1.0 INTRODUCTION

1.1 LEGAL AUTHORITY AND MANDATE

Section 19a-634 of the Connecticut General Statutes (CGS) charges the Department of Public Health (DPH) Office of Health Care Access (OHCA) with the responsibility of conducting an annual statewide health care facility utilization study, establishing and maintaining an inventory of all Connecticut health care facilities and services and certain equipment specified in statute, and developing and maintaining a Statewide Health Care Facilities and Services Plan (Appendix A). The Plan is one of nine permanent, enumerated guidelines contained in CGS Section 19a-639, as amended by Public Act 12-170, specifying that when reviewing a Certificate of Need (CON) application, OHCA must take into consideration the relationship of the proposed project to the statewide health care facilities and services plan.

1.2 PURPOSE AND VALUE

The Plan will serve as a blueprint for health care delivery in Connecticut by providing guidance on resource allocation decisions based on considerations of the appropriate balance of accessible quality health care for the state's residents.

In addition, the Plan will:

- Be a resource document for policymakers and for those involved in the Certificate of Need process; and
- Provide various entities (e.g., institutions, State and local governments and individuals) with information, policies and projections of need (in some cases) to guide the planning for specific health care facilities and services and the state's health care system.

The Plan is premised on establishing an inventory of health care services and facilities, examining access and utilization of certain services, and, as necessary, determining how best to distribute those resources in the most effective and efficient manner. It is intended to sustain hospital[5] and health care system financial viability by:

- Helping to prevent excess capacity and underutilization of medical facilities;
- Fostering fair competition and a level playing field for entry into the most profitable services;
- Providing clearer rules for adding services (via CON standards and guidelines);
- Limiting the proliferation of services that would undermine community providers' ability to maintain financial viability; and
- Promoting shared service arrangements.

The Plan is also intended to provide improved patient access to services by:

- Providing better access to services through planned geographic distribution;
- Enhancing primary care access and availability by identifying gaps in services and unmet need; and
- Lowering overall cost to the health care system by limiting duplication of services.

[5]The use of the words "hospitals" or "acute care hospitals" throughout this document generally refers to hospitals that provide acute care in a general hospital setting. In Connecticut, these hospitals are licensed by the Department of Public Health as either a General Hospital or a Children's General Hospital pursuant to Section 19a-490 of the Connecticut General Statutes and Section 19-13-D1 of the Connecticut Public Health Code.

1.3 ADVISORY BODY

In October 2010, the Office of Health Care Access invited representatives from a cross section of the health care industry and State government to participate in an advisory body that would be charged with providing guidance on the development of the Plan. Advisory Body members are listed in Appendix B. The advisory body met monthly beginning in November 2010. In May 2011, advisory body subcommittees were formed to conduct more in-depth work in the areas of Acute Care/Ambulatory Surgery, Behavioral Health and Primary Care. Subcommittee members are listed in Appendix C.

Both advisory body and subcommittee members provided OHCA with guidance and expertise in the development of CON guidelines, standards, methodologies and analyses used in the Plan, including:

- Reviewing research conducted by OHCA on other states' facilities plans' standards, guidelines and methodologies and providing feedback and discussion regarding adaptation and applicability for Connecticut's Plan;
- Recommending authoritative professional organizations, published studies, industry-recognized standards/guidelines/methodologies, etc., to be considered by OHCA in the development of its plan;
- Providing insight on industry best practices and evidenced based research;
- Recommending data sources; and
- Offering feedback on OHCA's use and interpretation of available data.

1.4 GUIDING PRINCIPLES

The goal of OHCA's planning and regulation activities is to improve the health of Connecticut's residents; increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services.

The guiding principles of the Plan are intended to:

- Promote and support the long term viability of the state's health care delivery system;
- Ensure that any regulated service will maintain overall access to quality health care;
- Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;
- Encourage and support health education, promotion and prevention initiatives;
- Encourage collaboration among health care providers to develop health care delivery networks;
- Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty care providers);
- Maintain and improve the quality of health care services offered to the state's residents;
- Promote planning that helps to contain the cost of delivering health care services to its residents;
- Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;
- Promote public policy development through measuring and monitoring unmet need; and
- Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state.

