAFT

Actions Subject to CON Review – Vote Tally Sheet - December 19, 2016

Certificate of Need (CON) Task Force Draft Recommendations

1. TRANSFERS OF OWNERSHIP – Choose One Option	Votes
<i>Status Quo</i> : CON review of transfers of ownership of all health care facilities and certain transfers of large group practices and expanded CON review (cost and market impact review, mandatory public hearing, stronger application criteria, post-transfer compliance monitoring) of certain <u>hospital</u> transfers of ownership	
<p>A. Strengthen CON review of hospital mergers and consolidations by:</p> <ul style="list-style-type: none"> i. Applying CON review only to <u>hospital</u> acquisition of health care facilities and large group practices ii. Applying expanded CON review to hospital acquisitions of health care facilities and large group practices (cost and market impact review, mandatory public hearing, stronger application criteria, post-transfer compliance monitoring) iii. Applying expanded CON review to all hospital mergers and acquisitions (not only those involving for-profit entities and larger hospital systems, as under current law) iv. Imposing consequences for non-compliance with post-transfer conditions 	
<p>B. Ensure all health care providers are treated equally by requiring review of transfer of ownership of healthcare facilities and large group practices by any acquirer including a hospital, a hospital system, an insurer, investor and any other entity seeking to acquire such facility or large group practice</p>	

2. CONVERSIONS – Choose One Option	Votes
<i>Status Quo</i> : Expanded CON review and enhanced role of AG in protecting charitable assets	
<p>A. Maintain status quo</p>	

Actions Subject to CON Review – Vote Tally Sheet - December 19, 2016

Certificate of Need (CON) Task Force Draft Recommendations

3. ACQUIRING EQUIPMENT – Choose One Option	Votes
<i>Status Quo: CON review of scanners, new technology, and non-hospital based linear accelerators</i>	
A. Maintain status quo	
B. Maintain status quo and clarify that the current exemption applied to the replacement of scanners previously acquired through the CON process includes any scanner currently in operation being replaced by any other type of scanner	
C. Maintain status quo and expand the current exemption applied to the replacement of scanners previously acquired through the CON process to the replacement of all equipment previously approved through the CON process, with notification to OHCA	
D. Eliminate CON review of equipment acquisitions and propose legislative remedy to restrict scanner self-referrals	
E. Eliminate CON review of equipment acquisitions (no restricting of self-referrals)	
F. Apply CON review to advanced imaging acquisitions only	
G. Apply CON review to advanced imaging acquisitions and new technology	

4. INITIATING SERVICES/INCREASING CAPACITY – Choose One Option	Votes
<i>Status Quo: CON review of (1) New hospitals, specialty hospitals, freestanding emergency departments, outpatient surgical facilities, mental health facilities, substance abuse treatment facilities, cardiac services, and central service facilities; (2) Increased licensed bed capacity; and (3) establishment of 2 or more operating rooms in a 3-year period</i>	
A. Apply CON review to the establishment of new hospitals, specialty hospitals, and freestanding emergency departments	
B. Apply CON review to the establishment of new hospitals, specialty hospitals, freestanding emergency departments, outpatient surgical facilities, and cardiac services	
C. Apply CON review to the establishment of new hospitals, specialty hospitals, freestanding emergency departments, outpatient surgical facilities, cardiac services, mental health facilities, and substance abuse treatment facilities	
D. Apply CON review to the establishment of new hospitals, specialty hospitals, freestanding emergency departments, outpatient surgical facilities, cardiac services, and for-profit inpatient behavioral health services	
E. Apply CON review to the establishment of new hospitals, specialty hospitals, freestanding emergency departments, outpatient surgical facilities, cardiac services, mental health facilities, substance abuse treatment facilities, and adding two or more operating rooms in a three-year period	

Actions Subject to CON Review – Vote Tally Sheet - December 19, 2016

Certificate of Need (CON) Task Force Draft Recommendations

5. TERMINATING SERVICES - Choose One Option	Votes
<i>Status Quo: CON review of terminating hospital emergency departments, hospital inpatient/outpatient services, hospital mental health and substance abuse treatment services, and surgical services at an outpatient surgical facility</i>	
A. Apply CON review when terminating hospital emergency departments, hospital inpatient/outpatient services, and hospital mental health/substance abuse treatment services	
B. Apply CON review when terminating hospital emergency departments, select inpatient/outpatient services, and hospital mental health/substance abuse treatment services	
C. Apply CON review when terminating hospital emergency departments, select inpatient/outpatient services, and mental health/substance abuse treatment services of hospitals and other entities	

6. REDUCTION OF SERVICES – Choose One Option	Votes
<i>Status Quo: No CON review required</i>	
A. Maintain status quo	
B. Apply CON review to the reduction of services by a hospital	
C. Apply CON review to the reduction of services by a hospital, and define “reduction of services” as a purposeful and planned reduction of 25% or more of volume (utilization) in inpatient or outpatient departments as defined in the Medicare hospital/institutional cost report	

7. RELOCATION OF SERVICES – Choose One Option	Votes
<i>Status Quo: CON review required if the population and payer mix served by the health care facility will substantially change as a result of the proposed relocation</i>	
A. Apply CON review to the relocation of services	
B. Apply CON review to the relocation of services, but require notification only for those applications that propose to relocate within a reasonable geographic area	
C. Apply CON review to the relocation of services, but require notification only for those applications that propose to relocate to an area identified as having unmet needs through a state health planning process	

Actions Subject to CON Review – Vote Tally Sheet - December 19, 2016

Certificate of Need (CON) Task Force Draft Recommendations

8. ACTIONS SUBJECT TO DSS CON PROCESS – Choose One Option	Votes
<p><i>Status Quo: Applies to nursing homes, residential care homes, and intermediate care facilities for individuals with intellectual disability and includes, but is not limited to, review of certain capital expenditures, acquisitions of major medical equipment in excess of \$400,000, new or expansion of services or function, terminations of health services, facility closures, substantial decreases in total bed capacity, and transfers of ownership</i></p>	
<p>A.</p> <ul style="list-style-type: none"> i. Maintain CON review for all actions other than the establishment of new continuing care retirement facilities (CCRCs); ii. conduct periodic reviews of the nursing home moratorium; iii. amend the current moratorium by allowing nursing homes to apply for CON review for a relocation or establishment of a new facility without adding beds 	
<p>B.</p> <ul style="list-style-type: none"> i. Maintain CON review for all actions other than the establishment of new continuing care retirement facilities (CCRCs); and ii. conduct periodic reviews of the nursing home moratorium 	
<p>C.</p> <ul style="list-style-type: none"> i. Eliminate CON review for the establishment of CCRCs only if the number of beds added by the new CCRC are not more than the estimated future need of the residents living in the CCRCs; ii. conduct periodic reviews of the nursing home moratorium; iii. amend the current moratorium by allowing nursing homes to apply for CON review for a relocation or establishment of a new facility without adding beds 	

CON Application Review Criteria - Vote Tally Sheet – December 19, 2016

Certificate of Need (CON) Task Force Draft Recommendations

9. APPLICATION REVIEW CRITERIA – Choose One Option	Votes
ACQUIRING EQUIPMENT AND INITIATING SERVICES/INCREASING CAPACITY	
<i>Status Quo: OHCA consideration of twelve guidelines and principles</i>	
A. Revise guidelines to reflect the updated CON program goals including: <ul style="list-style-type: none"> i. focusing on protecting access to underserved areas; ensuring provision of services to Medicaid recipients; increasing the role of state health planning; and limiting actions that adversely impact the health care market ii. removing barriers to market entry that affect the ability of the competitive environment to increase quality and decrease costs, including removing references to requiring a demonstration of “need” in order to enter the market 	
B. Maintain guidelines that reflect the demonstration of need, information on the population served, and the review of financial feasibility or ability to afford the proposed project	

10. APPLICATION REVIEW CRITERIA – Choose One Option	Votes
TERMINATING SERVICES	
<i>Status Quo: OHCA consideration of twelve guidelines and principles</i>	
A. Revise guidelines to reflect the updated CON program goals including focusing on protecting access to underserved areas, and whether a proposed termination will affect the provision of Medicaid services and if patients have access to alternative locations to obtain the service	

11. APPLICATION REVIEW CRITERIA – Choose One Option	Votes
TRANSFERS OF OWNERSHIP	
<i>Status Quo: OHCA consideration of twelve guidelines and principles and expanded review for certain hospital applications</i>	
A. Revise guidelines to reflect the updated CON program goals including: <ul style="list-style-type: none"> i. focusing on protecting access to underserved areas; ensuring provision of services to Medicaid recipients; increasing the role of state health planning; and limiting actions that adversely impact the health care market ii. Applying expanded CON review to all hospital mergers and acquisitions (not only those involving for-profit entities and larger hospital systems, as under current law) 	
B. Maintain guidelines requiring the demonstration of impact on the financial health of the health care system	

CON Decision-Making Process - Vote Tally Sheet – December 19, 2016

Certificate of Need (CON) Task Force Draft Recommendations

12. ORGANIZATION – Who reviews applications and render decisions	Votes	
<i>Status Quo:</i> OHCA staff review health care facility CON applications and DSS staff review LTC facility applications; final decisions rendered by the Deputy Commissioner of DPH and the Commissioner of DSS; AG has limited role in CON process in reviewing charitable assets in hospital conversion applications and providing legal guidance to OHCA as needed	YES	NO
A. Establish a panel of advisory subject matter experts to assist OHCA in application review with costs being covered by applicant <ul style="list-style-type: none"> i. Include reasonable limits and specify that expert review will be included as deemed appropriate by OHCA 		
B. Include front-line caregivers from relevant fields to serve as subject matter experts		
C. Allow the applicant to participate in selection of panel members and allow input into the expert’s review		

13. PUBLIC INPUT – Opportunities for consumer participation in the OHCA CON process	Votes	
<i>Status Quo:</i> For OHCA applications, there are requirements dictating when public hearings are held, and specifications on who can be designated as intervenors.	YES	NO
A. Expand current options of soliciting and accepting public input on pending OHCA CON applications, including requiring that the subject matter panel of experts includes consumer representation		
B. Requiring that hospital acquisitions of other health care facilities and large group practices receive a mandatory public hearing		
C. Establish a process for accepting public comment prior to decision being rendered by OHCA		

14. APPEALS PROCESS - Mechanisms through which the public can appeal an OHCA CON decision	Votes	
<i>Status Quo:</i> For OHCA applications, there are requirements dictating when public hearings are held, and specifications on who can be designated as intervenors. Members of the public and intervenors cannot appeal a CON decision.	YES	NO
A. Allow intervenors to appeal a CON decision		
B. Allow the public at large to appeal OHCA decisions and allow intervenors, or those who would have qualified as intervenors, to appeal OHCA decision to Superior Court		

CON Decision-Making Process - Vote Tally Sheet – December 19, 2016

Certificate of Need (CON) Task Force Draft Recommendations

15. TRANSPARENCY – Methods of informing the public about pending OHCA applications and consumer access to information	Votes	
<i>Status Quo:</i> For OHCA applications, there are requirements dictating when public hearings are held, and specifications on who can be designated as intervenors. Members of the public and intervenors cannot appeal a CON decision.	YES	NO
<p>A. Expand current methods of informing the public about the status of CON applications, public hearings, decisions and appeals including:</p> <ul style="list-style-type: none"> i. requiring applicants to provide a physical copy of the application/determination/appeals at local sites within the affected community (libraries, community centers, Town Halls) and on additional web sites (local health departments, municipal web sites) ii. continually researching and implementing new innovative ways to reach the public and solicit participation in the CON process; and iii. developing methods to regularly evaluate the effectiveness of public outreach strategies. 		
<p>B. Require applicant to attest that reasonable efforts to expand public notification were made and do not penalize applicant if public input was solicited in accordance with requirements</p>		

CON Application Process - Vote Tally Sheet – December 19, 2016

Certificate of Need (CON) Task Force Draft Recommendations

16. CON APPLICATION PROCESS	Votes	
<i>Status Quo</i> : OHCA must render a final decision within 90 days (or 60 days for a group practice or following a hearing).	YES	NO
A. Create an expedited CON application process for		
i. the establishment of new facilities or services or increasing capacity if the service/facility is located in a “high need” area		
ii. for the termination of services due to the loss of physicians		
iii. for the review of the acquisition of new imaging equipment		
iv. programs and services that have inadequate volumes to support the effective delivery of care		
v. transfers of ownership that do not result in a change of service, payer mix, or location		
vi. mental health and substance abuse facilities if they commit to serving a certain threshold of Medicaid and other underserved populations		
B. Require a single CON application and cost and market impact review for the sale of all assets for hospital conversions and acquisitions		
C. Require all applications for terminations to be handled through an expedited process no longer than sixty days		

CON Post Approval Compliance Mechanisms - Vote Tally Sheet – December 19, 2016
Certificate of Need (CON) Task Force Draft Recommendations

17. CON POST-APPROVAL COMPLIANCE MECHANISMS	Votes	
<p><i>Status Quo:</i> Under current law, OHCA may: (1) place conditions on the approval of a CON application involving a transfer of a hospital; (2) implement a performance approval plan should the applicant breach a condition and continue the reporting period for up to one year or until issue is resolved; and (3) require up to a \$1,000/day civil penalty for entities that willfully fail to seek a CON as required for each day information is missing, incomplete or inaccurate.</p>	YES	NO
<p>A. Modify the threshold needed to enforce penalties on CON applicants who do not conform with current laws from “willful” to “negligent”</p>		
<p>B. Increase enforcement authority by allowing OHCA to impose civil penalties on applicants who fail to comply with any provision or condition of a CON decision or agreed settlement</p>		
<p>C. Allow OHCA to exact remedies in the case where commitments involving prices were not met, including refunding to the original bill payer (insurer, patient) of amount in excess of the “promised” price and loss of part or all of the “approvals” granted in association with the CON application</p>		
<p>D. Align OHCA and DPH licensing division inspection and monitoring activities</p>		
<p>E. Require an independent entity to conduct non-compliance monitoring for transfer of ownership applications</p>		
<p>F. Fund additional inspection staff at OHCA to better conduct inspection, monitoring, and enforcement</p>		

CON Evaluation Methods - Vote Tally Sheet – December 19, 2016

Certificate of Need (CON) Task Force Draft Recommendations

18. CON EVALUATION METHODS	Votes	
<i>Status Quo:</i> There is currently no formal evaluation of the effectiveness of the OHCA CON program.	YES	NO
A. Expand OHCA’s role in quality monitoring to ensure alignment with clinical best practices and guidelines for quality and efficiency and align with licensure requirements when possible		
B. Ensure that the Statewide Health Care Plan tracks access to and cost of services across the state.		
C. Implement evaluation mechanisms beyond a point in time snapshot when an entity enters and exits the market to include factors that allow the state to determine CON impact on quality, access and cost		

Appendix F – Public Comment

DRAFT

Summary of Public Comment

I. List of Respondents

Hospitals

The CT Hospital Association
Charlotte Hungerford Hospital
CT Children's Medical Center
Day Kimball Healthcare
Middlesex Hospital
Norwalk Hospital & Western CT Health Network
Stamford Hospital
St. Vincent's Medical Center
Trinity Health-New England
Yale New Haven Health Care System

Physicians

American Medical Association
CT State Medical Society
Dr. Lawrence Lazor, Starling Physicians
Dr. Christopher Leary, Bristol Hospital & Radiologic Associates
Dr. Maria Christina Mirth, CT Colon and Rectal Surgery, LLC
Starling Physicians

Miscellaneous

CT Association for Ambulatory Surgery Centers
Cary S. Shaw, The Connecticut Coalition of Reason, The Secular Coalition for Connecticut, and Humanists and Free Thinkers of Fairfield County
Radiological Society of Connecticut
Universal Health Care Foundation of Connecticut



**TESTIMONY OF
THE CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO
THE CERTIFICATE OF NEED TASKFORCE
THURSDAY, DECEMBER 15, 2016**

The Connecticut Hospital Association (CHA) appreciates this opportunity to present comments on the draft recommendations of the Certificate of Need (CON) Taskforce.

