Certificate of Need (CON) Task Force Draft Recommendations

Per Executive Order 51A, the Certificate of Need Taskforce (CON) is established 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.

As a result of eight months of meetings, presentations by subject matter experts, and research reviews the CON Task Force has developed a series of draft recommendations to include in the final report to Governor Malloy by January 15, 2017. Recommendations are categorized into the following areas:

- Revised Purpose of the CON program
- Actions Subject to CON review
- CON Application Review Criteria
- CON Decision-Making Process
- CON Application Process
- CON Post-Approval Compliance Mechanisms
- CON Evaluation Methods

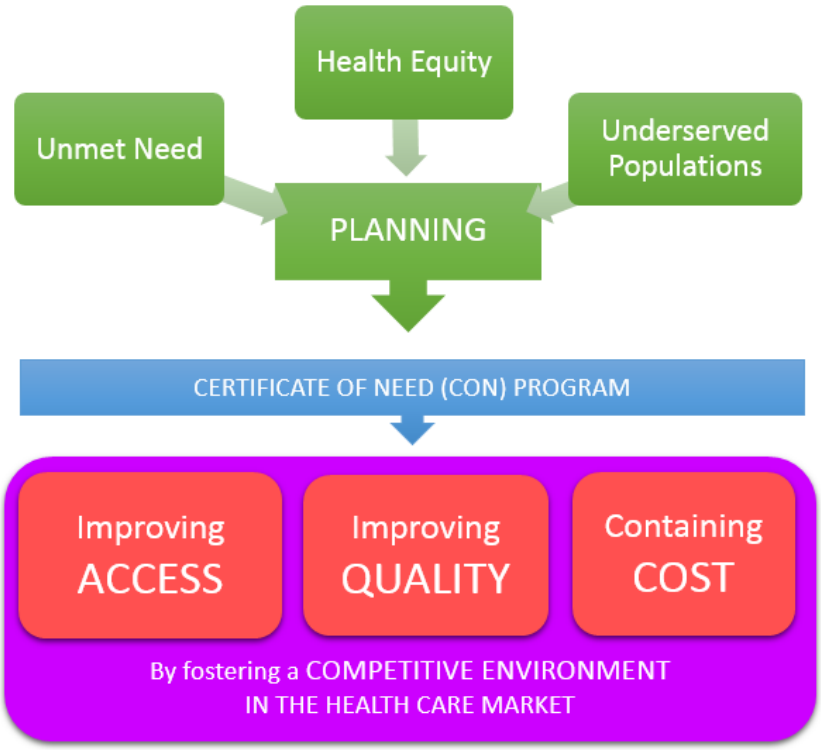
A complete list of CON Task Force members, Executive Order 51A, and all of the materials from past meetings can be found on the official CON Task Force Web page.

NOTE: For some categories of recommendations, multiple alternatives are proposed to be included in the report for Governor Malloy's consideration. In addition, task force members were given the opportunity to submit feedback on a draft set of recommendations. That feedback is included in this document but has not yet been considered by the entire CON Task Force.

If you wish to submit comments on the draft CON recommendations presented in this document please submit them in writing to CONTaskForce@ct.gov by 5:00 PM on Thursday, December 15th.

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.



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 evidence to show that CON programs, as they are currently implemented, improve quality or access to health care services.

Research does demonstrate that the consolidation and merging of health care facilities and services, by limiting competition, is a primary driver in increasing health care costs. In addition, research indicates that competition in the health care market can enhance quality.

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.

Actions Subject to CON Review

Certificate of Need (CON) Task Force Draft Recommendations

Note: Recommendations presented in the following section are mutually exclusive.

ACQUIRING EQUIPMENT
***Status Quo*: CON review of scanners, new technology, and non-hospital based linear accelerators**
Option 1: Maintain status quo *Alternative 1a*[a]: 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 *Alternative 1b*[b]: 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
Option 2: Eliminate CON review of equipment acquisitions and propose legislative remedy to restrict scanner self-referrals[c] *Alternative 2a*[d]: Eliminate CON review of equipment acquisitions (no restricting of self-referrals)
Option 3: Apply CON review to advanced imaging acquisitions only *Option 3a*[e]: Apply CON review to advanced imaging acquisitions and new technology

[a] Adapted from comments submitted by CON Task Force member David Whitehead.