1.5 OVERVIEW OF PLAN STRUCTURE

The Plan consists of five major sections:

Section One provides an overview of the Plan and examines overarching policy issues.

Section Two consists of chapters related to health care facilities, services and equipment for which Certificate of Need (CON) standards and guidelines are included (Acute Care, Outpatient Surgery, and Imaging Services/Equipment).[6]

Section Three consists of chapters on unmet need/gaps in services, Primary Care and Behavioral Health.

Section Four provides next steps/recommendations and discusses data sources and limitations.

Section Five consists of an inventory of health care facilities, services and imaging equipment in Connecticut.

Prior to the publication of this Plan, OHCA used Certificate of Need as its primary planning tool. With the release of this Plan, however, OHCA's ability to plan systematically for Connecticut's health care system will be improved. The Plan is, by design, an advisory document. The Plan includes new standards and guidelines for health-care related activities that will be utilized in the Certificate of Need review process once adopted into regulation.

NOTE: THESE STANDARDS AND GUIDELINES ARE NOT FINAL UNTIL ADOPTED AS REGULATION PURSUANT TO CHAPTER 54 OF THE CONNECTICUT GENERAL STATUES.

In addition to containing CON guidelines, standards and methodologies, the Plan incorporates available health care facilities and services utilization data.[7] Such data are useful from a policy and planning perspective in that they provide important information regarding shifts in the use of health care resources and services, identify what types of services specific populations use and how frequently, assist in examining the impact of new medical technologies or procedures, and may also indicate areas that warrant further study. These data serve as a foundation for projecting future health care needs and as the basis for determining resource needs (e.g., personnel, training or facilities planning).[8] Additionally, through the reporting of utilization of services, the Plan provides a means of monitoring the adequacy of access.

1.6 INTERPRETATION OF THE PLAN

The Plan becomes effective upon publication date, and will become applicable to Certificate of Need applications effective 90 days after its effective date.

The effective dates of this Plan are State Fiscal Year 2012 through 2014.

In its deliberations involving a CON application, when making findings concerning the relationship of a proposed project to the Plan, OHCA shall consider the most recent version of the Plan in effect on the date of the decision, regardless of when the application was filed or public hearing held.

In reviewing CON applications, OHCA first applies CGS 19a-639 guidelines and principles, and then considers any additional standards adopted through regulation and provided in the Plan. *As previously noted, these standards and guidelines will not be final until adopted as regulation pursuant to Chapter 54 of the Connecticut General Statutes.*

In reviewing CON applications, the latest version of the *Inventory of Connecticut Health Care Services and Facilities* and published utilization reports shall be considered.

The *Inventory of Connecticut Health Care Services and Facilities* shall be available from the Department of Public Health Office of Health Care Access, 410 Capitol Avenue, Hartford, CT 06134, (860) 418-7001 and at http://www.ct.gov/dph/cwp/view.asp?a=3902&q=277344

Unless otherwise noted, the five Connecticut Department of Emergency Services and Public Protection (DESPP) Division of Emergency Management and Homeland Security (DEMHS) regions are the geographic areas utilized in determining utilization rates but shall not be the service area for individual Certificate of Need applications. Recommendations for expansion of standards and guidelines are only effective and applicable to Certificate of Need

[6]Although they do not include standards and guidelines, Long Term Care and Rehabilitation Services are also broadly addressed in this section. While not part of the main focus of the plan, these services and facilities are part of its planning and inventorying efforts as they represent a significant portion of the continuum of care.
[7]In those years when a Facilities and Services Plan is not published, utilization data are presented in an annual utilization study.
[8]Bernstein A.B., Hing, E., Moss, A.J., Allen, K.F., Siller. A.B. & Tiggle, R.B. (2003). Health Care in America: 2003 Trends in Utilization. *National Center for Health Statistics*. 1. Retrieved from http://www.cdc.gov/nchs/data/misc/healthcare.pdf

applications once they have become enacted as regulations in accordance with the provisions of both Chapter 368z and the Uniform Administrative Procedures Act.