As the healthcare system undergoes significant transformation, hospitals continue to be focused on the health and well-being of every Connecticut citizen. The goals of this transformation are improved access to care, improved quality and safety, and reduced cost. The CON program plays an important role in achieving these goals.

CON safeguards the public's need for access to high quality health services, prevents unnecessary duplication of services, and sets a level playing field for deployment of healthcare resources in a financially responsible way.

Before commenting on the specific proposals as outlined in the December 5, 2016 document, it is important to emphasize several key principles that we urge the Taskforce to address as it considers changes to the CON program.

- The CON program must not discriminate against any specific type of provider or entity and must treat all providers and entities equally.
- The CON program must strive to ensure that all providers treat underserved populations, Medicaid recipients, and indigent persons.
- The CON program is not the regulatory vehicle to be used to analyze and investigate the cost of healthcare. The Lt. Governor's Healthcare Cabinet is the appropriate group to develop recommendations with respect to the cost of healthcare.

With respect to the specific proposals:

Actions Subject to Certificate of Need

Acquiring Equipment

- The CON program should maintain a review of all scanners, new technology, and non-hospital-based linear accelerators.

- The CON program should be modified to create an expedited procedure both in process and timeline for the review of the acquisition of new imaging equipment.
- The CON program should clarify that the current exemption applies to the replacement of equipment previously acquired through the CON process, including any scanner currently in operation that will be replaced by any other type of scanner.
- The CON program should expand the current exemption applied to the replacement of scanners to all equipment previously approved through CON, with notice to the Office of Health Care Access (OHCA).

Initiating Services/Increasing Capacity

- The CON program should maintain review of (1) New Hospitals; (2) New Specialty Hospitals; (3) New Freestanding Emergency Departments; (4) New Outpatient Surgical Facilities; (5) New cardiac services; and add (6) required review of two or more operating rooms in a three-year period.

Terminating Services

- The CON program should review terminations of (1) Hospital Emergency Departments; (2) Select hospital Inpatient Services; and (3) Hospital Mental Health/Substance Abuse Services.
- With respect to the termination of hospital outpatient services, the CON program should be modified to allow for the termination of certain outpatient services without CON review, such as physical or occupational therapy, sleep labs, diagnostic services, and/or multiple locations.
- The CON program should also review the termination of mental health/substance abuse services being proposed by entities other than hospitals.

Reduction of Services

- The CON program should not be modified to require CON review for the reduction of services.

Relocation of Services

- The CON program should allow the relocation of services within a reasonable geographic area without a CON review but with notice to OHCA.
- The CON program should allow for the relocation of services to an area with unmet needs through a state health planning process without a CON review but with notice to OHCA.

Transfer of Ownership

- The CON program should not have an inherent bias against any type of provider. It must treat all providers equally, and require the review of the transfer of ownership of a healthcare facility or certain large practices by any acquirer (e.g., a hospital, a hospital system, insurer, investor, and any other entity seeking to acquire ownership or control of such healthcare facility or certain large group practice.)

Conversions

- The CON program should maintain its current requirements for hospital conversions.

CON Application Review Criteria (OHCA CON Guidelines and Principles)

Application Criteria for Acquiring Equipment

- The first application criteria should be modified to assess whether the proposed project will serve Medicaid patients.

Application for Reducing or Terminating Services

- The CON program should not be modified to require CON review for the reduction of services.

CON Decision-Making Process

Organization: Who Reviews Applications, Renders Decisions, and Provides Public Input – Opportunities for Consumer Participation in the CON Process

- With respect to the Subject Matter Experts Panel, the proposal needs to be more specific to ensure that the panel members are serving as consultants or advisors, and that their comments are advisory only. The proposal needs to be more specific as to how the expert for a specific application will be selected and clarify that the panel comprises a list of approved persons from whom OHCA may choose to seek expert advice, but that OHCA is not required to do so.
- The proposal should be modified to allow the applicant, upon request, to have input into the selection of the expert and to comment on the expert's review.

Appeals Process: Mechanism through Which the Public Can Appeal a CON Decision

- The CON program should not be modified to allow intervenors to appeal a CON decision. This would be a significant departure from the existing administrative process and may be legally problematic.
- The CON program should not be modified to allow the public at large to appeal a CON decision. This would be a significant departure from the existing administrative process and may be legally problematic.

Transparency: Methods of Informing the Public about Pending Applications and Consumer Access to Information

- The proposal would require the applicant to state that it has made reasonable efforts to expand public notification. The proposal should be modified to indicate there will be no adverse impact on the applicant if the applicant is not able to carry out the expanded notification due to factors beyond its control (e.g., Town hall won't allow copies to be placed at a site or removes them).

CON Application Process

- The proposal for creating an expedited process should expand to cover the acquisition of imaging equipment.
- The proposal for creating an expedited process should expand to cover mental health and substance abuse facilities if they commit to serving Medicaid and other underserved populations.
- The proposal should be modified to require that all applications for terminations be handled through an expedited process of no more than 60 days.
- The CON program should be modified to provide that if an application is not acted upon timely, within the statutory time frames, it will be deemed approved (this feature was part of prior iterations of the CON process).

CON Post-Approval Compliance Mechanism

- With respect to proposal 1, “willful” should not be removed from CGS 19a-653 (a) – lowering the threshold would unfairly punish healthcare facilities that are acting in good faith to comply.

CON Evaluation Methods

- The CON program should be expanded to allow OHCA the ability to consider the quality of services, provided such review is based on generally accepted, nationally recognized clinical best practices and guidelines.

We look forward to working with the Lieutenant Governor and members of the Taskforce.

Thank you for consideration of our position.



Culture of Caring

LIVING OUR MISSION AND VALUES

TESTIMONY OF THE CHARLOTTE HUNGERFORD HOSPITAL SUBMITTED TO THE

THE CERTIFICATE OF NEED TASK FORCE December 15, 2016

The Charlotte Hungerford Hospital (CHH) of Torrington, CT appreciates this opportunity to submit comments on the draft recommendations of the Certificate of Need (CON) Task Force.

In 2016, CHH proudly marks its 100th year in serving the people of northwest Connecticut. Today our hospital, like all others, faces rising costs, reduced funding, and numerous clinical and care delivery challenges. Yet we remain thoroughly committed to achieving our original and steadfast Mission: *To provide quality, compassionate and affordable healthcare to the people of Northwest CT.*

As we navigate our course in this rapidly changing healthcare environment, we have keenly followed, embraced, and responded to the many public policy initiatives and reforms affecting health care, both at the state and federal levels. Observing the charge and work of the CON Task Force has been no exception to our keen interest in tracking policy direction. We appreciate the time and energy you have placed on assuring a well-purposed and high functioning CON process in this state, one that rightfully advances the goals of access, cost, and quality in our healthcare system.

Because we have directly participated in the Connecticut Hospital Association's review of the CON Task Force's draft recommendations, we fully endorse their comments and share their position on the specific proposals across each of the CON categories. Their testimony speaks for CHH and there is no reason for us to repeat these positions here.

Instead, we wish to offer additional comment on our experiences with CON in the state, and our hope for reframing the goals and expectations of the CON process going forward.

First, we believe that the CON process can and should be a necessary good. Government has always influenced the shaping of health care in our state and country, and the allocation of resources to its purpose. Because of this, the CON process can and should be an instrument to helping fulfill this important role of government, and in achieving important public policy goals for the greater good.

Although, relatively speaking, we are a limited “user” of CON, we have not found in our experiences that the requirements to justify changes, be transparent with our plans and intent, or accommodate conditions imposed by the state in connection with any CON approval to be onerous, irrelevant or retrograde. We have also found that it can effectively advance, or at least protect, access, cost and quality goals.

Notwithstanding the policy changes we are endorsing through CHA’s testimony to the Task Force, we have a generally favorable view of the purpose and practices of the state’s Office of Health Care Access. And, further, that our orientation is that a clear and vibrant CON process is both useful and productive.

With respect to revised purpose of the CON program contained in the draft recommendations, we appreciate that the CON Task Force is considering more than issues related to review scoping and process changes. It is our perception that the proposed revision to the CON’s purpose emphasizes that the application of “perfect market theory” is the single best way to achieve the goals of access, cost, and quality.

Per the draft report, this belief is based on research findings which suggest that a competitive environment keeps costs down and can enhance quality. Like the report’s findings, we believe there are many benefits to competition, particularly in health care. We also do not take any issue with the research findings that support this premise. We do however think that this “one silver bullet” approach is at best incomplete.

However, we also know that many externalities exist in the health care marketplace and access to care and the development of health services,

particularly for the poor, can go unaddressed, or even harmed, when decisions are left to market forces alone.

This last shortcoming regarding access is addressed in the report only by saying the CON review should focus on “...promoting health equity and improving access”. Yet it is not clear how this goal would be blended with the conclusion that the CON process should protect against limiting competition. Because the draft set of recommendations does not go so far as to propose a statutory construct, it is unclear how the CON review process would judge applications and inform and protect providers and consumers.

The report’s premise more specifically states that limiting competition is a “...primary driver in increasing health care costs”. Whether or not this is correct, there are many other well-researched drivers of cost that deserve the attention of public policy (e.g. health care overhead, regulatory burdens, unfunded mandates, variation in practice, consumer expectations, drug prices, malpractice, lifestyle behaviors, etc.).

Moreover, the report seems to indicate that mergers and acquisitions should receive the highest scrutiny under this framework, as these transactions “reduce competition”. Yet there is no discussion about under what circumstances a merger or acquisition could be viewed as in the public’s interest. It appears in the report’s concluding language that none should be viewed favorably.

As a provider with a pending transfer of ownership CON application, you would expect us to be particularly sensitive on this point. We think it would be useful for members of the Task Force to know, unlike many mergers and acquisitions of the past (we suspect those particularly the subject of the prevailing research cited in the report), among our motivating drivers were not just financial considerations, but more complex conditions, including:

- We can expect a growing difficulty in attracting and retaining physicians in both primary care and specialties for our underserved area.
- We can expect to continue to grow as a key access point for care for those covered by public insurance, which changes our ability to create positive operating margins at levels necessary for reinvesting in health care (dependency on Medicare and Medicaid is approaching 80% of our patient base, meaning we can’t operate in a true free market anyway).

- We can expect a growing importance in being part of a clinically-integrated network and continuum of care in order to sustain the quality of, and access to services, and experience any meaningful gains in the health of the population we serve.

After careful deliberation and consideration of alternatives, our community, through our Board of Governors, determined that an affiliation was necessary not just for financial advantages. In fact, clinical and continuum advantages heavily factored into our thinking and into our strategy to preserve and enhance health services for our area.

Further, for similar reasons, with CHH serving as a critical access point for care, it was determined that an affiliation better positions CHH to properly respond to our changing demographic, payer mix, and to health care reforms.

The essential point is this: we would not want the extreme focus on competition to confine thinking about the broader reasons why mergers and acquisitions could be deemed appropriate. Nor do we think that in the name of preserving competition, the spirit of collaboration that should exist among providers is doused, or when market forces exceed demand, conflicts in the marketplace should not be managed through a responsible regulatory environment.

We conclude from our CON experiences, and in reaction to the proposed revision to the purpose of Connecticut's CON process, that Connecticut's CON is better tied to a thoughtful, functional state health care plan and an articulated standards for the optimal allocation of resource against which the three goals of access, cost and quality are considered.

We believe access (e.g. underserved areas and populations) and quality (e.g. positive correlation between volume and outcomes) are best advocated for through this model. And, cost is best understood as a function of the degree to which the goals of access and quality can reasonably be achieved.

Regardless of where the wisdom of the Task Force ends up, any CON system requires an adequacy of resources, widespread public confidence, and right-sized expectations in terms of its purpose and limitations. Unfortunately,

these requirements for system success in Connecticut have not always been secure. Therefore, any statutory reconstruction of the system must also be accompanied by adjustments in the attitudes and willingness to support from those relying upon the system, including providers, public officials, and consumer advocates.

Once again, thank you for this opportunity to comment.



**Testimony of Connecticut Children's Medical Center
to the Certificate of Need Task Force
December 15, 2016**

Thank you for the opportunity to share our thoughts on the draft recommendations of the Certificate of Need (CON) Taskforce. Connecticut Children's Medical Center is dedicated to improving the physical and emotional health of children through family-centered care, research, education and advocacy. We embrace discovery, teamwork, integrity and excellence in all that we do. Connecticut Children's is a nationally recognized, 187-bed not-for-profit children's hospital serving as the primary teaching hospital for the University of Connecticut School of Medicine Department of Pediatrics.

A comprehensive array of pediatric services is available at our hospitals in Hartford and Waterbury, with neonatal intensive care units in Hartford (Level 4) and the University of Connecticut Health Center (Level 3), along with a state-of-the-art ambulatory surgery center, five specialty care centers and 10 practices across the state and in Massachusetts. Our Level 1 Pediatric Trauma Center and Primary Care Center are the busiest between Boston and New York. Connecticut Children's has more than 2,400 employees with a medical staff of more than 700, practicing in more than 30 subspecialties.

As the healthcare system undergoes significant transformation, hospitals continue to be focused on the health and well-being of every Connecticut citizen. The goals of this transformation are improved access to care, improved quality and safety, and reduced cost. The CON program plays an important role in achieving these goals.

CON safeguards the public's need for access to high quality health services, prevents unnecessary duplication of services, and sets a level playing field for deployment of healthcare resources in a financially responsible way.

Before commenting on the specific proposals as outlined in the December 5, 2016 document, it is important to emphasize several key principles that we urge the Taskforce to address as it considers changes to the CON program.

- The CON program must strive to ensure that all providers treat underserved populations, Medicaid recipients, and indigent persons.
- The CON program is not the regulatory vehicle to be used to analyze and investigate the cost of healthcare. The Lt. Governor's Healthcare Cabinet is the appropriate group to develop recommendations with respect to the cost of healthcare.

With respect to the specific proposals:

Actions Subject to Certificate of Need

Acquiring Equipment

- The CON program should maintain a review of all scanners, new technology, and non-hospital-based linear accelerators.
- The CON program should be modified to create an expedited procedure both in process and timeline for the review of the acquisition of new imaging equipment.
- The CON program should clarify that the current exemption applies to the replacement of equipment previously acquired through the CON process, including any scanner currently in operation that will be replaced by any other type of scanner.
- The CON program should expand the current exemption applied to the replacement of scanners to all equipment previously approved through CON, with notice to the Office of Health Care Access (OHCA).