[b] Adapted from comments submitted by CON Task Force member Susan Martin.

[c] The purpose of the proposed legislative remedy is to prohibit group practice providers from referring patients to a health care entity in which that health care practitioner or his/her family members, have a financial interest. Policy considerations include potential exemptions, penalties, grandfathering, and limiting upgrades.

[d] Adapted from comments submitted by CON Task Force member Gary Price. Concerns about limiting self-referral, particularly in its use in ACO arrangements, was expressed as well as the ability to define self-referral in current health care system due to increased vertical integration and consolidation of services.

[e] Adapted from comments submitted by CON Task Force member Commissioner Raul Pino and the Office of Health Care Access. CON review of new technology is proposed to be maintained in order to regulate potential for-profit capital investors acquiring expensive new equipment, which is usually not clinically proven for the population to be served and does not serve Medicaid or at risk populations.

INITIATING SERVICES/INCREASING CAPACITY
***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**
Option 1: Apply CON review to the establishment of new hospitals, specialty hospitals, and freestanding emergency departments
Option 2: Apply CON review to the establishment of new hospitals, specialty hospitals, freestanding emergency departments, outpatient surgical facilities, and cardiac services
Option 3: 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 *Alternative 3a*[f]: Limit CON review of mental health and substance abuse treatment facilities to for-profit inpatient behavioral health services only
Option 4[g]: 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

TERMINATING SERVICES
***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**
Option 1: Apply CON review when terminating hospital emergency departments, hospital inpatient/outpatient services, and hospital mental health/substance abuse treatment services
Option 2[h]*:* Apply CON review when terminating hospital emergency departments, select inpatient/outpatient services, and hospital mental health/substance abuse treatment services *Alternative 2a*[i]: Expand CON review for the termination of mental health/substance abuse treatment services to entities other than hospitals

[f] Adapted from comments submitted by CON Task Force member Commissioner Raul Pino and the Office of Health Care Access. CON review is proposed to be limited to for-profit inpatient behavioral health (mental health and substance abuse treatment) as non-profit behavioral health services currently are exempt from CON review and typically provide services to all populations. In addition, due to the dire need for behavioral health services, the elimination of CON review of for-profit outpatient services will serve to not unduly delay the establishment of these critical services in the community.

[g] Adapted from comments submitted by CON Task Force members Susan Martin and David Whitehead.

[h] Adapted from comments submitted by CON Task Force members Susan Martin and David Whitehead. Hospital inpatient/outpatient services proposed to be allowed to be terminated without CON review include physical and occupational therapy, sleep labs, diagnostic services, and multiple locations.

[i] Adapted from comments submitted by CON Task Force member Susan Martin.

Actions Subject to CON Review

Certificate of Need (CON) Task Force Draft Recommendations

REDUCTION OF SERVICES
***Status Quo*: No CON review required**
Option 1[j]*:* Maintain status quo
Option 2: Apply CON review to the reduction of services by a hospital *Alternative 2a*[k]: 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

RELOCATION OF SERVICES
***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**
Option 1: Apply CON review to the relocation of services *Alternative 1a*[l]:Require notification only for those applications that propose to relocate within a reasonable geographic area *Alternative 1b*[m]: Require notification only for those applications that propose to relocate to an area identified as having unmet needs through a state health planning process

TRANSFERS OF OWNERSHIP
***Status Quo*: CON review of transfers of ownership of all health care facilities; 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**
Option 1: Strengthen CON review of hospital mergers and consolidations by: • Applying CON review only to <u>hospital</u> acquisition of health care facilities and large group practices • 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
Option 2[n]*:* 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

[j] Adapted from comments submitted by CON Task Force member David Whitehead.

[k] Adapted from comments submitted by CON Task Force member Fred Hyde.

[l] Adapted from comments submitted by CON Task Force members Susan Martin and David Whitehead.

[m] Adapted from comments submitted by CON Task Force member David Whitehead.

[n] Adapted from comments submitted by CON Task Force members Susan Martin and David Whitehead.