Any references, guidelines or national standards mentioned in this Plan means the most current version, and the Plan incorporates the most recent version, as amended from time-to-time.

1.7 RELATIONSHIP OF PLAN TO HEALTHY PEOPLE 2020 AND CONNECTICUT STATE HEALTH PLANNING

Healthy People 2020 is a 10-year national strategic health initiative led by the US Department of Health and Human Services which establishes objectives for health promotion and disease prevention for Americans. The initiative tracks 1,200 objectives organized into 42 topic areas, each of which represents a specific public health area. Within the topic area "Access to Health Services" is the initiative's goal of improving access to comprehensive, quality health care services. Healthy People 2020 acknowledges the importance of access to a location where needed health care services are provided and identifies such access to health services as a determinant influencing health status. Lack of or limited access to health services may greatly impact an individual's health.

Barriers to access (e.g., the lack of availability of care) can lead to unmet health needs, delays in receiving appropriate care, the inability to obtain preventive services and, ultimately, preventable hospitalizations.[9] Healthy People 2020 specifically cites (1) increasing and measuring access to appropriate, safe and effective care, and (2) decreasing disparities and measuring access to care for diverse populations, including racial and ethnic minorities and older adults, as two issues that should be monitored over the next decade.

The Department of Public Health is the lead agency for public health planning and is mandated to assist in the development of collaborative planning activities that respond to public health needs. DPH is currently conducting a State Health Assessment and developing a comprehensive, long term State Health Improvement Plan (Healthy Connecticut 2020). Healthy Connecticut is our state's translation of the national Healthy People effort. Once completed, the Assessment and Improvement Plans will complement future facilities and services planning efforts by providing additional guidance and focus. Together, these Plans will provide a mechanism for identifying community need, assessing the health care system's capability of meeting those needs and allowing for the allocation of the necessary resources to address those needs.

1.8 CERTIFICATE OF NEED (CON) OVERVIEW

1.8.1 CON DEFINITION, PURPOSE AND HISTORY

Certificate of Need (CON) is a regulatory governmental program[10] requiring certain types of health care providers to obtain State approval prior to making substantial capital investments in new equipment or facilities, changing bed complement (in hospitals) and adding or sometimes discontinuing a health care service. The CON program is intended to guide the establishment of health 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 containment.

States maintain CON programs to achieve a number of health policy goals. While the specific goals may differ somewhat among states and vary from one health service to another, all CON regulation and related planning are intended to promote access, ensure quality, and help control costs by limiting market entry to those facilities and services that are found to be needed, appropriately supported and designed to promote quality and equitable access to care. The rationale for imposing market entry controls is that regulation, grounded in community-based planning, will result in more appropriate allocation and distribution of health care resources and thereby, help assure access to care, maintain or

[9]Healthy People 2020. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1

[10]Connecticut's CON program is regulated by two State agencies. The Department of Social Services (DSS) operates the program for nursing homes, homes for the aged and rest homes. The Department of Public Health (DPH) Office of Health Care Access administers the program for all other health care facilities.

improve quality, and help control health care capital spending.[11] CON regulation also provides certain restrictions on exiting the market to ensure appropriate access is maintained.

CON regulation in Connecticut has its roots in the early 1970s, when many states established such programs in an attempt to exercise control over a rapidly expanding health care system. Changes in health care delivery, increased health care spending, gains in private and public health insurance coverage, population growth and physician workforce expansion and specialization all contributed to states' push to require certificates of need in the health care industry. Connecticut's Certificate of Need (CON) program was established in 1973 (P.A. 73-117) in anticipation of the enactment of federal legislation, The National Health Planning and Resources Development Act (P.L. 93-641), which provided substantial funding for state and local health planning activities and CON programs.