Initiating Services/Increasing Capacity

- The CON program should maintain review of (1) New Hospitals; (2) New Specialty Hospitals; (3) New Freestanding Emergency Departments; (4) New Outpatient Surgical Facilities; (5) New cardiac services; and add (6) required review of two or more operating rooms in a three-year period.

Terminating Services

- The CON program should review terminations of (1) Hospital Emergency Departments; (2) Select hospital Inpatient Services; and (3) Hospital Mental Health/Substance Abuse Services.
- With respect to the termination of hospital outpatient services, the CON program should be modified to allow for the termination of certain outpatient services without CON review, such as physical or occupational therapy, sleep labs, diagnostic services, and/or multiple locations.
- The CON program should also review the termination of mental health/substance abuse services being proposed by entities other than hospitals.

Reduction of Services

- The CON program should not be modified to require CON review for the reduction of services.

Relocation of Services

- The CON program should allow the relocation of services within a reasonable geographic area without a CON review but with notice to OHCA.
- The CON program should allow for the relocation of services to an area with unmet needs through a state health planning process without a CON review but with notice to OHCA.

Conversions

- The CON program should maintain its current requirements for hospital conversions.

CON Application Review Criteria (OHCA CON Guidelines and Principles)

Application Criteria for Acquiring Equipment

- The first application criteria should be modified to assess whether the proposed project will serve Medicaid patients.

Application for Reducing or Terminating Services

- The CON program should not be modified to require CON review for the reduction of services.

CON Decision-Making Process

Organization: Who Reviews Applications, Renders Decisions, and Provides Public Input – Opportunities for Consumer Participation in the CON Process

- With respect to the Subject Matter Experts Panel, the proposal needs to be more specific to ensure that the panel members are serving as consultants or advisors, and that their comments are advisory only. The proposal needs to be more specific as to how the expert for a specific application will be selected and clarify that the panel comprises a list of approved persons from whom OHCA may choose to seek expert advice, but that OHCA is not required to do so.
- The proposal should be modified to allow the applicant, upon request, to have input into the selection of the expert and to comment on the expert's review.

Appeals Process: Mechanism through Which the Public Can Appeal a CON Decision

- The CON program should not be modified to allow intervenors to appeal a CON decision. This would be a significant departure from the existing administrative process and may be legally problematic.
- The CON program should not be modified to allow the public at large to appeal a CON decision. This would be a significant departure from the existing administrative process and may be legally problematic.

Transparency: Methods of Informing the Public about Pending Applications and Consumer Access to Information

- The proposal would require the applicant to state that it has made reasonable efforts to expand public notification. The proposal should be modified to indicate there will be no adverse impact on the applicant if the applicant is not able to carry out the expanded notification due to factors beyond its control (e.g., Town hall won't allow copies to be placed at a site or removes them).

CON Application Process

- The proposal for creating an expedited process should expand to cover the acquisition of imaging equipment.
- The proposal for creating an expedited process should expand to cover mental health and substance abuse facilities if they commit to serving Medicaid and other underserved populations.
- The proposal should be modified to require that all applications for terminations be handled through an expedited process of no more than 60 days.

CON Post-Approval Compliance Mechanism

- With respect to proposal 1, “willful” should not be removed from CGS 19a-653 (a) – lowering the threshold would unfairly punish healthcare facilities that are acting in good faith to comply.

CON Evaluation Methods

- The CON program should be expanded to allow OHCA the ability to consider the quality of services, provided such review is based on generally accepted, nationally recognized clinical best practices and guidelines.

We look forward to working with the Lieutenant Governor and members of the Taskforce.

Thank you for consideration of our position.

**TESTIMONY OF JOSEPH ADILETTA, PRESIDENT & CEO, DAY KIMBALL HEALTHCARE
SUBMITTED TO THE CERTIFICATE OF NEED TASKFORCE
THURSDAY, DECEMBER 15, 2016**

Day Kimball Healthcare appreciates the opportunity to submit comments and perspective on the draft recommendations made by the Certificate of Need (CON) Taskforce in its December 5, 2016 document. As an independent, nonprofit community hospital and healthcare system serving rural northeast Connecticut, Day Kimball Healthcare is acutely aware of the importance of ensuring access to high quality, safe and efficient healthcare services for all residents in our state.

The intention of the Certificate of Need process is to safeguard that access for the public while preventing unnecessary duplication of services and providing for the delivery of healthcare resources in a financially responsible manner. These are goals that Day Kimball Healthcare strives to fulfill within our own organization in the interest of the communities we serve and we support efforts that will strengthen fulfillment of those goals across the rest of our state as well.

Given our unique perspective as a small, independent community healthcare system, we ask that the Taskforce address the following key principles in evaluating any proposed changes to the CON process:

- The CON program must not discriminate against any specific type of provider and must treat all providers equally.
- The CON program must strive to ensure that all providers treat underserved populations, Medicaid recipients, and indigent persons.
- The CON program is not the regulatory vehicle to be used to analyze and investigate the cost of healthcare. The Lt. Governor's Healthcare Cabinet is the appropriate group to develop recommendations with respect to the cost of healthcare.

We also ask that the Taskforce give strong consideration to the following points regarding the specific proposals contained in its December 5, 2016 draft recommendations:

Actions Subject to Certificate of Need

Acquiring Equipment

- The CON program should maintain a review of all scanners, new technology, and non-hospital-based linear accelerators.
- The CON program should be modified to create an expedited procedure both in process and timeline for the review of the acquisition of new imaging equipment.
- The CON program should clarify that the current exemption applies to the replacement of equipment previously acquired through the CON process, including any scanner currently in operation that will be replaced by any other type of scanner.
- The CON program should expand the current exemption applied to the replacement of scanners to all equipment previously approved through CON, with notice to the Office of Health Care Access (OHCA).

Initiating Services/Increasing Capacity

- The CON program should maintain review of (1) New Hospitals; (2) New Specialty Hospitals; (3) New Freestanding Emergency Departments; (4) New Outpatient Surgical Facilities; (5) New cardiac services; and add (6) required review of two or more operating rooms in a three-year period.

Terminating Services

- The CON program should review terminations of (1) Hospital Emergency Departments; (2) Select hospital Inpatient Services; and (3) Hospital Mental Health/Substance Abuse Services.
- With respect to the termination of hospital outpatient services, the CON program should be modified to allow for the termination of certain outpatient services without CON review, such as physical or occupational therapy, sleep labs, diagnostic services, and/or multiple locations.
- The CON program should also review the termination of mental health/substance abuse services being proposed by entities other than hospitals.

Reduction of Services

- The CON program should not be modified to require CON review for the reduction of services.

Relocation of Services

- The CON program should allow the relocation of services within a reasonable geographic area without a CON review but with notice to OHCA.
- The CON program should allow for the relocation of services to an area with unmet needs through a state health planning process without a CON review but with notice to OHCA.

Transfer of Ownership

- The CON program should not have an inherent bias against any type of provider. It must treat all providers equally, and require the review of the transfer of ownership of a healthcare facility or certain large practices by any acquirer (e.g., a hospital, a hospital system, insurer, investor, and any other entity seeking to acquire ownership or control of such healthcare facility or certain large group practice.)

Conversions

- The CON program should maintain its current requirements for hospital conversions.

CON Application Review Criteria (OHCA CON Guidelines and Principles)

Application Criteria for Acquiring Equipment

- The first application criteria should be modified to assess whether the proposed project will serve Medicaid patients.

Application for Reducing or Terminating Services

- The CON program should not be modified to require CON review for the reduction of services.

CON Decision-Making Process

Organization: Who Reviews Applications, Renders Decisions, and Provides Public Input – Opportunities for Consumer Participation in the CON Process

- With respect to the Subject Matter Experts Panel, the proposal needs to be more specific to ensure that the panel members are serving as consultants or advisors, and that their comments are advisory only. The proposal needs to be more specific as to how the expert for a specific application will be selected and clarify that the panel comprises a list of approved persons from whom OHCA may choose to seek expert advice, but that OHCA is not required to do so.
- The proposal should be modified to allow the applicant, upon request, to have input into the selection of the expert and to comment on the expert's review.

Appeals Process: Mechanism through Which the Public Can Appeal a CON Decision

- The CON program should not be modified to allow intervenors to appeal a CON decision. This would be a significant departure from the existing administrative process and may be legally problematic.
- The CON program should not be modified to allow the public at large to appeal a CON decision. This would be a significant departure from the existing administrative process and may be legally problematic.

Transparency: Methods of Informing the Public about Pending Applications and Consumer Access to Information

- The proposal would require the applicant to state that it has made reasonable efforts to expand public notification. The proposal should be modified to indicate there will be no adverse impact on the applicant if the applicant is not able to carry out the expanded notification due to factors beyond its control (e.g., Town hall won't allow copies to be placed at a site or removes them).

CON Application Process

- The proposal for creating an expedited process should expand to cover the acquisition of imaging equipment.
- The proposal for creating an expedited process should expand to cover mental health and substance abuse facilities if they commit to serving Medicaid and other underserved populations.
- The proposal should be modified to require that all applications for terminations be handled through an expedited process of no more than 60 days.

CON Post-Approval Compliance Mechanism

- With respect to proposal 1, "willful" should not be removed from CGS 19a-653 (a) – lowering the threshold would unfairly punish healthcare facilities that are acting in good faith to comply.

CON Evaluation Methods

- The CON program should be expanded to allow OHCA the ability to consider the quality of services, provided such review is based on generally accepted, nationally recognized clinical best practices and guidelines.

We thank you again for the opportunity to provide insight into this important process and we look forward to working with the Lieutenant Governor and the rest of the Taskforce members. Thank you for your consideration.

**TESTIMONY OF
MIDDLESEX HOSPITAL
SUBMITTED TO
THE CERTIFICATE OF NEED TASKFORCE
THURSDAY, DECEMBER 15, 2016**

Middlesex Hospital appreciates this opportunity to present comments on the draft recommendations of the Certificate of Need (CON) Taskforce.

As the healthcare system undergoes significant transformation, hospitals continue to be focused on the health and well-being of every Connecticut citizen. The goals of this transformation are improved access to care, improved quality and safety, and reduced cost. The CON program plays an important role in achieving these goals.

CON safeguards the public's need for access to high quality health services, prevents unnecessary duplication of services, and sets a level playing field for deployment of healthcare resources in a financially responsible way.

Before commenting on the specific proposals as outlined in the December 5, 2016 document, it is important to emphasize several key principles that we urge the Taskforce to address as it considers changes to the CON program.

- The CON program must not discriminate against any specific type of provider and must treat all providers equally.
- The CON program must strive to ensure that all providers treat underserved populations, Medicaid recipients, and indigent persons.
- The CON program is not the regulatory vehicle to be used to analyze and investigate the cost of healthcare. The Lt. Governor's Healthcare Cabinet is the appropriate group to develop recommendations with respect to the cost of healthcare.

With respect to the specific proposals:

Actions Subject to Certificate of Need

Acquiring Equipment

- The CON program should maintain a review of all scanners, new technology, and non-hospital-based linear accelerators.
- The CON program should be modified to create an expedited procedure both in process and timeline for the review of the acquisition of new imaging equipment.

- The CON program should clarify that the current exemption applies to the replacement of equipment previously acquired through the CON process, including any scanner currently in operation that will be replaced by any other type of scanner.
- The CON program should expand the current exemption applied to the replacement of scanners to all equipment previously approved through CON, with notice to the Office of Health Care Access (OHCA).

Initiating Services/Increasing Capacity

- The CON program should maintain review of (1) New Hospitals; (2) New Specialty Hospitals; (3) New Freestanding Emergency Departments; (4) New Outpatient Surgical Facilities; (5) New cardiac services; and add (6) required review of two or more operating rooms in a three-year period.

Terminating Services

- The CON program should review terminations of (1) Hospital Emergency Departments; (2) Select hospital Inpatient Services; and (3) Hospital Mental Health/Substance Abuse Services.
- With respect to the termination of hospital outpatient services, the CON program should be modified to allow for the termination of certain outpatient services without CON review, such as physical or occupational therapy, sleep labs, diagnostic services, and/or multiple locations.
- The CON program should also review the termination of mental health/substance abuse services being proposed by entities other than hospitals.

Reduction of Services

- The CON program should not be modified to require CON review for the reduction of services.

Relocation of Services

- The CON program should allow the relocation of services within a reasonable geographic area without a CON review but with notice to OHCA.
- The CON program should allow for the relocation of services to an area with unmet needs through a state health planning process without a CON review but with notice to OHCA.

Transfer of Ownership

- The CON program should not have an inherent bias against any type of provider. It must treat all providers equally, and require the review of the transfer of ownership of a healthcare facility or certain large practices by any acquirer (e.g., a hospital, a hospital system, insurer, investor, and any other

entity seeking to acquire ownership or control of such healthcare facility or certain large group practice.)

Conversions

- The CON program should maintain its current requirements for hospital conversions.

CON Application Review Criteria (OHCA CON Guidelines and Principles)

Application Criteria for Acquiring Equipment

- The first application criteria should be modified to assess whether the proposed project will serve Medicaid patients.

Application for Reducing or Terminating Services

- The CON program should not be modified to require CON review for the reduction of services.

CON Decision-Making Process

Organization: Who Reviews Applications, Renders Decisions, and Provides Public Input – Opportunities for Consumer Participation in the CON Process

- With respect to the Subject Matter Experts Panel, the proposal needs to be more specific to ensure that the panel members are serving as consultants or advisors, and that their comments are advisory only. The proposal needs to be more specific as to how the expert for a specific application will be selected and clarify that the panel comprises a list of approved persons from whom OHCA may choose to seek expert advice, but that OHCA is not required to do so.
- The proposal should be modified to allow the applicant, upon request, to have input into the selection of the expert and to comment on the expert's review.

Appeals Process: Mechanism through Which the Public Can Appeal a CON Decision

- The CON program should not be modified to allow intervenors to appeal a CON decision. This would be a significant departure from the existing administrative process and may be legally problematic.
- The CON program should not be modified to allow the public at large to appeal a CON decision. This would be a significant departure from the existing administrative process and may be legally problematic.

Transparency: Methods of Informing the Public about Pending Applications and Consumer Access to Information

- The proposal would require the applicant to state that it has made reasonable efforts to expand public notification. The proposal should be modified to indicate there will be no adverse impact on the applicant if the applicant is not able to carry out the expanded notification due to factors beyond its control (e.g., Town hall won't allow copies to be placed at a site or removes them).

CON Application Process

- The proposal for creating an expedited process should expand to cover the acquisition of imaging equipment.
- The proposal for creating an expedited process should expand to cover mental health and substance abuse facilities if they commit to serving Medicaid and other underserved populations.
- The proposal should be modified to require that all applications for terminations be handled through an expedited process of no more than 60 days.

CON Post-Approval Compliance Mechanism

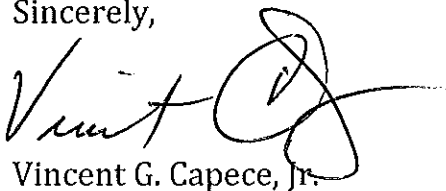
- With respect to proposal 1, "willful" should not be removed from CGS 19a-653 (a) – lowering the threshold would unfairly punish healthcare facilities that are acting in good faith to comply.

CON Evaluation Methods

- The CON program should be expanded to allow OHCA the ability to consider the quality of services, provided such review is based on generally accepted, nationally recognized clinical best practices and guidelines.

Thank you for consideration of our position.