CONVERSIONS
***Status Quo*: Expanded CON review and enhanced role of AG in protecting charitable assets**
Option 1: Maintain status quo

ACTIONS SUBJECT TO DSS CON PROCESS
***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**
Option 1: Maintain CON review for all actions other than the establishment of new continuing care retirement facilities (CCRCs); conduct periodic reviews of the nursing home moratorium; 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 *Alternative 1a[o]:* Do not allow nursing homes to apply for a relocation or establishment of a new facility *Alternative 1b[p]:* 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.

[o] Adapted from comments submitted by CON Task Force member Jennifer Smith. Given that there is a state moratorium on new nursing home beds, the relocation of beds from one location to an entirely different community has the very real potential of permanently reducing access to nursing home services in certain socioeconomic and geographic areas.

[p] Adapted from comments submitted by CON Task Force member Mag Morelli.

Note: Recommendations presented in the following sections are not mutually exclusive and should be considered individually.

APPLICATION REVIEW CRITERIA **ACQUIRING EQUIPMENT AND INITIATING SERVICES/INCREASING CAPACITY**
***Status Quo*: OHCA consideration of twelve guidelines and principles (see Appendix A)**
Option 1: Revise guidelines to reflect the updated CON program goals including: • 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 • 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
Option 2[q]*:* 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

APPLICATION REVIEW CRITERIA **TERMINATING SERVICES**
***Status Quo*: OHCA consideration of twelve guidelines and principles (see Appendix A)**
Option 1: 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

APPLICATION REVIEW CRITERIA **TRANSFERS OF OWNERSHIP**
***Status Quo*: OHCA consideration of twelve guidelines and principles and expanded review for certain hospital applications (see Appendix A)**
Option 1: Revise guidelines to reflect the updated CON program goals including: • 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 • 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)
Option 2[r]*:* Maintain guidelines requiring the demonstration of impact on the financial health of the health care system

[q] Adapted from comments submitted by CON Task Force member Commissioner Raul Pino and the Office of Health Care Access.

[r] Adapted from comments submitted by CON Task Force member Commissioner Raul Pino and the Office of Health Care Access.

ORGANIZATION – Who reviews applications and render decisions
***Status Quo*: 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**
Option 1: Establish a panel of advisory subject matter experts to assist OHCA in application review with costs being covered by applicant; otherwise, maintain status quo *Alternative 1a*[s]: Allow applicant to participate in selection of panel members and allowed input into the expert's review *Alternative 1b*[t]: Include front-line caregivers from relevant fields to serve on the subject matter panel of experts *Alternative 1c*[u]: Control costs to applicant by specifying that expert review will be included as deemed appropriate by OHCA, and include reasonable limits

PUBLIC INPUT – Opportunities for consumer participation in the OHCA CON process
***Status Quo*: For OHCA applications, there are requirements dictating when public hearings are held, and specifications on who can be designated as intervenors. (See Appendix B)**
Option 1: Expand current methods of soliciting and accepting public input on pending OHCA CON applications by: • 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 *Alternative 1a*[v]: Do not require formal hearing for all hospital acquisitions; establish a process for accepting public comment prior to decision being rendered by OHCA

APPEALS PROCESS – Mechanisms through which the public can appeal an OHCA CON decision
***Status Quo*: 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. (See Appendix B)**
Option 1: Allow intervenors to appeal a CON decision *Alternative 1a*[w]: Maintain status quo, do not allow intervenors to appeal a CON decision
Option 2[x]*:* 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

[s] Adapted from comments submitted by CON Task Force members Susan Martin and David Whitehead.
[t] Adapted from comments submitted by CON Task Force member Jennifer Smith.
[u] Adapted from comments submitted by CON Task Force member Gary Price.
[v] Adapted from comments submitted by CON Task Force members Susan Martin and David Whitehead.
[w] Adapted from comments submitted by CON Task Force members Susan Martin and David Whitehead.
[x] Adapted from comments submitted by CON Task Force member Fred Hyde.

TRANSPARENCY – Methods of informing the public about pending OHCA applications and consumer access to information
***Status Quo*: For OHCA applications, there are requirements dictating when public hearings are held, and specifications on who can be designated as intervenors. (See Appendix B)**
Option 1: Expand current methods of informing the public about the status of CON applications, public hearings, decisions and appeals including: • 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) • continually researching and implementing new innovative ways to reach the public and solicit participation in the CON process; and • developing methods to regularly evaluate the effectiveness of public outreach strategies.
Option 2[y]*:* Require applicant to attest that reasonable efforts to expand public notification were made; do not penalize applicant if public input was solicited in accordance with requirements

[y] Adapted from comments submitted by CON Task Force members Susan Martin and David Whitehead.