1.8.2 RECENT CON CHANGES

For nearly four decades, CON has shaped the structure of the health care system in Connecticut. The state's CON program has evolved over time and most recently, the scope of the program has become more focused on a limited number of health care facility and project categories. In 2010, Connecticut's CON program underwent significant changes, in part, to be responsive to impending shifts in the health care delivery system resulting from federal health care reform efforts focused on the development of a patient-centered integrated delivery system. The changes also improved CON's utility as a planning tool by:

- Better aligning health care resources with community needs;
- Simplifying CON procedural requirements;
- Focusing CON oversight on preserving access to "safety net" services;
- Avoiding potential areas of over-saturation or over-utilization; and
- Improving CON criteria to address the financial stability of the health care delivery system and enhance quality of patient care.

1.8.3 CON STATUTES AND IMPLEMENTATION

Health care projects that fall within certain jurisdictional parameters are subject to review and decision by OHCA. Connecticut General Statutes Section 19a-638 specifies that a CON is required for:

1) The establishment of a new health care facility;
2) A transfer of ownership of a health care facility;
3) The establishment of a free-standing emergency department;
4) The termination of inpatient or outpatient services offered by a hospital, including, but not limited to, the termination by a short-term acute care general hospital or children's hospital of inpatient and outpatient mental health and substance abuse services;
5) The establishment of an outpatient surgical facility, as defined in section 19a-493b, or as established by a short-term acute care general hospital;
6) The termination of surgical services by an outpatient surgical facility, as defined in section 19a-493b, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care general hospital, provided termination of outpatient surgical services due to (A) insufficient patient volume, or (B) the termination of any subspecialty surgical service, shall not require certificate of need approval;
7) The termination of an emergency department by a short-term acute care general hospital;
8) The establishment of cardiac services, including inpatient and outpatient cardiac catheterization, interventional cardiology and cardiovascular surgery;

[11] American Health Planning Association. CON Background. Retrieved from http://www.ahpanet.org/copn.html

9) The acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners, by any person, physician, provider, short-term acute care general hospital or children's hospital (except for acquisition of any equipment by any person that is to be used exclusively for scientific research that is not conducted on humans);
10) The acquisition of non-hospital based linear accelerators;
11) An increase in the licensed bed capacity of a health care facility;
12) The acquisition of equipment utilizing technology that has not previously been utilized in the state;
13) An increase of two or more operating rooms within any three-year period, commencing on and after October 1, 2010, by an outpatient surgical facility or by a short-term acute care general hospital; and
14) The termination of inpatient or outpatient services offered by a hospital or other facility or institution operated by the State that provides services that are eligible for reimbursement under Title XVIII or XIX of the Federal Social Security Act, 42 USC 301, as amended.

Connecticut General Statutes Section 19a-639, as amended by Public Act 12-170, specifies that when considering a CON application, OHCA must take into consideration each of the following guidelines and principles:

1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;
2) The relationship of the proposed project to the statewide health care facilities and services plan;
3) Whether there is a clear public need for the health care facility or services proposed by the applicant;
4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;
5) Whether an applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region;
6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix;
7) Whether an applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;
8) The utilization of existing health care facilities and health care services in the service area of the applicant; and
9) Whether an applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities.

In November, 2010, the Department of Public Health, in accordance with Public Act 10-179, adopted interim Certificate of Need Policies and Procedures for Implementation of Public Act 10-179, §87, 89-93, which will be utilized by OHCA until official regulations are adopted by the General Assembly.