Sincerely,



Vincent G. Capece, Jr.
President/CEO

VGC:aac



Comments of Michael Daglio

President, Norwalk Hospital and Chief Strategy Officer, Western Connecticut Health Network, Inc.

(Danbury, New Milford and Norwalk Hospitals)

Submitted to the CON Task Force

Thursday, December 15, 2016

Western Connecticut Health Network, Inc. (WCHN) appreciates the opportunity to provide written comments relative to the Certificate of Need (CON) Task Force recommendations.

At WCHN, our goal is to transform the health of our communities so they are thriving and well, by providing care at the most appropriate care setting. In doing so, our work is aligned with the Triple Aim of reducing costs, while improving health outcomes and the patient experience. We are committed to this effort with much thoughtful and innovative work underway despite a challenging fiscal environment, burdensome hospital tax and the lowest Medicaid reimbursement rates in the country.

In the current rapidly evolving era of health care reform and the associated transformation, health care organizations are striving to address the health needs of their local communities with more innovative solutions. Collaboration and partnerships enable providers to improve and enhance the quality of care provided while addressing increasing demands of the health care environment. This approach aligns with the State's objectives outlined in the *Statewide Health Care Facilities and Services Plan* – improve health; increase access, continuity, and quality; prevent duplication; and provide financial stability and cost-containment. The CON program plays an important role in achieving these goals aimed at promoting health equity and fulfilling unmet needs. CONs also set a level playing field for deployment of healthcare resources in a financially responsible way.

As an organization, we acknowledge the Office of Health Care Access (OHCA) staff for their work in implementing CON regulations and standards but offer the viewpoint that the CON process today does not fully respond to the challenges of a contemporary healthcare market. In reviewing the recommendations brought forward, we appreciate the opportunity to express our perspective with respect to the specific proposals provided in the December 5, 2016 document:

Actions Subject to the Certificate of Need

Acquiring Equipment

- The CON program should maintain a review of advanced imaging equipment, including MRI, CT, and PET CT scanners, new technology and non-hospital located linear accelerators.
- The CON program should clarify and expand current exemptions applied to all equipment previously approved through CON, with notification only to OHCA.

Initiating Services/Increasing Capacity

- The CON process should review the establishment of new hospitals, specialty hospitals, free standing emergency departments, new outpatient surgical facilities, and the addition of two or more operating rooms in a three-year period.

Terminating Services

- CON review should not be required for the termination of specific inpatient and outpatient services, including physical therapy, occupational therapy, sleep laboratories, diagnostic services, and services where multiple locations are offered.
- OHCA's authority should be limited so that specific criteria in Agreed Settlements for reporting should not be contrary to this understanding.

Reduction of Services

- The CON program should remain as structured and not require a CON to reduce services.

Relocation of Services

- The CON program should permit a provider to relocate existing services without a CON to a new location within the providers existing service area and with notice to OHCA.

Transfers of Ownership

- The CON program should treat all providers equally, and require the review of the transfer of ownership of a healthcare facility or certain large practices by any acquirer. By way of example, for-profit entities have acquired large group practices without the same requirement, thereby creating an uneven playing field.

Conversions

- The CON program should maintain its current requirements for hospital conversions.

CON Application Review Criteria

- The twelve guidelines and principles reflected in §19a-639(a) should be modified to explicitly address the provision of services to Medicaid recipients.

CON Decision-Making Process

Organization

- The proposal for a Subject Matter Expert Panel needs to be more specific as to how the expert for a specific application will be selected, how the Applicant can have input into the selection of the expert, and clarify that the panel is acting in an advisory capacity only.

Public Input

- The CON program should maintain the existing administrative process which defines how consumers can participate in the OHCA CON process and who can be designated as an intervenor.

Appeals Process

- The CON program should not be modified to allow appeals of the CON decision by either an intervenor or consumer.

Transparency

- The CON program should recognize and accept the applicant's attestation that it has made reasonable efforts to provide public notification of its proposed CON and associated actions.

CON Application Process

- The CON program should create an expedited application and review process to cover mental health and substance abuse facilities if they commit to serving Medicaid and other underserved populations.
- The CON program should be modified to require all applications for terminations be determined within 60 days.

CON Post-Approval Compliance Mechanism and CON Evaluation Methods

- In setting post-approval requirements, the CON approval should establish time limits for reporting with a rationale for the frequency and duration of these reports and educate the health care community about how such reporting enhances OHCA's oversight of the goals of the CON process.

In closing, we urge the Taskforce to address the CON program with the following understanding as it evaluates potential changes:

- The CON program must strive to treat all providers equally.
- The CON program must ensure all providers are evaluated equally on their ability to address access and treat underserved populations, Medicaid recipients and indigent persons.
- A growing Medicare-eligible population and changing reimbursement models from CMS are pushing providers to take on more financial and utilization risk for the care that they deliver. The CON program must recognize the evolving health care delivery system and support innovative solutions by providers who seek to expand access, improve quality and reduce the cost of care in their respective communities.

Thank you for your consideration of our position. I welcome your questions at Michael.Daglio@wchn.org.

Michael Daglio

**TESTIMONY OF
STAMFORD HOSPITAL
SUBMITTED TO
THE CERTIFICATE OF NEED TASKFORCE
THURSDAY, DECEMBER 15, 2016**

Stamford Hospital (SH) appreciates this opportunity to present comments on the draft recommendations of the Certificate of Need (CON) Taskforce. As an acute care hospital in southwestern Fairfield County, we are committed to providing all of our patients with high quality, patient-focused health services including underserved populations, Medicaid recipients and the indigent in our communities.

As the healthcare delivery system is transformed more toward a value-based care model, the goals remain improved access to care, improved quality and safety, and reduced costs. The CON process is intended to safeguard the public, prevent unnecessary duplication of services and, importantly, set a level playing field for deployment of healthcare resources in a financially responsible way. The CON program should not discriminate against any specific type of provider and should ensure that all providers treat underserved populations, and Medicaid recipients. In so doing, the state would indeed provide more of a level playing field for hospitals.

Stamford Hospital concurs with the Connecticut Hospital Association's position as it pertains to actions subject to Certificate of Need, which includes acquiring equipment, initiating services/increasing capacity; terminating services, reduction and relocation of services; transfer of ownership and conversions that meet certain thresholds.

SH concurs with the CHA position on CON Application Review Criteria (OHCA CON Guidelines and Principles) as follows: The first application criteria should be modified to assess whether the proposed project will serve Medicaid patients.

SH concurs with the CHA position regarding Application for Reducing or Terminating Services, as the CON program should not be modified to require CON review for the reduction of services.

With respect to the CON Decision-Making Process, SH concurs with the position of CHA, specifically as it pertains to the Subject Matter Experts Panel, which needs to be more specific to ensure that the panel members are serving as consultants or advisors, and that their comments are advisory only. We agree with CHA in that the proposal should be modified to allow the applicant, upon request, to have input into the selection of the expert and to comment on the expert's review. Similarly, we agree with the CHA position that the appeals process should not be modified to allow intervenors to appeal a CON decision, as it would be a significant departure from existing administrative process and may be legally problematic.

Also, the CON program should not be modified to allow the public at large to appeal a CON decision. This would also be a significant departure from the existing administrative process and may be legally problematic.

SH concurs with CHA on transparency and methods of informing the public about pending applications and consumer access to information. The proposal should be modified to indicate there will be no adverse impact on the application due to factors beyond its control.

The CON application process should include a proposal to create an expedited process to cover the acquisition of imaging equipment; it should expand to cover mental health and substance abuse facilities if they commit to serving Medicaid and other underserved populations. The proposal should be modified to require that all applications for terminations be handled through an expedited process of no more than 60 days.

With respect to proposal 1 in the CON Post-Approval Compliance Mechanism, “willful” should not be removed from CGS 19-a653 (a) – lowering the threshold would unfairly punish healthcare facilities that are acting in good faith to comply.

With respect to the CON Evaluation Methods, the CON program should be expanded to allow OHCA the ability to consider the quality of services, provided such review is based on generally accepted, nationally recognized clinical best practices and guidelines.

Our understanding is that the Lt. Governor’s Healthcare Cabinet will develop recommendations with respect to the cost of healthcare. We thank you for consideration of our position in this matter.

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**TESTIMONY OF
VINCENT C. CAPONI, PRESIDENT AND CEO
ST. VINCENT'S MEDICAL CENTER
SUBMITTED TO
THE CERTIFICATE OF NEED TASKFORCE
THURSDAY, DECEMBER 15, 2016**

My name is Vincent Caponi, and I serve as the President and CEO of St. Vincent's Medical Center in Bridgeport.

On behalf of our patients, our associates, medical staff and the patients and families we serve, St. Vincent's Medical Center appreciates this opportunity to present comments on the draft recommendations of the Certificate of Need (CON) Taskforce.

For more than 113 years, St. Vincent's has served the Greater Bridgeport community. We are the largest employer in the City of Bridgeport with more than 3,000 associates, including our medical staff. In 2015, St. Vincent's total direct economic impact on our community was greater than \$900 million.

As the healthcare system undergoes significant transformation, hospitals continue to be focused on the health and well-being of every Connecticut citizen. The goals of this transformation are improved access to care, improved quality and safety, and reduced cost. The CON program plays an important role in achieving these goals.

St. Vincent's Medical Center supports the efforts of the CON Taskforce to achieve these goals. We are also driving toward the healthcare reform objective of improving care quality and accountability, and the shift from payment for the volume of services provided to payment for value – focusing on the outcomes and quality of care people receive. Like all hospitals in Connecticut, we are also diligently exploring cost saving opportunities, including outsourcing of services, shared service centers, consolidation of services and possible changes in scope of services.

CON safeguards the public's need for access to high quality health services, prevents unnecessary duplication of services, and sets a level playing field for deployment of healthcare resources in a financially responsible way.

Before commenting on the specific proposals as outlined in the December 5, 2016 document, we believe it is important to state that we endorse the principles urged by the Connecticut Hospital Association in its testimony, as follows, as the Taskforce considers changes to the CON program:

- The CON program must not discriminate against any specific type of provider and must treat all providers equally.
- The CON program must strive to ensure that all providers treat underserved populations, Medicaid recipients, and indigent persons.
- The CON program is not the regulatory vehicle to be used to analyze and investigate the cost of healthcare. The Lt. Governor's Healthcare Cabinet is the appropriate group to develop recommendations with respect to the cost of healthcare.

With respect to the specific proposals:

Actions Subject to Certificate of Need

Acquiring Equipment

- The CON program should maintain a review of all scanners, new technology, and non-hospital-based linear accelerators.
- The CON program should be modified to create an expedited procedure both in process and timeline for the review of the acquisition of new imaging equipment.
- The CON program should clarify that the current exemption applies to the replacement of equipment previously acquired through the CON process, including any scanner currently in operation that will be replaced by any other type of scanner.
- The CON program should expand the current exemption applied to the replacement of scanners to all equipment previously approved through CON, with notice to the Office of Health Care Access (OHCA).

Initiating Services/Increasing Capacity

- The CON program should maintain review of (1) New Hospitals; (2) New Specialty Hospitals; (3) New Freestanding Emergency Departments; (4) New Outpatient Surgical Facilities; (5) New cardiac services; and add (6) required review of two or more operating rooms in a three-year period.

Terminating Services

- The CON program should review terminations of (1) Hospital Emergency Departments; (2) Select hospital Inpatient Services; and (3) Hospital Mental Health/Substance Abuse Services.
- With respect to the termination of hospital outpatient services, the CON program should be modified to allow for the termination of certain outpatient services without CON review, such as physical or occupational therapy, sleep labs, diagnostic services, and/or multiple locations.
- The CON program should also review the termination of mental health/substance abuse services being proposed by entities other than hospitals.

Reduction of Services

- The CON program should not be modified to require CON review for the reduction of services.

Relocation of Services

- The CON program should allow the relocation of services within a reasonable geographic area without a CON review but with notice to OHCA.
- The CON program should allow for the relocation of services to an area with unmet needs through a state health planning process without a CON review but with notice to OHCA.

Transfer of Ownership

- The CON program should not have an inherent bias against any type of provider. It must treat all providers equally, and require the review of the transfer of ownership of a healthcare facility or certain large practices by any acquirer (e.g., a hospital, a hospital system, insurer, investor, and any other entity seeking to acquire ownership or control of such healthcare facility or certain large group practice.)

Conversions

- The CON program should maintain its current requirements for hospital conversions.

CON Application Review Criteria (OHCA CON Guidelines and Principles)

Application Criteria for Acquiring Equipment

- The first application criteria should be modified to assess whether the proposed project will serve Medicaid patients.

Application for Reducing or Terminating Services

- The CON program should not be modified to require CON review for the reduction of services.

CON Decision-Making Process

Organization: Who Reviews Applications, Renders Decisions, and Provides Public Input – Opportunities for Consumer Participation in the CON Process

- With respect to the Subject Matter Experts Panel, the proposal needs to be more specific to ensure that the panel members are serving as consultants or advisors, and that their comments are advisory only. The proposal needs to be more specific as to how the expert for a specific application will be selected and clarify that the panel comprises a list of approved persons from whom OHCA may choose to seek expert advice, but that OHCA is not required to do so.
- The proposal should be modified to allow the applicant, upon request, to have input into the selection of the expert and to comment on the expert's review.

Appeals Process: Mechanism through Which the Public Can Appeal a CON Decision

- The CON program should not be modified to allow intervenors to appeal a CON decision. This would be a significant departure from the existing administrative process and may be legally problematic.
- The CON program should not be modified to allow the public at large to appeal a CON decision. This would be a significant departure from the existing administrative process and may be legally problematic.

Transparency: Methods of Informing the Public about Pending Applications and Consumer Access to Information

- The proposal would require the applicant to state that it has made reasonable efforts to expand public notification. The proposal should be modified to indicate there will be no adverse impact on the applicant if the applicant is not able to carry out the expanded notification due to factors beyond its control (e.g., Town hall won't allow copies to be placed at a site or removes them).

CON Application Process

- The proposal for creating an expedited process should expand to cover the acquisition of imaging equipment.
- The proposal for creating an expedited process should expand to cover mental health and substance abuse facilities if they commit to serving Medicaid and other underserved populations.
- The proposal should be modified to require that all applications for terminations be handled through an expedited process of no more than 60 days.

CON Post-Approval Compliance Mechanism

- With respect to proposal 1, “willful” should not be removed from CGS 19a-653 (a) – lowering the threshold would unfairly punish healthcare facilities that are acting in good faith to comply.

CON Evaluation Methods

- The CON program should be expanded to allow OHCA the ability to consider the quality of services, provided such review is based on generally accepted, nationally recognized clinical best practices and guidelines.

St. Vincent's Medical Center appreciates the work of the CON Taskforce and looks forward to continuing to share our input with members of the taskforce, including sharing our own best practices and additional information about our efforts to transform our healthcare system and to work with them to do so within the State of Connecticut.

Thank you for this opportunity to share our thoughts on this important work.

TESTIMONY OF
Joseph Connolly
Regional Vice President
Marketing, Communications &
Connecticut Government Relations
Trinity Health-New England

SUBMITTED TO THE
CERTIFICATE OF NEED TASK FORCE
Thursday, December 15, 2016

Trinity Health-New England is honored to take this opportunity to submit written testimony on the Draft Recommendations of the Certificate of Need Task Force as presented today.

