



**Independent Assessment of the
Connecticut Department of Public Health
Office of Health Care Access
Certificate of Need and Supporting Programs**



Completed February 28, 2014

Acknowledgements

This report presents an assessment of most aspects of Connecticut's Certificate of Need (CON) Program. It was commissioned by the Department of Public Health (DPH), Office of Health Care Access (OHCA), and conducted by MacQuest Consulting, LLC, pursuant to DPH Contract Log #2014-0089-2, for the time period of November 1, 2013 through February 28, 2014.

Connecticut CON and related programs in OHCA have been examined in the context of regulatory and health planning practices and trends nationally, and in the light of evolving health care industry, health care reform, and market conditions. The opinions and recommendations expressed in this report were based on the interviews during two site visits with government officials, telephone interviews with health association representatives, and analysis of numerous materials provided by OHCA and others.

Traditional health planning and regulatory principles realize that the classic anti-competition arguments of health care entrepreneurs is inconsistent with the health and welfare of consumers. State efforts to ensure reasonable cost, equitable access and high quality of health care is akin to regulating water purity, highway safety, and quality education. Because the free market is fiction for health care due to health insurance standards, government payments, and provider guidance, government oversight is imperative, particularly since health services are not a commodity.

The assurance of public safety nets, rural and medically underserved access, emergency medical services availability, financially stable hospitals and reliable freestanding services does promote long term economic development, if based on fair state health planning and regulatory processes. This report promotes these concepts.

MacQuest Consulting appreciates the cooperation and assistance of the many state government and health care industry officials who provided their observations, advice and expertise (*see listing of interviewees in Appendix G*). Comparative information provided by OHCA and other CON programs nationwide has also been invaluable.

Special thanks to the Connecticut Department of Public Health (DPH), and particularly the dedicated efforts of the OHCA staff. Their responsiveness and assistance in gathering the large volume of information and data used in this assessment are greatly appreciated, and without which, this report could not have been completed. Their detailed experiences, extensive knowledge, and expressive candor during the site visits, as well as feedback afterwards, has made this report's observations, conclusions and recommendations both pertinent and timely to the rebalancing of their operations.

Thomas R. Piper, CEO
MacQuest Consulting, LLC

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Introduction and Background

The Connecticut Certificate of Need Program was a result of Public Law 93-641 in 1974 when the Federal Government mandated State Health Planning and Development Agencies across the country. Connecticut in 1973 was one of 15 states who initiated their program prior to the federal mandate, largely motivated by the preceding Comprehensive Health Planning federal initiatives.

The early emphasis of federal guidance focused on the development of state health plans which used encouragement and financial incentives for implementation. If all else failed, it was believed that certificate of need (CON) would be a persuasive motivating tool.

Federal funding ended in 1987 after which 36 states (plus the District of Columbia) continued their health planning and regulatory efforts using local resources. Unlike most other states which used state General Revenue, Connecticut has since supported its efforts with funds from the acute care hospitals in the state. Many states also discontinued their State Health Plans, instead relying on specific need criteria and standards for guidance, both in statute and in regulation.

Today, 34 states actively regulate the development of new and expanded services and facilities (in 2013, Wisconsin ended their efforts, and South Carolina defunded their CON program). During the past 25 years, these states have widely diverged in what and how they review, as shown in a comparative spreadsheet (*see Appendix A*) and map (*see Appendix B*).

Effective November 1, 2013, a three-month contract (later extended to four months) was executed with MacQuest Consulting, LLC to “conduct an on-site assessment of the Department’s certificate of need (CON) and supporting programs as operated by the Office of Health Care Access (OHCA).” The scope of the assessment was specified to include:

1. a review of its financial data reporting program;
2. a review of its CON program;
3. a review of its health data reporting program;
4. a review of its compliance program;
5. a review of Statewide Healthcare Facilities and Services Plan;
6. a review of general work flow conducted by OHCA staff;
7. a review of staff skillsets;
8. a review of workload, staffing levels within OHCA;
9. a review of internal communications within OHCA and external communications with Department administration, programs, other agencies, and customers that utilize OHCA’s services;
10. a review of OHCA’s organizational structure and operations;
11. a review of the sufficiency of available resources within OHCA;
12. a review of mechanisms to monitor ongoing compliance;
13. a review of applicable statutes and regulations;
14. a review of facilities, equipment and services currently subject to CON review;
15. a review of criteria, standards and methods used to determine “need” and “access”;
16. a review of CON standards and guidelines in the Statewide Health Care Facilities and Services Plan;
17. a review of the effectiveness of the CON program to inform the health care delivery system and alignment with health care reform;

18. a review of the feasibility of considering economic development and benefits to the state as part of the CON process;
19. a review of the feasibility of including strategies of aligning community benefits programs as part of the CON process; and
20. a review of the aforementioned items in conjunction with best practices and other similar states.