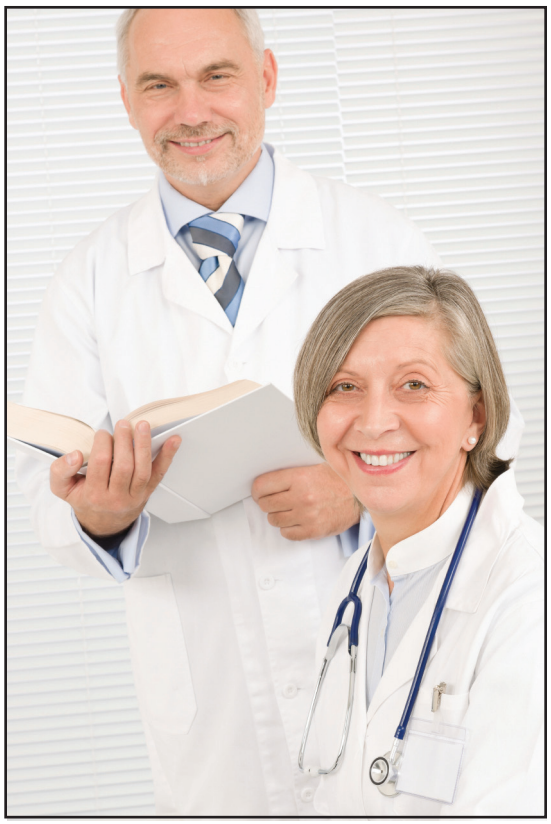
1.8.4 CERTIFICATE OF NEED AND HEALTH CARE REFORM

The 2010 Patient Protection and Affordable Care Act (PPACA) includes two provisions that may affect Connecticut's CON program: an increase in the insured population that will demand more services, which, in turn, may call for increased provider capacity; and provider payment reforms, which may restore some of the market constraints on prior health care system expansion. While it is unclear what the exact effect of these provisions will be, certain communities or regions may have adequate capacity to absorb increased demand, whereas those with a higher proportion of currently uninsured and less capacity may increase health care providers' reliance upon the CON program for health planning.[12]

1.8.5 MERGERS, ACQUISITIONS AND AFFILIATIONS

Even before health care reform has been fully implemented, the state's health care system has begun a transformation in response to and in anticipation of major changes in the way health care is financed and delivered. Many provisions of the PPACA favor integrated systems to create efficiencies and address quality. Hospital mergers and the acquisitions of imaging centers and physician practices are key issues surrounding Connecticut's CON process today.

Hospitals are pursuing affiliation arrangements and mergers in an effort to contend with growing financial pressures driven by such factors as providing uncompensated care, treating the uninsured in crowded emergency departments, caring for Medicaid patients whose cost of care often exceeds federal and State reimbursement rates, the threat of reduced reimbursement by government payers and tough negotiations with health insurers over contract terms related to the cost of medical services. Financially struggling hospitals see mergers with stronger hospitals as a way to survive in the face of thin profits, gain access to capital to make needed facilities improvements or acquire technological equipment and contend with debt and liability issues. Affiliations help smaller hospitals share the cost of new technology, provide the opportunity to access specialists at larger hospitals and also offer patients a wider range of treatment and services.[13]



A growing number of Connecticut hospitals have become members of larger corporate health care systems. This trend may be the result of a variety of factors including: a weak economy, increased competition in the health care market, anticipation of changes due to federal health care reform, an attempt to gain leverage in payer contract negotiations, to develop economies of scale when purchasing supplies and services, and to improve access to capital. Additional hospitals are currently in discussion with other health care systems or have officially submitted applications for regulatory approval that would alter the current structure of Connecticut's existing hospitals. It should be noted that while every hospital is analyzing the advantages and disadvantages of pursuing affiliations and possible mergers, some hospitals are deciding that affiliating or merging is not the best route for their institutions or their communities. Table 1.1 represents general hospitals that are part of a larger health care system at the time this document was published.