CON APPLICATION PROCESS
***Status Quo*: OHCA must render a final decision within 90 days (or 60 days for a group practice or following a hearing).**
Option 1: Create an expedited CON application process for (1) the establishment of new facilities or services or increasing capacity if the service/facility is located in a "high need" area and (2) for the termination of services due to the loss of physicians *Alternative 1a[z]:* Allow an expedited process for the review of the acquisition of new imaging equipment *Alternative 1b[aa]:* Allow an expedited process for the review of programs and services that have inadequate volumes to support the effective delivery of care *Alternative 1c[bb]:* Allow an expedited process for the review of transfers of ownership that do not result in a change of service, payer mix, or location *Alternative 1d[cc]:* Allow an expedited process for mental health and substance abuse facilities if they commit to serving a certain threshold of Medicaid and other underserved populations
Option 2: Requiring a single CON application and cost and market impact review for the sale of all assets for hospital conversions and acquisitions
Option 3[dd]: Require all applications for terminations to be handled through an expedited process no longer than sixty days

[z] Adapted from comments submitted by CON Task Force members Susan Martin and David Whitehead.

[aa] Adapted from comments submitted by CON Task Force members Susan Martin and David Whitehead.

[bb] Adapted from comments submitted by CON Task Force member David Whitehead.

[cc] Adapted from comments submitted by CON Task Force member Jennifer Smith.

[dd] Adapted from comments submitted by CON Task Force member David Whitehead.

CON POST-APPROVAL COMPLIANCE MECHANISMS
***Status Quo*: 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.**
Option 1: Modify the threshold needed to enforce penalties on CON applicants who do not conform with current laws from "willful" to "negligent" *Alternative 1a*[ee]: Do not lower the threshold.
Option 2: 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 *Alternative 2a*[ff]: 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
Option 3: Align OHCA and DPH licensing division inspection and monitoring activities
Option 4[gg]*:* Require an independent entity to conduct non-compliance monitoring for transfer of ownership applications
Option 5[hh]*:* Fund additional inspection staff at OHCA to better conduct inspection, monitoring, and enforcement

[ee] Adapted from comments submitted by CON Task Force members Susan Martin and David Whitehead.

[ff] Adapted from comments submitted by CON Task Force member Fred Hyde.

[gg] Adapted from comments submitted by CON Task Force member Jennifer Smith.

[hh] Adapted from comments submitted by CON Task Force member Jennifer Smith.

CON EVALUATION METHODS
***Status Quo*: There is currently no formal evaluation of the effectiveness of the OHCA CON program.**
Option 1: 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
Option 2: Ensure that the Statewide Health Care Plan tracks access to and cost of services across the state.
Option 3: 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 *Option 3a*[ii]: Remove the measure of quality from the evaluation of the CON program

[ii] Adapt from comments submitted by CON Task Force member Gary Price. Concerns expressed include defining "quality" and the abundance of other regulatory oversight in this area by other agencies.

APPENDIX A -

CON Application Review Criteria

(1) APPLICATIONS SUBJECT TO CON REVIEW

- **a. Acquiring Equipment**
- **b. Initiating Services and Increasing Capacity**
- **c. Terminating Services**
- **d. Changes in Ownership**[jj]

Twelve OHCA Guidelines and Principles - §19a-639(a)

1. Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;
2. The relationship of the proposed project to the state-wide health care facilities and services plan;
3. Whether there is a clear public need for the health care facility or services proposed by the applicant;
4. Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;
5. Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons;
6. The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;
7. Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;
8. The utilization of existing health care facilities and health care services in the service area of the applicant;
9. Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;
10. Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;
11. Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;
12. Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care.

[jj] Please note that applications submitted after December 1, 2015 regarding transfers in ownership of hospitals are subject to not only these twelve guidelines and principles, but also an addition set of criteria. Because of this expanded review, hospital transfer of ownership applications are reviewed in a separate part of this survey.