By way of background, Trinity Health-New England (“TH-NE”) is a regional health ministry which includes both Saint Francis Hospital and Medical Center, Inc. and Mount Sinai Rehabilitation Hospital, Inc., in Hartford, Saint Mary’s Hospital, Inc., in Waterbury, Johnson Memorial Hospital, Inc., in Stafford Springs and The Mercy Hospital, Inc., in Springfield, Massachusetts. In addition, our ministry includes physician practices, a behavioral health hospital in Massachusetts, home health and various post-acute care services. We are more than 13,000 health care providers committed to providing compassionate care and improving the health of our community. We are also part of Trinity Health, a nationwide ministry with more than 90 hospitals, making us one of the largest health care ministries in the United States.

We believe the Certificate of Need (“CON”) process plays an important role in regulating healthcare services throughout this state. CONs safeguard the public’s need for access to high quality health services, prevent unnecessary duplication of services and guide the deployment of healthcare resources in a financially responsible way. We believe that the CON process and our cooperative and mutually respectful partnership with OHCA have served our ministry and, therefore, our communities well.

As a result, we concur with a number of the Task Force's recommendations to support existing CON regulations currently in place. We feel that maintaining the current CON process on a number of recommendations is appropriate. This would apply to the acquisition of equipment, reduction of services, relocation of services and termination of services to name a few. The existing Twelve OHCA Guidelines and Principles - §19a-639(a) have worked successfully for us in the past as we became TH-NE and continue to guide our journey going forward. Making these processes more complex would provide no additional benefit and significantly may impair our ability to meet our community's needs.

We acknowledge that there are always opportunities for improving the process and expediting decision making. In today's healthcare market, rapid change and flexibility are becoming the new norm. During these times of limited resources, an expedited process could be of benefit to all concerned. For example, the development of an expedited CON process for the establishment of new facilities or services or increasing capacity if the service/facility is located in a "high need" area, and for the termination of services due to a loss of physicians is of great merit. In addition, TH-NE embraces those recommendations that the main intent is to expedite the CON process.

TH-NE believes that the current CON process has been of great value, but there are several areas that can be improved. The first is the termination of services of which TH-NE is in agreement that the current process can be further refined by identifying select inpatient/outpatient services. The second is expanding the transfer of ownership oversight beyond just a hospital as the acquirer. The recommendations listed in the CON decision-making process related to review of the application and rendering decisions are ones that TH-NE may be open to if we had a better understanding of each of these alternatives and how they may be an improvement to the process we have had confidence in. The recommendation for the CON post approval compliance mechanisms that TH-NE considers an improvement would be the alignment of the OHCA and DPH licensing division inspection and monitoring activities. We believe that this recommendation would help to expedite and better coordinate the process.

We at Trinity Health-New England believe that the recommendations aforementioned will maintain the elements of the current system that work well, while taking advantage of opportunities for improvement.

Thank you again for this opportunity and we trust that you will give our comments serious consideration.

TESTIMONY OF
Yale-New Haven Health System
SUBMITTED TO
THE CERTIFICATE OF NEED TASKFORCE
THURSDAY, DECEMBER 15, 2016

Yale New Haven Health (YNHHS) appreciates this opportunity to submit comments on the draft recommendations of the Certificate of Need (CON) Taskforce.

With the significant transformation of the health care system, YNHHS, and our affiliates, Bridgeport, Greenwich, Lawrence & Memorial, Yale-New Haven and Westerly Hospitals, along with our medical foundation, North East Medical Group, continue to focus on access to high quality health care and the well-being of every Connecticut citizen. Together with our nearly 25,000 employees, YNHHS provides care to 35 percent of the people insured by Medicaid.

In concurrence with the Connecticut Hospital Association, we urge the Taskforce to embrace the principles they have outlined in their testimony. They are:

- *The CON program must not discriminate against any specific type of provider or other organization in the healthcare industry and must treat all of these organizations equally.*
- *The CON program must strive to ensure that all providers treat underserved populations, Medicaid recipients, and medically indigent persons.*
- *The CON program is not the regulatory vehicle to be used to analyze and investigate the cost of healthcare. The Lt. Governor's Healthcare Cabinet is the appropriate group to develop recommendations with respect to the cost of healthcare.*

With respect to the specific proposals as outlined in the December 5, 2016 document, we respectfully urge the following:

Actions Subject to Certificate of Need

Acquiring Equipment

- The CON program should maintain a review of all scanners, new technology, and non-hospital-based linear accelerators.
- The CON program should be modified to create an expedited procedure both in process and timeline for the review of the acquisition of new imaging equipment.

- The CON program should clarify that the current exemption applies to the replacement of equipment previously acquired through the CON process, including any scanner currently in operation that will be replaced by any other type of scanner.
- The CON program should expand the current exemption applied to the replacement of scanners to all equipment previously approved through CON, with notice to the Office of Health Care Access (OHCA).

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- The CON program should maintain review of (1) New Hospitals; (2) New Specialty Hospitals; (3) New Freestanding Emergency Departments; (4) New Outpatient Surgical Facilities; (5) New cardiac services; and add (6) required review of two or more operating rooms in a three-year period.

Terminating Services

- The CON program should review terminations of (1) Hospital Emergency Departments; (2) Select hospital Inpatient Services; and (3) Hospital Mental Health/Substance Abuse Services.
- With respect to the termination of hospital outpatient services, the CON program should be modified to allow for the termination of certain outpatient services without CON review, such as physical or occupational therapy, sleep labs, diagnostic services, and/or multiple locations.
- The CON program should also review the termination of mental health/substance abuse services being proposed by entities other than hospitals.
- The CON program should be expanded to allow closure of very low volume inpatient and outpatient services with notification of OHCA.

Reduction of Services

- The CON program should not be modified to require CON review for the reduction of services.

Relocation of Services

- The CON program should allow the relocation of services within one's primary service area without a CON review and with notice to OHCA.
- The CON program should allow for the relocation of services to an area with unmet needs through a state health planning process without a CON review and with notice to OHCA.

Transfer of Ownership

- The CON program should treat all health care providers and organizations equally, and require the review of the transfer of ownership of a healthcare facility or certain large practices by any acquirer (e.g., a hospital, a hospital system, insurer, investor, and any other entity seeking to acquire ownership or control of such healthcare facility or certain large group practice.)

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- The CON program should maintain its current requirements for hospital conversions.

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CON Application Process

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- The proposal for creating an expedited process should expand to cover mental health and substance abuse facilities if they commit to serving Medicaid and other underserved populations.
- The proposal should be modified to require that all applications for terminations be handled through an expedited process of no more than 60 days.

CON Post-Approval Compliance Mechanism

- With respect to proposal 1, “willful” should not be removed from CGS 19a-653 (a) – lowering the threshold would unfairly punish healthcare facilities that are acting in good faith to comply.

CON Evaluation Methods

- The CON program should be expanded to allow OHCA the ability to consider the quality of services, provided such review is based on generally accepted, nationally recognized clinical best practices and guidelines.

Together with CHA, we look forward to working with Lieutenant Governor Wyman and members of the Taskforce. Thank you for your consideration of our position.

STATEMENT

of the

American Medical Association

to the

Connecticut Certificate of Need (CON) Task Force

RE: Certificate of Need (CON) Task Force Draft Recommendations, December 15, 2016

The American Medical Association (AMA) appreciates the opportunity to provide comments regarding the Certificate of Need (CON) Task Force Draft Recommendations. The AMA strongly supports and encourages competition between and among health care providers, facilities and insurers as a means of promoting the delivery of high quality, cost effective health care and providing patients with more choices for health care services and coverage that stimulates innovation and incentivizes improved care, lower costs and expanded access. Because CON programs restrict competition, the AMA consistently advocates for CON program repeal.

I. CON programs and their failure to achieve stated goals.

The advocates of CON program frequently claim that CON programs are necessary to control health care costs and/or improve health care quality and access. The great weight of the evidence shows that CON has failed to achieve these goals.

A. CON does not control health care costs, and, in fact, may increase health care costs.

There is a compelling body of peer-reviewed academic research spanning over many years, as well as numerous state legislative-commissioned CON studies, demonstrating that CON programs have failed to achieve their purported purpose—to restrain health care costs. In fact, some studies have concluded that CON programs have actually increased health care costs. Going only as far back as 1998, two noted public policy scholars from Duke University, Christopher Conover and Frank Sloan, published a study that examined the purported cost-control claims of CON over a twenty-year period and focused on whether CON repeal led to increased health care costs. The study concluded that “[t]here is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations.”¹ Likewise, another review of CON research concluded that “[a]t a minimum, it seems fair to conclude that direct CON effects on costs are not negative.”²

¹ Christopher J. Conover & Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?* 23 *Journal of Health Policy and Law* 3, 455-81 (1998).

² David S. Salkever, Regulation of Prices and Investment in Hospitals in the United States, in *Handbook of Health Economics* 1527 (Culyer & Newhouse eds., Elsevier Science vol. 1B, 2000).

Similarly, in 2000 a noted CON economist, Michael Morrissey, PhD, stated that:

[CON] has attracted many empirical studies. They find virtually no cost containment effects. However, they do show higher profits and restricted entry by for-profit hospitals, hospital systems, and contract management firms. The rather exhaustive literature on CON yields virtually no evidence that it has controlled health care costs.³

Dr. Morrissey's article also found that "[t]he [CON] mechanism serves to prevent or delay the entry of new sources of supply. The empirical evidence suggests that as a result of CON, hospital costs are no lower and may be higher. Prices are higher."⁴ Another study by Dr. Morrissey, along with David Grabowski, PhD and Robert Ohsfeldt, PhD, stated that "[s]tate legislators have little to fear in the way of cost consequences from the repeal of CON laws. [...] CON laws are not an effective means of limiting Medicaid expenditures."⁵ Another article in 2007 found that "CON laws had a positive, statistically significant relationship to hospital costs per adjusted admission."⁶ Still more recent researched, published in 2013, in *Medical Care Research Review*, concluded that:

[S]tates that dropped CON experienced lower costs per patient for [certain cardiac procedures]. Average Medicare reimbursement was lower [...] in states that dropped CON. The cost savings from removing CON regulations slightly exceed the total fixed costs of new [cardiac surgery] facilities that entered after deregulation.⁷

In addition to the findings of this peer-reviewed evidence, a litany of state CON studies demonstrates that CON not only does not control costs, but may actually increase costs. A 2007 report from the Lewin Group, entitled *An Evaluation of Illinois' Certificate of Need Program*, concluded that "review of the evidence indicates that CONs rarely reduce health care costs, and on occasion, increase costs in some states."⁸ In 2006, Georgia State University provided a report to the Georgia Commission on the "Efficacy of the Certificate of Need Program" pursuant to a request from the state legislature, which created the commission. This report stated that "[a]cross all markets, states ranked as having the most rigorous CON regulation have statistically significantly less competition than non-CON states" and that "[l]ower levels of competition are associated with higher

³ Michael A. Morrissey, *State Health Care Reform: Protecting the Provider, in American Health Care: Government, Market Processes, and the Public Interest* 243-66 (Roger D. Feldman ed., Transaction Publishers 2000).

⁴ Id.

⁵ David C. Grabowski, Robert L. Ohsfeldt, & Mark A. Morrissey, *The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Expenditures*, 40 *Inquiry* 2, 146-57 (2003).

⁶ Patrick A Rivers, Myron D. Fottler & Mustafa Z. Younis, Abstract, Does Certificate of Need Really Contain Hospital Costs in the United States? 66 *Health Education Journal* 3, 229-44 (Sept. 2007).

⁷ Vivian Ho & Meei-Hsiang Ku-Goto, abstract, State Deregulation and Medicare Costs for Acute Cardiac Care, 70 *Medical Care Research Review* 2, 185-205 (Apr. 2013).

⁸ The Lewin Group, *An Evaluation of Illinois' Certificate of Need Program*, State of Illinois, Commission on Government Forecasting and Accountability, February 2007.

costs.”⁹ It also found that “CON regulation is associated with higher private inpatient costs” and that “increased CON rigor is associated with higher costs.”¹⁰ Another 2006 study performed by the Missouri Senate Interim Committee on Certificate of Need stated that CON “acts as an artificial barrier to entry, stifling competition and innovation in the healthcare market” and “[n]ot only does this lead to higher healthcare costs but it also limits patient choice.”¹¹ Further, a 2003 Michigan CON study found that “[t]here is little evidence that CON results in a reduction in costs and some evidence to suggest the opposite,”¹² while a 1999 Washington State CON study reached a similar conclusion, stating that “[t]he weight of the research evidence shows that CON has not restrained overall per capita health care spending.”¹³

There are additional academic and peer reviewed sources that can be cited demonstrating that CON programs have either failed to control, or have actually increased, health care costs. However, an article published in the economics journal *Inquiry* in 2003 may have summed it up best when it stated that “[s]tate legislators have little to fear in the way of cost consequences from the repeal of CON laws.”¹⁴

B. CON is not an effective quality improvement mechanism.

Because CON programs have utterly failed to control health care costs, some CON proponents have tried to support CON programs by claiming that CON can promote quality. However, these quality claims have also been closely examined, and the results are, *at best*, inconclusive. For example, the previously-cited Georgia CON study legislative study stated that while “[t]here is considerable variation on a number of dimensions of quality across markets [...] there is no apparent pattern with respect to [CON] regulation and no statistical correlation.”¹⁵ The Lewin Group report similarly concluded that, concerning the ability of CON laws to increase the quality of care:

[E]ven the strongest supporters of maintaining the program agree that the area where CON can directly influence quality is narrow [...]. CON laws’ impact on quality and care is limited.¹⁶

The Washington State Joint Legislative CON study discussed above likewise found that “[t]he evidence is weak regarding the ability of CON to improve quality by concentrating

⁹ Glenn M. Landers, Bernette Sherman, Mei Zhou, with William Custer and Pat Ketsche, *Report of Data Analyses to the Georgia Commission on the Efficacy of the Certificate of Need Program*, for the Georgia Commission on the Efficacy of the Certificate of Need Program, October 2006.

¹⁰ *Id.*

¹¹ Report of the Senate Interim Committee on Certificate of Need, State of Missouri, Senate Interim Committee on Certificate of Need, December 2006.

¹² Christopher J. Conover and Frank A. Sloan, *Evaluation of Certificate of Need in Michigan*, Final Report, Duke University, Center for Health Policy, Law, and Management, March 2003.

¹³ *Effects of Certificate of Need and Its Possible Repeal*, Washington State Joint Legislative Audit and Review Committee, January 1999.

¹⁴ *Supra*, note 5.

¹⁵ *Supra*, note 8.

¹⁶ *Supra*, note 7.

volume of specialized services.”¹⁷ Similarly, the comprehensive 1998 Duke University CON study by Conover and Sloan stated that “[i]t is doubtful that CON regulations have had much effect on quality of care, positive or negative.”¹⁸ Another Conover and Sloan study, which was commissioned by the Michigan Department of Community Health in 2003 to evaluate Michigan’s CON program, concluded that:

Research findings are inconclusive regarding the ability of CON to improve quality by concentrating volume of specialized services at certain facilities. Evidence is mixed regarding CON’s effect on the market share of for-profit providers and any resulting impacts on quality.¹⁹

This study added that “[i]t may make little sense to rely on CON to carry out quality assurance functions that might be better approached by more direct and cost effective means such as regulation and licensing and/or outcome reporting to the public.”²⁰

More recent studies continue to demonstrate that CON programs are not quality-effective. For example, the authors of a 2016 study of CON and cardiac care wrote: “[W]e find no evidence that cardiac CON regulations lower procedural mortality rates for [cardiac surgery] interventions.”²¹ A November 2016 study of CON and its relationship to all-cause mortality found that CON programs have no statistically significant effect on all-cause mortality. Point estimates indicate that if they have any effect, they are *more likely to increase mortality than decrease it*.²² (Emphasis added).