This report addresses each of these items separately in the order specified in the contract. Each item lists the documents and information reviewed (over 80 in total), impressions gained from each, a listing of observations from each of the site visits (November 16-20 and December 17-18, 2013), a description of conclusions based on review of information and observations, and a defined set of recommendations to assist in the resolution of any identified concerns.

The Communications section also includes observations distilled from four separate telephone interviews with health industry leaders. These people represent the facilities and services that regularly submit CON applications and monitor CON issues. These discussions focused on CON communication, efficiency and effectiveness, with suggestions for improvement.

An Executive Summary of all 64 unduplicated recommendations in seven categories (listed in priority order) immediately follows this Introduction and Background to facilitate an understanding of what measures should be taken to assist a return to balance for OHCA operations. The Detailed Responses to Scope of Assessment section generally follows a bullet-point format used to capture reactions to all information gathered, and to allow for quick review.

SPECIAL NOTE: The impressions and observations listed are interpretations of what was seen, heard and read, stated in outline form to represent important considerations during the gathering of information. Unless specifically listed in quotes, they should be considered the author's brief recollections and perceptions rather than findings of fact or legal inferences.

The conclusions are intended to integrate summary interpretations with transitional rationale leading to the recommendations which culminate each section. Cross-references are highlighted in *blue italics*. Some recommendations are repeated in multiple sections due to overlapping categories and cross-over priorities. Ultimately, this information represents opinions based on 42 years of health planning, management and regulatory experience, combined with knowledge gained from 24 years of information sharing with all CON programs, and the excellent contributions of people interviewed in state government and the health care industry.

The Office of Health Care Access conducts its CON program, data functions and other activities very commendably in comparison with most state CON programs, where it ranks at the midpoint. It is staffed by a skilled, passionate and experienced group of professionals who are sincerely seeking to ensure access to quality health care for the public. Armed with an excellent data system, new health plans, general health industry support, and health reform mandates, this DPH office has the opportunity to achieve outcomes.

But, having weathered a number of substantial changes over the last five years, available resources and evolving expectations have shifted to create numerous areas of imbalance. This report provides a multi-faceted administrative, policy and legislative plan to help revitalize, refortify and restabilize OHCA's path to efficiency, effectiveness, and equilibrium.

Executive Summary

This is a collection of all 64 recommendations assembled by area of interest, listed in order of suggested implementation priority. The detailed documents and information reviewed, impressions and observations, and resulting conclusions and rationale which lead to these recommendations are shown and cross-referenced (*in blue notes*) in the 20 detailed sections that follow this Summary.

I. Staffing and Resources

1. In order to restore staff capacity and skill levels, four new staff positions should be added including a lead planning analyst (a generalist with exceptional editing, management, analytical and motivational skills) to supervise CON reviews, an associate research analyst (data, survey, report writing, and communication skills) to meet this increasing workload, a health care analyst (writing, analytical, multi-tasking skills) to conduct reviews, and an office assistant (detail-oriented, copying, filing, correspondence, and communication skills) to provide general support services, all of whom are critically needed due to the rapidly expanding workload, increasing complexity of reviews, growing demand for detailed financial and utilization reports of regulated services, pressing need for multiple planning updates, and new research priorities pursuant to health reform activities (*Note: this only reflects current need, but even more analysts should be added if legislative changes, such as new conversion statutes, require more planning standards, CON analysis and data reports*).
2. In order to fund the necessary additional staff and support expenses, at least \$300,000 plus fringe benefits and operational expenses should be added to OHCA's annual budget.
3. In order to better align skills and experience with defined results management and future opportunities, OHCA staff should be reorganized into the basic disciplines of data, planning, and analysis teams with articulated cross-team advisory responsibilities.
4. In order to spark more staff interest and enthusiasm:
 - a. Establish a Culture of Accountability beginning with clearly defined results, mandated deadlines, designated responsibility for achievement, committed team spirit, attractive incentives, sincere recognition, and sustained feedback (*educational documents, training packages, webinars, videos, regional seminars and onsite workshops are available from resources such as www.partnersinleadership.com and www.ozprinciple.com*);
 - b. Expand professional development opportunities by requiring attendance at innovative training and skills building sessions throughout the year; and
 - c. Promoting health industry field trips to improve knowledge of how regulated health care facilities and services are evolving and the changes that are necessary.
5. In order to accommodate OHCA's "can do" attitude and maintain a consistent workload, the response to requests for new activities and priorities must be met with "yes, if" answers such that considerations of time, resources and competing priorities must accompany the acceptance of additional workload.
6. In order to maximize the team concept and facilitate continual communication and coordination, redesign the office arrangements such that the staff cubicles are clustered close to their functional area supervisors, and include strategic open assembly areas to encourage productive intermittent meetings, while maintaining current building location.