(2) HOSPITAL TRANSFERS OF OWNERSHIP

Expanded Review - §19a-639(d)

1. Whether the applicant fairly considered alternative proposals or offers in light of the purpose of maintaining health care provider diversity and consumer choice in the health care market and access to affordable quality health care for the affected community;
2. Whether the plan submitted pursuant to section 19a-639a demonstrates, in a manner consistent with this chapter, how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services.
3. The office shall deny any certificate of need application involving a transfer of ownership of a hospital unless the commissioner finds that the affected community will be assured of continued access to high quality and affordable health care after accounting for any proposed change impacting hospital staffing.
4. The office may deny any certificate of need application involving a transfer of ownership of a hospital subject to a cost and market impact review pursuant to section 19a-639f if the commissioner finds that (A) the affected community will not be assured of continued access to high quality and affordable health care after accounting for any consolidation in the hospital and health care market that may lessen health care provider diversity, consumer choice and access to care, and (B) 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.

Twelve OHCA Guidelines and Principles - §19a-639(a)

1. Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;
2. The relationship of the proposed project to the state-wide health care facilities and services plan;
3. Whether there is a clear public need for the health care facility or services proposed by the applicant;
4. Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;
5. Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons;
6. The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;

7. Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;
8. The utilization of existing health care facilities and health care services in the service area of the applicant;
9. Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;
10. Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;
11. Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;
12. Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care.

(3) CONVERSIONS

Expanded Review – Attorney General - §19a-486c(a)

The Attorney General shall **deny** an application as not in the public interest **if** the Attorney General determines that **one or more of the following conditions exist**:

1. The transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities;
2. the nonprofit hospital failed to exercise due diligence in (A) deciding to transfer, (B) selecting the purchaser, (C) obtaining a fairness evaluation from an independent person expert in such agreements, or (D) negotiating the terms and conditions of the transfer;
3. the nonprofit hospital failed to disclose any conflict of interest, including, but not limited to, conflicts of interest pertaining to board members, officers, key employees and experts of the hospital, the purchaser or any other party to the transaction;
4. the nonprofit hospital will not receive fair market value for its assets, which, for purposes of this subsection, means the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market;
5. the fair market value of the assets has been manipulated by any person in a manner that causes the value of the assets to decrease;
6. the financing of the transaction by the nonprofit hospital will place the nonprofit hospital's assets at an unreasonable risk;
7. any management contract contemplated under the transaction is not for reasonable fair value;

8. a sum equal to the fair market value of the nonprofit hospital's assets (A) is not being transferred to one or more persons to be selected by the superior court for the judicial district where the nonprofit hospital is located who are not affiliated through corporate structure, governance or membership with either the nonprofit hospital or the purchaser, unless the nonprofit hospital continues to operate on a nonprofit basis after the transaction and such sum is transferred to the nonprofit hospital to provide health care services, and (B) is not being used for one of the following purposes: (i) For appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose, (ii) for the support and promotion of health care generally in the affected community, or (iii) with respect to any assets held by the nonprofit hospital that are subject to a use restriction imposed by a donor, for a purpose consistent with the intent of said donor; or
9. the nonprofit hospital or the purchaser has failed to provide the Attorney General with information and data sufficient to evaluate the proposed agreement adequately, provided the Attorney General has notified the nonprofit hospital or the purchaser of the inadequacy of the information or data and has provided a reasonable opportunity to remedy such inadequacy.

Expanded Review - OHCA - §19a-486d(a)

The commissioner shall **deny** an application **unless** the commissioner finds that:

1. In a situation where the asset or operation to be transferred provides or has provided health care services to the uninsured or underinsured, the purchaser has made a commitment to provide health care to the uninsured and the underinsured; and
2. in a situation where health care providers or insurers will be offered the opportunity to invest or own an interest in the purchaser or an entity related to the purchaser safeguard procedures are in place to avoid a conflict of interest in patient referral.

APPENDIX B -

CON Decision-Making Process

CON Decision-Making: PUBLIC INPUT

Public Hearings. For applications submitted to OHCA, a public hearing is held when:

- OHCA independently elects to hold a hearing;
- 3 or more individuals request a hearing in writing;
- An individual representing a group of 5 or more people requests a hearing in writing;
- For the transfer of a large group practice, 25 people (or an individual representing a group of 25 or more people) request a hearing in writing
- The application involves a hospital transfer of ownership

A request for a hearing must be made not later than 30 days after the office determines the application is complete. Once OHCA has determined a public hearing will be held, it will notify the applicant at least two weeks in advance and will place an advertisement in a newspaper in the area of the proposed project announcing the time, place, and topic of the hearing.