C. CON does not improve access to care.

There is little evidence that CON positively affects access to care. For example, the 2003 Conover and Sloan Michigan CON study found that “CON has a limited ability to impact the overall cost of health care or to address issues raised by care for the uninsured and underinsured.”²³ The Georgia legislative commission study found that CON’s effect on access was no more than “mixed.”²⁴ The Washington State CON study concluded that not only had Washington’s CON law “had no effect on improving access,” but “[i]n some instances, CON rules are used to restrict access by preventing the development of new facilities.”²⁵

CON programs can also impair patient access by reducing the availability of medical providers, according to January 2016 study, published by the George Mason University.

¹⁷ Supra, note 12.

¹⁸ Supra, note 1.

¹⁹ Evaluation of Certificate of Need in Michigan, A Report to the Michigan Community Department of Health, Christopher J. Conover, Pd.D., and Frank A. Sloan, Pd.D. (2003).

²⁰ Id.

²¹ Vivian Ho, Meei-Hsiang Ku-Goto, & James G. Jollis, *Certificate of Need (CON) for Cardiac Care: Controversy over the Contributions of CON*, 44 Health Services Research 2, 483-500 (Apr. 2009).

²² James Bailey, The Effect of Certificate of Need Laws on All-Cause Mortality, Health Services Research (Nov. 2016).

²³ Supra, note 18.

²⁴ Supra, note 8.

²⁵ Supra, note 12.

This study found that CON laws reduce the overall number of medical providers, suggesting less availability of imaging services in CON states, and that residents of CON states are more likely to travel out of state to obtain imaging services than are residents of non-CON states.²⁶ Also, by delaying facilities from offering the most advanced equipment to patients and staff (because obtaining CONs for new technology may take upward to 18 months), CON “reportedly affect[s] providers’ ability in some states to recruit top-tiered specialist physicians.”²⁷

II. Competition, not CON, is the right prescription to controlling costs, improving health care quality and access.

Competition, not CON programs, is the right prescription for lowering health care costs, improving health care quality, increasing patient access to health care physicians, providers and services and fostering the development and implementation of innovative alternatives to integrated delivery systems (IDS)—alternatives that will benefit patients. In addition to their failure to control costs, increase quality and improve patient access, CON programs can stifle competition by protecting incumbent hospitals and IDS from competition. One state study found that:

CON acts as an artificial barrier to entry stifling competition and innovation in the healthcare market. The onerous cost and process of undergoing CON review has a distinct chilling effect on those seeking to undertake modernization, specialization and efficiency in healthcare.²⁸

Recent research has also noted that while “hospitals initially had mixed views about the benefits of CON, but banded together to support the process after realizing it was a valuable tool to block new physician-owned facilities.”²⁹ This research is supported by a 2016 finding that “CON laws are negatively associated with services provided by nonhospital providers, but not with services by hospital providers.”³⁰

CON’s effect of insulating hospitals and integrated delivery systems from competition reduces the incentive of hospitals to compete on cost and quality factors such as the hospital’s level of investment in modernizing and maintaining its physical plant and equipment, the quality and experience of the nurses and other professionals who practice there and the resources it makes available to physicians.

Protecting hospitals and IDS from competition reduces the incentive of hospitals to compete on these factors, allowing incumbent hospitals and IDS to provide potentially sub-optimal care for patients. By restricting the entry of competitors, such as physician-

²⁶ Thomas Stratmann & Matthew Baker, *Are Certificate-of-Need Laws Barriers to Entry? How They Affect Access to MRI, CT, and PET Scans*, working paper, Mercatus Center, George Mason University (Jan. 2016).

²⁷ Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics?* Research Brief 4, National Institute for Health Care Reform (May 2011).

²⁸ *Supra*, note 11.

²⁹ *Supra*, note 27.

³⁰ *Supra*, note 26.

owned facilities, CON laws have weakened the market's ability to contain health care costs, undercut consumer choice and stifled innovation. Facilitating competitive entry into hospital and IDS markets is the best means of ensuring that patients reap the many benefits of competition.

One crucial means of facilitating entry is to eliminate, or at least restrict, CON, which is a significant barrier to entry into hospital markets. According to the National Conference of State Legislatures, the existing CON programs concentrate activities on outpatient facilities because these tend to be freestanding, physician-owned facilities that constitute an increasing segment of the health care market.³¹ Many of these physician-owned facilities are ambulatory surgical centers (ASC) that, as a class of provider, have been found in numerous studies of quality to have complication rates that are low and patient satisfaction rates that are high.³² For example, a recent study published in *Health Affairs* concluded that ASC “provide a lower-cost alternative to hospitals as venues for outpatient surgeries.”³³ Instead, CON has taken on particular importance as a way to claim territory and to restrict the entry of new competitors. It should go without saying that competition requires competitors. By restricting the entry of competitors, such as physician-owned facilities and services, including but not limited to ASCs, CON laws have weakened the market's ability to contain health care costs, undercut consumer choice and stifled innovation, such as the creation of value-based payment initiatives.

There is another strong overriding policy reason for eliminating or restricting CON so as to encourage the entry and development of competitive alternatives to IDS. One of the most important ways to reduce healthcare costs is to prevent the need for hospitalizations through more effective prevention programs, early detection, improved chronic disease management and other proactive measures. These programs are achieved primarily or exclusively through the actions of physician practices, not by hospitals themselves. Moreover, to the extent that these initiatives are successful, they will not only reduce the hospitals' revenues, but they may have a negative impact on the hospital's margins, assuming hospital revenues decline more than their costs can be reduced. Thus, when CON protects hospital owned IDS from competition, the hospital may be more likely to resist physician efforts to reduce the need for hospitalizations.

III. Conclusion.

The AMA greatly appreciates the opportunity to provide comments regarding the Certificate of Need (CON) Task Force Draft Recommendations. A wealth of studies show that CON has failed to achieve its goals, whether those goals pertain to cost control, quality of care or patient access to care. In fact, by insulating incumbent hospitals and IDS from competition by physician-led and other initiatives, CON has fostered price increases, limited patient choice and stifled innovation at a time when it is universally

³¹ See National Conference of State Legislatures, Certificate of Need: State Health Laws and Programs (July 2014), available at: <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>.

³² See L. Casalino et al., “Focused Factories? Physician-owned Specialty Facilities”, *Health Affairs* (Millwood) 2003; 22(6): 56-67.

³³ See Munnich and Parente, “Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up,” *Health Affairs* (Millwood) 2014, 33(5): 764-769.

recognized the swift development of innovations, such as value-based purchasing initiatives, is imperative. Further, even if there were a time when CON had effectively addressed excess supply issues, the shift to value-based purchasing now obviates CON, particularly given CON's anticompetitive effects. The AMA therefore urges that any Connecticut CON program be structured so that it does not inhibit in any way entry by physician-led and other potential hospital competitors into hospital or IDS markets.



127 Washington Avenue, East Building, 3rd Floor, North Haven, CT 06473
Phone (203) 865-0587 Fax (203) 865-4997 www.csms.org

Comments on Recommendation of the Certificate of Need Task Force December 15, 2016

Lieutenant Governor Wyman and members of the Certificate of Need Task Force, on behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS) and the members of the undersigned organizations, we submit these comments to you today in response to draft recommendations of the Task Force.

We must first express our strong opposition to the Certificate of Need (CON) process as a whole. In a day and age when most states have dropped the use of CON, and even the Federal Trade Commission (FTC) has expressed its concern with CON processes and their anti-competitive nature, we are baffled that Connecticut continues to cling to this outdated concept. CSMS continues to oppose the CON for any reason and believes it should be eliminated, for all services, including the acquisition of imaging equipment, and especially for the delivery of office based procedures. The CON stifles competition, hinders the natural progression of healthcare services and has been a significant factor in our inability to recruit and retain physicians. This is further supported in comments contained within the recommendations under the section *Proposed Goals of the Certificate of Need Program*. Among other statements identifying the ineffectiveness of CON programs, the report clearly states that “there is also a lack of evidence to show that CON programs, as they are currently implemented, improve quality or access to health care services.” With that said, we have reviewed the proposed recommendations of the Task Force and comment on them specifically.

Regarding the acquisition of equipment several options are proposed. Again, we must be very clear that we do not support the need for a CON for acquisition or transfer of any imaging equipment at any cost. However, the closest recommendation to this position would be Option 2. Alternative 2a, “Eliminate CON review of equipment acquisitions (no restricting of self-referrals).” We see no need for language limiting self-referrals for two reasons. First, referrals within the healthcare system would continue to be regulated by federal “Stark Laws.” Second, the recommendation would have a significant impact on smaller practices from “referring” for services to entities under their control. In many situations, these services are more efficient and cost-effective than those provided by larger entities. Limiting of the providers of these services has a significant potential to increase costs. Furthermore, in a situation where several large health care institutions have now vertically integrated from the primary care level to the most complex tertiary care and control health care markets in regional monopsonies, the definition of self-referral becomes very difficult to apply.

As for initiating services/increasing capacity, we again oppose the need for any CON. However, should the Task Force continue to recommend keeping its use, Option 1b would be most acceptable as it would remove the need for a CON for Outpatient Surgical Facilities. CSMS advocated strongly against the establishment of a CON for these facilities. Unfortunately, the legislature decided in 2003 to establish such a requirement. This has resulted in an increased difficulty for physicians to remain independent, as well as the proliferation of costly facility fees burdening patients.

As for the termination, reduction of services, and relocation of services, we once again question the need for a CON. There is no doubt that the aforementioned large healthcare institutions can have a significant impact on communities when the decision to terminate, reduce or relocate is made. We agree that some form or state oversight is necessary to ensure a continuity of care is afforded to patients.

However, a process that could force entities to remain in situations in which there is no viability would exacerbate the problem. Rather than the heavy-handed use of the CON, the state should continue efforts to identify the causes of access problems.

The entire section related to the decision making process raises significant concern for us. Our understanding at the onset of the establishment by the Governor of this Task Force was that the charge was to review current CON laws and offer recommendations regarding efficiency, effectiveness, and cost implications. Yet several proposals, particularly those in this section, seem contrary to this charge. The establishment of “expert panels” to review CON proposals at cost to the applicant opens an unlimited universe of those who may challenge a CON, and with unfettered ability to do so, will guarantee that the CON process continues to stifle progress.

Finally, we are significantly concerned that discussion regarding the Certificate of Need has extended into the realm of evaluating “quality.” This clearly shows that members of the Task Force have extended its intent in an attempt to address issues clearly outside its purview. Quality has proven to be a term in medicine that defies definition in a practical sense. Yet it is an area in which multiple efforts at regulation and oversight of “quality” have been made by various agencies. Attempts to regulate in this area have thus far been major sources of inefficiency and frustration for those attempting to care for our citizens and have undermined the credibility of the agencies involved.

Unfortunately, while this task force was established to promote a system to encourage competition, the majority of the proposed recommendations will do exactly the opposite.

CT Chapter of the American College of Surgeons
CT ENT Society
CT Orthopaedic Society
CT Society of Dermatology and Dermatologic Surgery
CT Society of Eye Physicians
CT Society of Urology

From: Lawrence Lazor [mailto:llazor@starlingphysicians.com]

Sent: Monday, December 12, 2016 1:51 PM

To: CONTaskForce <CONTaskForce@ct.gov>

Subject: Surgery Centers

The healthcare field is changing quickly. Costs are too expensive (20% of the GDP) and this is influencing where people want to work and what discretionary money they have left for their families. Outpatient surgery is an important part of healthcare costs. Private companies that manage outpatient surgery centers and physicians that manage centers themselves have done so at a much lower cost, higher patient satisfaction and lower risks. Please do not take away the ability of physicians to take charge of centers. Insurance companies are already noticing these benefits and making incentives for physicians and patients to stay out of hospital based systems and into free standing surgery centers. This will keep CT competitive and health care costs down. If you have questions, my cell is 860-833-4113, LLazor@Starlingphysicians.com. Best Dr Lawrence Lazor

12/15/2016

CON Task Force
State of Connecticut

Re: Certificate of Need Program

Dear Task Force members:

I write to you in support of the current CON process regarding the purchase and installation of new, advanced imaging equipment. The underlying premise of the CON process is to ensure the highest quality of service while maintaining or improving access to care with cost containment. The current process has achieved these goals, and eliminating this process will undoubtedly result in a decrease in the quality of care. This will indirectly lead to an increase in healthcare costs.

The current process restricts the number of advanced imaging scanners based on current utilization and the need, if any, to improve access to imaging. The effect of this process has limited such capital purchases almost entirely to hospitals and to board certified radiologists, either in the private setting or in conjunction with a hospital system. As such, these scanners are maintained and utilized according to the standards of the American College of Radiology (ACR). The ACR certification process is required for all advanced imaging equipment and ensures the highest quality and safety standards for patients. Additionally, radiologists, trained specialists in imaging, must also demonstrate continued education and training as part of the accreditation process. Radiologists not only provide expert interpretation of these studies but also supervise the quality of the scanners, technologists, and exam protocols. We also function as gatekeepers for this technology, ensuring the appropriate exam is selected for any given clinical situation.

Without the CON law, the floodgates will be opened, allowing anyone to purchase and install advanced imaging equipment in the state of Connecticut. While this may seem to be a benefit due to increased competition, it will actually result in a greater potential for harm to the residents of our state. Without barriers to the purchase and installation of advanced imaging equipment, new machines will be purchased by non-radiologists, leading to self-referral. Self-referral will result in inappropriate utilization. Unnecessary or inappropriate studies will be ordered and performed leading to a waste of healthcare dollars. Additionally, these new systems will not need to undergo the rigorous accreditation process implemented by the ACR. The result of this will be a decrease in image and exam quality, potentially resulting in misdiagnosis. This in turn could result in additional, unnecessary testing or treatment, further wasting critical healthcare dollars.

Furthermore, in our practice area, there is no limitation to access of care. The patients we serve have no issue in scheduling an exam within an acceptable time frame. There is availability in our

schedules to accommodate many more patients, also with the option for weekend appointments that has not been necessary to this point in our practice. I cannot confirm if this is true throughout all radiology practices within the state but I suspect, if surveyed, this may hold true almost universally. I suspect that access to care is currently a non-issue.

Competition in business and medicine can enhance quality as long as this competition occurs between similar competitors, each adhering to the same rules. If one competitor is not required to follow certain regulations, such as those provided by the ACR, then quality can and likely will decrease. If one competitor is allowed to order exams that may be unnecessary or inappropriate, cost containment measures will no longer apply. The current CON process has worked to ensure high quality, cost-effective care. The loss of the program will have deleterious effects for our patients.

Sincerely,

Christopher Leary, MD
Chairman, Dept. of Diagnostic Imaging
Bristol Hospital, Bristol, CT
President
Radiologic Associates, P.C.