II. CON Review Process

1. In order to improve the CON analytical process:
 - a. Add four new staff positions including a lead planning analyst (a generalist with exceptional editing, management, analytical and motivational skills) to supervise CON reviews, an associate research analyst (data, survey, report writing, and communication skills) to meet this increasing workload, a health care analyst (writing, analytical, multi-tasking skills) to conduct reviews, and an office assistant (detail-oriented, copying, filing, correspondence, and communication skills) to provide general support services, all of whom are critically needed due to the rapidly expanding workload, increasing complexity of reviews, growing demand for detailed financial and utilization reports of regulated services, pressing need for multiple planning updates, and new research priorities pursuant to health reform activities (*Note: this only reflects current need, but even more analysts should be added if legislative changes, such as new conversion statutes, require more planning standards, CON analysis and data reports*).
 - b. Create a new Review Manual which includes styles, punctuation, templates, tables, format, legal expectations, and time frames;
 - c. Establish a team approach to overall CON application review processes (while maintaining individual analysis) building on the objectives and ideas defined in the Kaizen approach, and building into it a firm implementation schedule complete with feedback and quarterly updates;
 - d. Request that Department of Administrative Services reassess OHCA's skills and functions; and
 - e. Post a revised set of questions based on the ten CON criteria and customized by individual review category.
2. In order to enhance the decision-making process:
 - a. Establish a CON Advisory Panel appointed by the DPH Commissioner with ten volunteer members representing the healthcare industry, medical professions, business, insurance, and community who share their expertise about whether a CON proposal should be approved, conditions added, or denied (*based on examples such as Hawaii, New Jersey, New York, Rhode Island, Tennessee, and Vermont*);
 - b. Utilize conditions on CON approvals through "agreed settlements" to promote more extensive CON applicant involvement in health planning activities such as State Health Improvement Plan, Statewide Health Care Facilities and Services Plan, and Community Health Needs Assessments, as well as funding local economic development efforts; and
 - c. Provide streamlining incentives such as abbreviated applications and shorter review times for joint ventures among health providers for unique proposals such as new and emerging technologies, existing equipment acquisition, and equipment replacement.
3. In order to restore alignment with statutory criteria and ensure an improved completeness process, the CON review forms should be revised to build on the current ten statutory criteria, ensure consistency of format among all forms, tables and charts, and simplify the CON application process.
4. In order to assist CON applicants and improve the review process, a high priority should be committed to the completion and implementation of regulations for the criteria and standards in the Statewide Health Care Facilities and Services Plan.

5. In order to better manage workload and because it requires legal interpretation, inquiries into potential CON projects and requests for CON determinations should be conducted by OHCA legal counsel, with assistance from CON and compliance staff, a transition which has already begun.
6. In order to better manage workflow, requests for extensions beyond the second year CON end date should be moved from the CON Analyst to the Compliance Analyst.
7. In order to encourage the development of new facilities and services in areas of unmet need as defined in the Statewide Health Care Facilities and Services Plan, provide incentives such as creative conditions (relocation of proposals, transportation of patients, exception to standards), expedited review and waived process to CON applicants.
8. In order to reduce delays and keep OHCA informed of an applicant's steps toward project completion, brief periodic progress reports should be electronically submitted by the applicant every six months after CON approval until a final report upon completion.
9. In order to improve public understanding of CON:
 - a. Update annually the OHCA PowerPoint presentation and post on CON website;
 - b. Update annually the OHCA 101 video and add a step-by-step online training webinar for CON applicants; and
 - c. Create and post a CON Guidebook (*see attached Appendix H as an example*) on the website, as well as a paper version, for distribution to potential applicants, media, planners, legislators and other interested persons.

III. Statutes and Regulations

1. In order to better manage workload, workflow and priorities, in statutes:
 - a. Institute a quarterly system of review cycles for at least the general categories of Ownership Change, Imaging, Termination, Cardiac and Behavioral Health (*such as Missouri, Michigan, and North Carolina*);
 - b. Require a Letter of Intent at least 30 days before application submission;
 - c. Implement a statutory decision due date for 90 days after an application has been deemed complete after which a CON application would be automatically approved if a decision is not otherwise rendered; and
 - d. Establish an Expedited CON review process to reduce the time and detail required for certain types of review such as existing equipment acquisition, replacement equipment, and compliant non-controversial applications (*such as in Rhode Island, New Jersey and North Carolina*).
2. In order to add clarity and distinction to CON review, the following terms should be defined in statute as:
 - a. "Public Need" . . . Health care services and facilities necessary for the people of Connecticut as a whole as specifically measured by the applicable standards of the Statewide Health Care Facilities and Services Plan, as well as consideration of other statutory certificate of need guidelines and principles;
 - b. "Termination" . . . The operational discontinuance or elimination by a health care facility (excluding affiliates) as defined by Subsection (10) of Section 19a-630, C.G.S of a health care service (not including a temporary suspension lasting six months or less) with the