[12]Yee, T., Stark, L.B., Bond, A. M. & Carrier, E. (2011). Health Care Certificate of Need Laws: Policy or Politics? National Institute for Health Care Reform. (Research Brief Number 4). 7. Retrieved from http://www.nihcr.org/CON_Laws.html

[13]Sturdevant, M. (2012, February 3). Hartford Hospital, Backus in Norwich Consider Joining Forces. *The Hartford Courant*. Retrieved from http://articles.courant.com/2012-02-03/business/hc-hartford-hospital-backus-20120203_1_hartford-healthcare-hartford-hospital-windham-hospital

Table 1.1: General Hospitals within Health Care Systems

General Hospital Name	Town(s)	Parent Corporation	Higher Level Parent Corporation
Hartford Hospital	Hartford	Hartford Health Care Corporation	N/A
Hospital of Central CT	New Britain, Southington	Hartford Health Care Corporation	N/A
MidState Medical Center	Meriden	Hartford Health Care Corporation	N/A
Windham Community Memorial Hospital, Inc.	Willimantic	Hartford Health Care Corporation	N/A
Manchester Memorial Hospital	Manchester	Eastern Connecticut Health Network, Inc.	N/A
Rockville General Hospital	Vernon	Eastern Connecticut Health Network, Inc.	N/A
Yale-New Haven Hospital[a]	New Haven	Yale New Haven Network Corporation	Yale-New Haven Health Services Corporation
Greenwich Hospital	Greenwich	Greenwich Health Care Services, Inc.	Yale-New Haven Health Services Corporation
Bridgeport Hospital	Bridgeport	Bridgeport Hospital & Healthcare Services, Inc.	Yale-New Haven Health Services Corporation
St. Vincent's Medical Center	Bridgeport	St. Vincent's Health Services Corporation	Ascension Health[b]
Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital	Sharon	Sharon Hospital Holding Company, Inc.	Essent Healthcare, Inc.[c]
Danbury Hospital	Danbury	Western Connecticut Healthcare, Inc.	N/A
New Milford Hospital	New Milford	Western Connecticut Healthcare, Inc.	N/A

Source: Department of Public Health, Office of Health Care Access – Short Term General Hospitals' Annual Financial Filing

[a]This table does not reflect the recent change, effective September 12, 2012, when Yale-New Haven Hospital acquired the assets of the Hospital of Saint Raphael and became a single hospital with two main campuses.

[b]Ascension Health is a nationally based Catholic health system, which, according to the St. Vincent's Medical Center FY 2010 Audited Financial Statements, consists primarily of "nonprofit corporations that own and operate local health care facilities, or Health Ministries, located in 20 of the United States and the District of Columbia."

[c]Essent Healthcare, Inc., is a for-profit company organized for the purpose of owning and operating acute care hospitals. As of September 30, 2010, Essent Healthcare, Inc. through its various subsidiaries, owned hospitals in Connecticut and various other states.

Similarly, free-standing imaging centers are feeling the effects of reimbursement cuts, increasing regulatory restrictions on the operation of referral source imaging and large capital requirements for equipment.[14] In addition, physician practices are currently confronted with the pressures of reimbursement cuts, investing in electronic health records (EHR) systems and other technological improvements[15] and caring for a growing population of chronically ill patients.

The current wave of mergers, acquisitions and affiliations is likely to continue throughout implementation of health care reform as health care providers react to shrinking payments and changes in the delivery of health care. The strategic financial and quality-of-care advantages associated with the integration of hospitals, physician practices and imaging centers are important drivers in today's CON environment.

[14]Jeter, C. E. & Sorensen, T. (2010, August 15). Why Hospitals Buy Imaging Centers. *ImagingBiz*. Retrieved from http://www.imagingbiz.com/articles/view/why-hospitals-buy-imaging-centers

[15]The Health Information Technology for Economic and Clinical Health Act, or HITECH Act, is intended to increase the use of Electronic Health Records (EHR) by physicians and hospitals. It stipulates that healthcare providers will be offered financial incentives for demonstrating meaningful use of electronic health records. Penalties may be levied for failing to demonstrate such use.