From: Maria Mirth [mailto:maria.mirth@sbcglobal.net]

Sent: Thursday, December 15, 2016 10:44 AM

To: CONTaskForce <CONTaskForce@ct.gov>

Subject: CON Task force comments

To Whom It May Concern,

As a physician who has been in practice for 26 years, and practiced in South Carolina for 13 years before returning to the northeast in 2005, I was surprised at the lack of Ambulatory Endoscopy and Surgery Centers. In addition, only a few actually charge ambulatory fee schedules, which saves money for the patients and state of CT employees. This is due to the difficult CON process. Now there is a 6% tax which further hinders any consideration of building these needed healthcare facilities. A group of private practice physicians recently looked at a business proposal to build such a center in central CT but the tax, CON process, and growing number of Medicaid patients put an end to the plan. I currently do not own any shares, and never had, in such centers. I simply want to give my patient a good financial option without compromising quality or safety, in the age of large deductible insurance plans.

Respectfully,

Maria Christina Mirth MD



53 Russ Street, 2nd Floor
Hartford, CT 06106
December 15, 2016

To Whom It May Concern:

My name is Thomas Farquhar. I am on the Executive Committee of the Radiological Society of Connecticut (RSC), whose membership includes over 300 radiologist physicians. Our members work in a variety of settings, from hospital radiology departments to physician-owned private practice outpatient offices, in communities across the state. I would like to offer public comment on the Certificate of Need (CON) Task Force's draft recommendations with specific attention to the acquisition of imaging equipment including review of scanners and new technology. My comments have the unanimous endorsement of the RSC Executive Committee, which met on Wednesday evening, December 14, 2016.

We support the goal of the Task Force to review the existing CON program and identify areas of improvement in efficiency, effectiveness, and alignment with state and federal health care reform efforts. At the same time, we believe the existing CON process for imaging ensures safeguards for quality and safety, controlling imaging costs, and serving the public need that should be maintained regardless of any modifications.

Through years of work, the existing CON process mandates patient protections that ensure medical personnel will be prepared in the event of a medical emergency or adverse reaction during a scan and to assure the safest use of radiation and radioactive materials. The citizens of the state of Connecticut benefit from these requirements and deserve to see them continue.

The existing CON process serves to control health care costs and elimination of CON requirements will lead to increasing costs. It is a misconception to assume that the market forces of supply and demand apply to health care (i.e. health care demand is fairly inelastic). Instead, competition in health care does not usually lead to lower costs because health care providers control supply and determine most demand, while patients lack adequate information to "shop" for health care based on price and quality. Moreover, patients do not pay, or even realize, the true cost of health care as it is paid by third-party payers. Although new health care reimbursement methodologies are moving from volume and "cost-based" systems to payment models based on value and quality, these new payment models are untested. They account for a very small minority of health plans, and we are years if not decades away from a health care system that has eliminated the incentives for health care providers to expand services regardless of demand. Until such time, the existing CON process serves to limit increasing health care costs.



One of the most specific ways the existing CON process limits health care costs from advanced imaging is by limiting self-referral – the practice of health care providers referring patients to imaging facilities in which they have an ownership interest. In following the proceedings of the CON Task Force, we know that Dr. Kaye has presented extensive documentation of that self-referral increases utilization, increases cost to consumers, limits access to the uninsured and underinsured, reduces quality of care, and restricts competition among providers in the market area. For example, one study showed that doctors who owned machines ordered 4 – 4.5 time more imaging tests than doctors who did not. Another study showed self-referring physicians employed diagnostic tests 1.7 to 7.7 times more frequently than physicians referring to radiologists, with charges being 1.6 to 6.2 times greater. Most recently, in 2012, The United States General Accounting Office released a Congressionally mandated report showing that self-referral of advanced imaging results in markedly increased volumes of scans and costs the Medicare and Medicaid programs billions of dollars. As a direct response to that report and the many similar studies over the years, President Obama called for passage of a law removing legal loopholes that permit self-referral. The Office of Management and Budget estimated that this measure would save the Medicare and Medicaid program \$6 Billion over 10 years.

The CON Task Force has also been presented evidence that when states remove existing CON curbs on imaging equipment, the number of machines in service explodes. As health care dollars become increasingly scarce, we cannot afford to weaken one of the few limits on wasteful expansion of services. In fact, now may be the absolute right time to strengthen the CON laws with respect to acquisition of imaging equipment.

For these reasons, as physician experts in medical imaging, the Radiological Society of Connecticut opposes elimination of the CON process for advanced imaging acquisition and strongly advocates that any changes to the process strengthen protection against self-referral and maintain the existing guarantees for quality and safety.

Sincerely,

Thomas Farquhar, MD, PhD

Member, Executive Committee
Co-Chair, Legislative Committee
Radiological Society of Connecticut



To: CONTaskForce@ct.gov

From: Starling Physicians, PC
Michael G. Genovesi, MD, President

Date: December 15, 2016

Subject: CON Task Force Draft Recommendations

Starling Physicians appreciates the opportunity to share our ideas about the CON Task Force Draft Recommendations. Starling Physicians is a 200+ member multispecialty physician group headquartered in Rocky Hill, created on January 1, 2016 as a result of the merger of the former Grove Hill Medical Centers and Connecticut Multispecialty Group. The two groups came together because their physician partners share a common interest in putting the patient – provider relationship first, both in terms of quality of care and value, and believed that their collective efforts would help them achieve that goal.

As we survey the landscape in our north/central CT service area, it's increasingly clear that facilities for outpatient procedural care (gastroenterology, ophthalmology, gynecology, imaging, etc.) are mostly owned by hospitals. That ownership structure leads to higher facility costs, because hospitals must, by necessity, spread the overhead costs of running a complex organization over all owned entities. In our experience, physician -owned outpatient facilities and diagnostic imaging centers are better positioned to deliver high quality care at much lower costs to payors and patients. Starling Physicians would appreciate the option to create outpatient procedural centers where we could provide care to our patients at much lower costs than we can now. Within that context, Starling Physicians offers the following observations on the sections of the Draft Recommendations addressing Initiating Service and Transfer of Ownership:

- We recommend lowering thresholds for new outpatient services initiated by non-hospitals, especially when local payors testify to anticipating lower costs to patients, employers and health plans.
- We believe that physicians groups like ours can create non-hospital owned facilities that deliver care of equivalent or enhanced quality to patients in settings that are more cost-effective and delivery better value to patients, employers and health plans. There are working examples of non-hospital-owned outpatient facilities in our community that already deliver high value, and more such facilities are needed to ensure that value is present in more cases.
- We support creating a level playing field for non-hospital entities that wish to acquire health care facilities and practices. Recent experience in our community has demonstrated that hospital acquisitions of outpatient facilities lead to increased prices while locking private investors out of the marketplace, thus preventing competition.
- Starling welcomes the state's support in scrutinizing acquisitions of outpatient facilities in order to create a more level playing field for physician practices organizations like ours to establishing facilities that deliver much better value for the healthcare dollar.

We would welcome the opportunity to discuss or elaborate upon any of the ideas we raise in this letter. We applaud the task force's efforts to revisit the CON legislation with the objective of providing high quality and more cost-effective options for patients and payors alike.



THE CONNECTICUT ASSOCIATION OF AMBULATORY SURGERY CENTERS' TESTIMONY ON DRAFT CERTIFICATE OF NEED RECOMMENDATIONS

The Connecticut Association of Ambulatory Surgery Centers (“CAASC” or “Association”) appreciates this opportunity to comment on the draft Certificate of Need (“CON”) recommendations that have been issued by the CON Task Force. We also wish to thank its members for the collaborative manner in which they are addressing this important aspect of health care regulation. The CAASC has had the privilege of working with the Connecticut Department of Public Health and other constituent groups on similar issues in the past, and we truly believe that open dialog is the best way to bring about positive change.

The members of our Association, which are defined under state statute as “outpatient surgical facilities”, are proud to add to the fabric of the diverse health care delivery system in Connecticut by providing a high quality, lower cost alternative for same-day surgery and other procedures. In this rapidly changing and uncertain time for health care as a whole, Ambulatory Surgery Centers (“ASCs”) remain committed to improving the experience of care for our patients as technological improvements and the need to control health spending shift increasingly more services to the outpatient setting.

While our industry can cite data which, for example, shows that the Medicare program and its beneficiaries share in more than \$2.3 billion in savings each year when procedures are performed at ASCs as opposed to other outpatient surgical facilities such as hospital outpatient departments (“HOPDs”), it is important to point out that this is accomplished, in significant part, by the lower reimbursement paid to our facilities. Like other providers, we too are feeling constant downward pressure as we struggle to reconcile what we are paid from government-sponsored and private insurance plans, and the continually escalating costs associated with meeting consumer expectations, maintaining regulatory compliance, staffing, training and other operational expenses. Like acute care hospitals, ASCs in Connecticut also pay a significant provider tax, but unlike non-profit hospitals, our members also pay real estate, personal property and sales taxes as well.

It is through this perspective – as vital components of the modern-day delivery system that are also dealing with its challenges – that we offer our comments on the recommendations most directly affecting ASCs.

With respect to the recommendations concerning initiating services, we do not think rolling back CON to cover only the establishment of new hospitals, specialty hospitals and freestanding EDs

is the right path to take for ensuring that a high quality and stable health system is in place for Connecticut residents. Therefore, we would favor an approach that would subject not only those facilities to CON review, but maintain CON oversight for establishing new outpatient surgical facilities and the other key providers categories listed in Option 3 of the draft recommendations in this area. However, we do favor eliminating the CON requirement for adding two or more new operating rooms, to an existing facility, within a 3-year period as we think that this determination should ultimately be decided by patient choice and left to the purview of the individual providers who incur the financial risk of increasing their capacity in this manner.

As for continuing to require CON review for the termination of services at outpatient surgical facilities, this has not been a source of significant regulatory activity since the CON laws were amended a few years ago to include this provision. Accordingly, we see no reason why a more streamlined approach dispensing with this requirement should not be adopted. As for relocation of services or facilities, we favor adopting “notification only” requirements for relocations that occur within a reasonable geographic distance from the current location. The CAASC would also favor the same sort of notice only requirement for relocations to areas of unmet need that is determined through the state planning process.

With respect to the recommendations for transfers of ownership, we believe that CON regulation in this area is unnecessarily confusing and burdensome, so we do not support maintaining the status quo. If the Task Force is going to pursue Option 2 of the proposed recommendations in this area, the CAASC would favor changes that would clarify that notification to the Office of Health Care Access and possible CON approval for transfers of ownership in outpatient surgical facilities should only be required where a “change of control” as commonly defined (i.e., any change of ownership of more than 50% of the voting capital stock or interests changes hands) takes place. Transfers of minority interests in outpatient surgical facilities should be exempt from this requirement. Additionally, we also support expedited review of transfers of ownership in existing facilities.

The CAASC would not favor mechanisms that would allow intervenors to appeal a CON decision for many reasons, including that it could add years to an already prolonged regulatory process. As for the other proposed recommendations regarding CON application review criteria and the decision-making process, we stand ready to work with Task Force members to make improvements and achieve efficiencies in these areas as well.

Thank you again for this opportunity to address the draft Task Force recommendations.

COMMENT ON DRAFT RECOMMENDATIONS OF
THE GOVERNOR'S CERTIFICATE OF NEED (CON) TASKFORCE
December 14, 2016

Testimony of Cary S. Shaw,
Board Member of the Connecticut Coalition of Reason (CT CoR);
Patient's Right to Know Act Lead for the Secular Coalition for Connecticut (SC-CT); and
President of Humanists and Freethinkers of Fairfield County;

Who We Are

The Gallup Poll found, in its February 2016 report, that 39% of Connecticut's population describes themselves as non-religious (1). Some researchers would put that number significantly higher, as many people are afraid or shamed into not admitting their non-belief. CT CoR and SC-CT are the voices of this constituency, with organizations and independent individuals throughout the state.

The component organizations of the Connecticut Coalition of Reason have over 8,000 adherents, and include The Humanist Association of Connecticut; Connecticut Valley Atheists; the Congregation for Humanistic Judaism of Fairfield County; Hartford Area Humanists; Humanists and Freethinkers of Fairfield County; Atheist Humanist Society of Connecticut and Rhode Island; and the Yale Humanist Community.

We believe in a progressive life stance that, without supernaturalism, affirms our ability and responsibility to lead meaningful, ethical lives capable of adding to the greater good of humanity.

In my professional life, I developed a mathematical model for Yale Medical School and Yale-New Haven Hospital for use in surgically treating primary hyperparathyroidism. It tells the endocrine surgeon in real time when cure is achieved. This work is published in the peer-reviewed World Journal of Surgery (World J Surg (2014) 38:525-533). I add this so that you will know that I care about the proper use of evidence-based science to help patients.

Disclosure – Patient's Right to Know

We commend the Governor's CON Taskforce in taking the time and energy to develop recommendations to improve healthcare in Connecticut.

Improving competition in the healthcare environment, providing access to care for the underserved, and creating superior patient outcomes, are goals that are clearly enunciated by the CON Task Force, and which we support.

A meaningful component of any competitive environment is the provision of information to consumers, in this case the patients, in advance of the decision to purchase. Today a “health care provider” may choose, by policy, to refuse to provide “standard of care” medical procedures, claiming religious reasons, and to avoid informing potential and actual patients, not only that it does not provide these treatments, but even the fact that these treatments exist and are medically appropriate.

For example, a thorough examination of the websites of Connecticut’s major religious hospitals reveals that none of them mention under the category of Services, or elsewhere, that there are medical services they will not allow to be performed.

We agree with the 2016 statement by the organization of ObGyn doctors, the American College of Obstetricians and Gynecologists (ACOG):

“ACOG is concerned that a growing number of U.S. health care systems and hospitals limit the scope of reproductive health care services that they provide.

... Women should have access to scientifically based health care. Prohibitions on essential care that are based on religious or other non-scientific grounds can jeopardize women’s health and safety.

Restrictive hospital policies can damage the patient-physician relationship. In some instances, physicians are prohibited from informing patients about treatment options that are not permitted at the hospital, depriving patients of valuable information and the option of going elsewhere for treatment (if alternatives exist in the community).”

Some problems extend uniquely to men’s health, such as removal of diseased reproductive tissue. And, in geographic areas where patients are especially vulnerable for financial and educational reasons, the impact is especially serious.

We recommend that a regulation be adopted to assure full disclosure, described as “Patient’s Right to Know”; Model wording attached. This regulation does not in any way restrict a healthcare entity or cause it any material expense; it merely requires clear and upfront disclosure.

Precarious Position of Doctors

In the popular mind the term “healthcare provider” means a doctor or other medical person. Perniciously, the term may refer to an institution, controlled by an out-of-state healthcare conglomerate, which forbids its trained medical personnel from providing necessary and appropriate medical services.

As Dr. Amy Breakstone testified on the Emergency Contraception bill, which CT then passed into law:

“My concern is also for the medical provider....(Don’t) continue to place those providers in the untenable position where following what they know to be correct medical protocol is to place their jobs in jeopardy. Too often emergency facilities must find ‘a work

around' or a 'creative solution' in order to do what is medically right. Please provide these conscientious medical providers your support."