Public hearings are open to all members of the public. Individuals who wish to comment may do so in person at the hearing or in writing prior to the official closing of the record.

Intervenors: Individuals who have an interest in the matters at issue can petition the hearing officer to be designated an intervenor. The hearing officer may grant intervenor status if s/he finds that the individual has, at least 5 days prior to the hearing, sent a petition to the agency and all other parties that shows the individual's legal rights, duties or privileges will be specifically affected by OHCA's decision in the case. The hearing officer may also set the scope of an intervenor's participation by limiting the ability to cross-examine witnesses, setting the issues for which an intervenor may contribute, and determining the intervenor's ability to inspect and submit evidence.

Intervenors have the opportunity to speak at the public hearing and present witnesses, whose testimony is included in the public record on which OHCA bases its decision.

CON Decision-Making: TRANSPARENCY

The Office of Health Care Access maintains CON informational web pages as part of the Department of Public Health web site. The site contains the state's CON statutes, regulations, information for applicants that includes CON process flow charts and timelines, a list of pending applications and accompanying materials, public hearing information, and final decisions. OHCA updates the online Status Report for pending CON applications on a weekly basis and usually posts materials related to applications with 24 hours of being received or issued by OHCA. OHCA also provides a Frequently Asked Questions page that includes information on how to obtain additional materials through the Freedom of Information Act process.

OHCA informs the public of upcoming public hearings through the following mechanisms: (1) publishes a legal notice informing the public in the major local newspaper where the proposal/project is to be located; (2) files its weekly calendar with the Secretary of State; (3) publishes information on the front webpage of OHCA's website; and (4) posts notice of the public hearing on the Department of Public Health's online calendar.

APPENDIX B -

CON Decision-Making Process

CON Decision-Making: APPEALS PROCESS

Connecticut's CON Appeals Process

Connecticut's CON appeals process can occur through three paths: (1) upon release of proposed final decision the applicant can request a an oral argument with the Deputy Commissioner of DPH to change the decision before a final decision is issued; (2) upon formal denial the applicant can file a petition for a reconsideration; and/or (3) if the reconsideration is denied, or the terms to file a reconsideration are not met, the applicant may file an appeal with the state Superior Court.

1. Oral Argument

Prior to a final decision including a denial of a CON application, OHCA releases a proposed final decision. An oral argument is a formal dialogue between the Deputy Commissioner of DPH and the applicant where the applicant can make a case for why the application should not be denied such as highlighting an error in facts used to support the decision. New information may not be presented during an oral argument. Oral arguments are open to the public but only the applicant and Deputy Commissioner may speak. There is no opportunity for public comment.

2. Application Reconsideration:

Once an application final decision is rendered, applicants may request a reconsideration. To request a reconsideration, applicants must file a petition within 15 days of OHCA's mailing the decision. The petition must be based on one of the following: an error of law or fact; newly discovered relevant evidence that was not, for good reason, presented previously; or other good cause. [kk]

If, after 25 days of receiving the petition, OHCA determines the denial does not warrant additional review, the petition for reconsideration is considered rejected. If OHCA does decide to reconsider the application, it has 90 days after receipt of the petition to issue a new decision affirming, modifying or reversing the denial. OHCA may request additional information. If it does not issue a decision within those 90 days, the original denial will remain the final decision.[ll] Only applicants or parties as designated by OHCA can request a reconsideration. Intervenors and the general public cannot request a reconsideration[mm].

3. Appeals to the State Superior Court:

Applicants may, after a final decision has been rendered, appeal to Superior Court. Applicants must file an appeal within 45 days of either the mailed final decision or the rejection of a petition for reconsideration. Only applicants or parties as designated by OHCA can file an appeal. The general public and intervenors cannot appeal a final decision.

[kk] Contested cases. CONN. GEN. STAT §4-181a (2015).
[ll] Contested cases. CONN. GEN. STAT §4-181a (2015).
[mm] Department of Public Health, Office of Health Care Access; *Certificate of Need Application Guide*; January 13, 2016.