Transfers of Ownership

In Connecticut there not only is merger activity among hospital institutions, but the consolidation activity of larger institutions taking over smaller ones, such as surgical centers and doctor's practices. We fully support the Recommendation under "Actions: Transfers of Ownership: Option 1, bullet points 2,3,and 4:

- Applying expanded CON review to hospital acquisitions of health care facilities and large group practices (cost and market impact review, mandatory public hearing, stronger application criteria, post-transfer compliance monitoring)
- Applying expanded CON review to all hospital mergers and acquisitions (not only those involving for-profit entities and larger hospital systems, as under current law)
- Imposing consequences for non-compliance with post-transfer conditions

And we request that such review specifically include examining any resultant termination, reduction or relocation of services, for non-medical reasons.

Other Recommendations

The Draft Recommendations of the Certificate of Need (CON) Taskforce contains many recommendations and alternatives. Among additional ones we especially support or wish to comment upon are:

- Under "Terminating Services" we recommend keeping in the Status Quo language "CON review of...surgical services at an outpatient surgical facility." If it is too onerous for OHCA (Office of Health Care Access) to monitor all such facilities, then the proper solution in our opinion is to add the caveat "terminating services for religious reasons."
- Actions: Reduction of Services: Support Option 2: apply to a hospital
- Actions: Transfers of Ownership (discussed above)
- Organization: Support 1b: include front-line caregivers...to serve...(as) experts.
- Public Input: Support Option 1, (not alternative 1a):
 - Requiring that the subject matter panel of experts includes consumer representation
 - Requiring that hospital acquisitions of other health care facilities and large group practices receive a mandatory public hearing
- Transparency: Support Option 1: Expand ...methods of informing the public...


--CON Post-Approval Compliance Mechanisms: Support the strengthening (Options 1,2,4,5)

--CON Evaluation Methods: Option 2, Support that Plan tracks access to and cost of services across the state.

Summing Up

As Denise Merrill, now Secretary of the State, testified as an elected state Representative, "The women of Connecticut should expect that when they enter a hospital they are being provided with all legal healthcare options."

We ask that the Taskforce and Governor implement these ideas fully and clearly, without delay.



Cary S, Shaw
Humanists and Freethinkers of Fairfield County
11 Lycett Ct
Norwalk CT 06850
caryshaw@optonline.net
(203)849-8978
(203)505-3180 cell

Footnote:

(1) <http://www.gallup.com/poll/125066/State-States.aspx>

Attached:

Patient's Right to Know Model Act

Introduction

In the United States, religious hospitals account for more than 17 percent of all hospital beds, and religiously based hospitals, physicians, and other health care entities treat more than 1 in 6 Americans each year.

Current law allows these health care providers to opt out of providing medical services such as abortions, birth control, tubal ligation, hormone replacement therapy, and nearly any other treatment that conflicts with the provider's religious beliefs or the religious doctrine of the affiliated religious group. There are no state or federal laws or regulations that require health care providers to inform patients of services or treatments a provider will not provide because of the provider's religious beliefs.

The Patient's Right to Know Act, a proposed piece of legislation drafted by American Atheists, seeks to ensure that patients are able to make completely informed medical decisions about their health by requiring health care providers to disclose to patients and prospective patients exactly which types of medical care they do not provide because of their religious beliefs.

"This is about disclosure, not about forcing providers to do anything they have a religious objection to. If a religiously affiliated hospital or health care provider has some objection to a specific treatment, they can continue to opt out of providing those services. What they can't do is pull a bait and switch on patients and potential patients," said Amanda Knief, National Legal and Public Policy Director of American Atheists.

Model Patient's Right to Know Act Summary:

Reconciling patients' rights to know all their health care options with the desire of some health care providers to not provide certain care based on religious or philosophical beliefs.

This model act balances the religious liberty of health care providers with the basic health care rights of their patients.

This act requires that any health care provider who uses **religious beliefs** to determine patient care instead of standard medical guidelines and practices,

subsequently resulting s in any health care options being omitted or favored based on these religious beliefs, **to inform patients in writing** of health care services that are not available to the patients through this particular provider; **patients must provide signed consent acknowledging they have received this information.** Additionally, this act requires health care providers who use religious beliefs to determine patient care to inform health insurance companies of specific health care options that are not provided; health insurance companies will share that information with their enrollees and insured participants.

Section 1. (Title) This Act may be cited as the “Patient’s Right to Know Act”.

Section 2. (Definitions)

1. The term “clinical privileges” includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity.
2. The term “health care entity” means— a. A hospital that is licensed to provide health care services by the State in which it is located. b. An entity that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care. c. A licensed health care practitioner such as a doctor, physician, nurse, nurse practitioner, or other practitioner licensed to provide health care services by the State in which the practitioner is located.
3. The term “health care services” means inpatient hospital services, inpatient critical access hospital services, or extended care services; outpatient nursing services, outpatient diagnostic or therapeutic items or services, outpatient surgical or medical services, with a physician who has clinical privileges; any services provided by a physician or licensed health care practitioner; or private-duty nursing or other privateduty attendant duties.
4. The term “hospital” means an entity that is primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled,

or sick persons; maintains clinical records on all patients; and has bylaws in effect with respect to its staff of physicians.

5. The terms “licensed health care practitioner” and “practitioner” mean, with respect to a State, an individual (other than a physician) who is licensed or otherwise authorized by the State to provide health care services.

6. The term “physician” means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).

7. The term “State” means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

8. The term “religious beliefs” means any set of philosophical or religious beliefs, guidelines, decrees, directives, or other instructions determining patient care that is not based on legal, peer-reviewed, or scientifically accepted standards of health care, and may be imposed on health care entities through employment or clinical privileges.

Section 3.

Not later than 12 months after the effective date of this Act, a health care entity which does not provide certain health care services based on the religious beliefs of the entity shall adopt a policy that provides a complete list of health care services that will not be provided to patients of the health care entity, based on the entity’s religious beliefs.

Prior to initiation of treatment or in the case of an emergency as soon as the patient is able or patient’s representative is available, the health care entity which adopted such a policy shall provide a written notice to every patient that includes the list of services that will not be provided by the entity based on the entity’s religious beliefs and requires the patient or patient’s representative to acknowledge receipt of the notice and the list of services that will not be provided.

Section 4.

Not later than 12 months after the effective date of this Act, health care entities shall provide a complete list of any health care services the health care entity will not provide based on religious beliefs to all group health plan providers and health insurance issuers offering group or individual health insurance coverage from whom the health care entity seeks and accepts payments.

The health care entities shall prominently list on the entities' websites the health care services that will not be provided to patients based on the entities' religious beliefs and shall provide the list of health care services not provided based on the entities' religious beliefs upon request to any person.

Section 5.

Not later than 18 months after the effective date of this Act, group health plan providers and health insurance issuers offering group or individual health insurance coverage shall provide enrollees with a list of any health care entities within their network of health care providers that do not provide certain health care services based on religious beliefs and provide a list of health care services that will not be provided by each health care entity listed. Such information shall also be available on the providers' and issuers' websites.

Section 6.

Not later than 12 months after the effective date of this Act, a health care entity that does not provide health care services based on religious beliefs shall inform any State or Federal agency that licenses the health care entity of all health care services that are not provided. State and Federal agencies that enroll or otherwise oversee the application of health care entities into state or federal health care reimbursement programs shall amend the application process to include a requirement that health care entities disclose any health care services the entity does not provide based on the entity's religious beliefs.

Section 7.

Health care entities shall provide information about health care services that are not provided by the health care entities based on religious beliefs when applying for any State or Federal grant related to providing any kind of health care services.
Written by Amanda Knief, Esq., August 2015.



Public Comment on Draft Recommendations of the Certificate of Need Task Force

Lynne Ide, Director of Program and Policy
Universal Health Care Foundation of Connecticut
December 15, 2016

Universal Health Care Foundation of Connecticut appreciates the opportunity to comment on the Draft Recommendation of the Certificate of Need (CON) Task Force, released on December 5, 2016.

We offer comments to address core issues in our statewide health system by thinking outside the confines of the CON box. We also address hospital and health system transactions under the CON program.

We speak from experience of participating in at least five recent CON processes and public hearings, the experience of communities and stakeholders affected by past CON approvals of hospital transactions, and the process of the Health Care Cabinet Cost Containment Study and Recommendations.

Consider Recommendations Outside of the CON Program

The CON Task Force's charge from the Governor is broad, and the Task Force should consider bold, creative ideas for the challenges our state's health care system faces. We want to specifically point out that the Task Force has been asked to "deliver recommendations on how to improve the existing CON programs and *address any identified challenges or gaps in the state's regulation of health care services and facilities*" (emphasis added, see page 2 of Draft Recommendations).

One of the major limitations of the CON program is that it only influences the state health care landscape at the point of a transaction. While recent changes to the CON program have strengthened the Office of Health Care Access' (OHCA) oversight of hospital transactions, there is no way to apply new statutes that address the present and future challenges of the health care system to past CON approvals of hospital transactions.

The proposed goals of the CON program are to improve access, improve quality and contain cost, by utilizing planning to address health equity, unmet need, and underserved populations (page 2, Drafted Recommendations).

We urge the CON Task Force to consider how "gaps in the state's regulation of health care services and facilities" impact the proposed goals of the CON, as well as how those gaps impact access, quality, and prices (so in turn affordability, which deeply impacts access) at the state level. We offer a perspective of "out of the box" thinking, or rather, outside of the CON program thinking. We believe that the Governor's charge is broad enough to welcome recommendations that ultimately accomplish the same goals, with or without the existence of a CON transaction.

Ideas for consideration:

- State-level standards for:
 - Community Health Needs Assessments and subsequent Implementation Plans that bring community members to the table in meaningful engagement, with hospital and health system accountability to the Plan.
 - How community benefit dollars are spent, including directing a percentage to community building activities that invest in social determinants of health.

- A way to monitor hospital price increases and price variations in the state, across payers, with triggers for limiting both.
 - Note that the recent *Recommended Health Care Cost Containment Strategies: Health Care Cabinet Report in Response to PA 15-146* recommends the creation of an Office of Health Strategy (OHS) that could work with OHCA on this, or take the lead on this work. OHS is also tasked with studying provider rate setting, which could be informed by this information on hospital price increases and price variation.
- Requiring health system boards to have a certain percentage of voting community representation.
- Stronger penalties for violations of statutes and CON conditions, including fines that are significant enough to prompt corrective action by the hospital or health system.
- Leverage the existing Consumer Advisory Board (CAB, under the State Innovation Model – SIM) to also serve as an advisory board to the Department of Public Health and OHCA. The CAB can raise issues with access, quality, and affordability in real-time. DPH and OHCA should also have the power to correct these issues.

Recent experience informs these additional recommendations:

- Ensure that statutes and orders are applied consistently to all entities seeking approval under the CON program. It is important that all hospitals play by the same rules, are held to the same standards, and have to follow the same process in any dealings with the state.
 - Our concerns stem from the recent approval of the CON for Yale New Haven Health Systems Corporation's acquisition of L+M Corporation, despite a moratorium in place for hospital transactions meeting a certain threshold.
- Place a moratorium of at least five years on non-profit to for-profit hospital conversions, in light of three such conversions taking place in the state this year, to have the opportunity to see the impact these conversions have on access to critical services, quality and affordability (cost and price) of services.
 - We further suggest that after the three-year monitoring period put in place by OHCA's CON conditions, a public report be produced to assess the performance of these converted hospital. Ideally, this report would have a follow up conducted a year or two after the monitoring period end, which would provide important information on whether to continue or lift such a moratorium.
- Hospitals and health systems should be held accountable to demonstrated robust public consultation and input.
- The public, particularly communities and other stakeholders of the affected hospital, should have the ability to challenge CON Determinations.
 - Our suggestion comes from the fact that, despite community outcry, the change from a Critical Care Unit to a Progressive Care Unit at Windham Memorial Community Hospital was determined to not require a CON.

Ensuring a high-quality, accessible, affordable, and accountable health care system in the state requires planning, coordination and creative solutions.

Universal Health Care Foundation of Connecticut (UHCF) is an independent, nonprofit foundation working to shape our state's health care system to provide quality, accessible, affordable care and promote good health for all state residents. We work with a diverse array of partner organizations, as well as with individual consumers from throughout Connecticut.

Appendix G – Record of Votes

[INSERT AFTER JANUARY VOTE]

Appendix H – Sources Utilized During the Development of Task Force Recommendation Options

[Being Populated]

Appendix I - Minority Recommendations

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Minority Recommendation Options

A. Actions Subject to CON Review

Acquiring Equipment

ACQUIRING EQUIPMENT – Members Could Only Choose One Option	Votes
<i>Status Quo: CON review of scanners, new technology, and non-hospital based linear accelerators</i>	<i>Support</i>
A. <i>Maintain status quo and expand the current exemption applied to the replacement of scanners previously acquired through the CON process to the replacement of all equipment previously approved through the CON process, with notification to OHCA</i>	<i>3 out of 15</i>
B. <i>Apply CON review to advanced imaging acquisitions only</i>	<i>1 out of 15</i>
C. <i>Apply CON review to advanced imaging acquisitions and new technology</i>	<i>4 out of 15</i>
D. <i>Maintain status quo, and apply the replacement of scanners to CON review (remove the current exemption)</i>	<i>1 out of 15</i>
<i>Self-Referral⁵¹ Options</i>	<i>Do Not Support</i>
E. <i>Statutorily restrict the process of self-referral for scanners</i>	<i>6 out of 15</i>
F. <i>Restrict the practice of self-referral of scanner through application review criteria</i>	<i>6 out of 15</i>

Initiating Services/Increasing Capacity

[INSERT AFTER JANUARY VOTE]

Terminating Services

[INSERT AFTER JANUARY VOTE]

Reduction of Services

[INSERT AFTER JANUARY VOTE]

Relocation of Services

⁵¹ Self-referral in this context is defined as the practice of referring a patient for imaging tests to a facility that physician owns or leases. Source: Sunshine, Jonathan and Bhargavan, Mythreyo; *The Practice of Imaging Self-Referral Doesn't Produce Much One-Stop Service*; Health Affairs 29, no.12 (2010).

[INSERT AFTER JANUARY VOTE]

Transfers of Ownership

1. TRANSFERS OF OWNERSHIP	Votes	
<i>Status Quo</i> : CON review of transfers of ownership of all health care facilities and certain transfers of large group practices and expanded CON review (cost and market impact review, mandatory public hearing, stronger application criteria, post-transfer compliance monitoring) of certain <u>hospital</u> transfers of ownership		
A. <i>Strengthen CON review of hospital mergers and consolidations by: Applying CON review only to hospital acquisition of health care facilities and large group practices</i>	3 Out of 15	

Conversions

2. CONVERSIONS – Members Could Only Choose One Option	Votes	
<i>Status Quo</i> : Expanded CON review and enhanced role of AG in protecting charitable assets		
A. <i>Maintain status quo</i>	No 1 out of 14	Abstain 2 out of 14

Actions Subject to DSS CON Review

[INSERT AFTER JANUARY VOTE]

- B. CON Application Review Criteria
[INSERT AFTER JANUARY VOTE]
- C. CON Decision-Making Process
[INSERT AFTER JANUARY VOTE]
- D. Application process
[INSERT AFTER JANUARY VOTE]
- E. CON Post-Approval Compliance Mechanisms
[INSERT AFTER JANUARY VOTE]
- F. CON Evaluation Methods
[INSERT AFTER JANUARY VOTE]

Appendix J - Opinion of Members Not Present for Official Vote

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