- exception of the merger, transfer or relocation of health care services which are located up to five miles apart in an urban area;
- c. “Expedited” . . . An abbreviated certificate of need process requiring only basic application forms and a decision within 45 days after deemed complete, after which a CON application would be automatically approved if a decision is not otherwise rendered, for facility and equipment replacement applications; and
 - d. “Service Area” . . . The geographic area, usually comprised of census tracts, in which the health care facility or service is located from which approximately 80% of their patients currently originate or reside, or are expected to originate;
 - e. “Healthcare Quality” . . . The extent to which health services provided to individuals and patient populations improve desired health outcomes whereas the care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision-making (*see Institute of Medicine*); and
 - f. “Healthcare Access” . . . The ability of a person to receive necessary health care services, which is a function of availability of personnel and supplies, and the ability to pay for those services (*see McGraw-Hill Dictionary of Modern Medicine*).
3. In order to promote various aspects of health reform, consider in statute a change from CON review of “transfer of ownership” to a public notification process, except for hospital conversions which affect tax status, such as not-for-profit to for-profit.
 4. In order to recognize state-of-the-art medical practice and streamline equipment acquisitions, remove computerized tomography (CT) and cone-beam imaging equipment in any setting from review (*consistent with two-thirds of the other CON states*).
 5. In order to balance the level of services reviewed, add by statute the review category of new hospital inpatient and outpatient services.
 6. In order to avoid confusion and promote industry cooperation, a statutory provision should be established requiring that the pre-requisite CON be included as part of the licensure application process for those facilities and services requiring CON.
 7. In order to assure predictable, consistent and accurate statistical information, amend the statutes to require that population projections for CON applications be obtained from the Department of Public Health.
 8. In order to assure a level playing field for all CON review facilities and services, an independent study should be conducted concerning the CON implications of the urgent care facility, hybrid medical facility (such as “med spas” and vein clinics) and other new service proliferations which conduct surgical procedures.
 9. In order to clarify how termination review would be applied and articulate clearly statutory intent, the legislature should define the term “healthcare service” including the specific types of health care facility resources to be affected.

IV. Statewide Health Care Facilities and Services Plan

1. In order to better measure the public quantitative need for CON reviewed facilities, equipment and services, the CON standards and guidelines in the Statewide Health Care Facilities and Services Plan should be expanded to include population-based predictive formulas, unmet needs and surpluses (*see Missouri CON standards for simplicity, the New*

York and Michigan CON standards for well-researched details, and the North Carolina State Medical Facilities Plan for statistical methodologies and conclusions).

2. In order to facilitate the updating of CON rules, add a new part to the executive summary of the Statewide Health Care Facilities and Services Plan which highlights the recommended standards for each facility and service category reviewed by the CON program.
3. In order to better link potential CON conditions with the Statewide Health Care Facilities and Services and State Health Improvement Plans, establish a new chapter showing facilities and services opportunities to meet unmet need or gaps in services.
4. In order to illustrate the DEMHS regions, if used in future editions, the boundaries of these regions should be shown on key maps showing the locations of various facilities.

V. Internal and External Communications

1. In order to accomplish CON decisions on a timely basis, OHCA should improve its operations by streamlining workflow to include statutory decision deadlines, expedited application review, analyst review manual, and disciplined staff oversight.
2. In order to encourage early planning, improve application completeness and promote coordination with OHCA, require that prospective CON applicants meet with a review analyst prior to submission of their CON application.
3. In order to improve customer relations and public receptiveness, OHCA staff should be empowered and trained in effective communication, particularly with CON applicants and the media, emphasizing early intervention, continual information exchange, and effective delivery of public information.
4. In order to improve connections with licensure section in DPH, the assigned analyst for a CON application should notify this section by telephone with the specifics of the application, notify the same sections by email when a final decision is rendered, and all analysts should hold at least quarterly meetings with these sections in order to provide CON status reports.
5. In order to improve public knowledge and simplify electronic access to OHCA information, the CON portion of the website should be restructured similar to the Facilities Plan page which sequences Goal, Background, Issues, Outcomes and Content (*worthy examples of other state CON websites include Massachusetts, Georgia, Missouri, and Maine*).
6. In order to reduce inefficiencies, maintain effective coordination, and enhance relations with legal services for the CON program and other activities, OHCA should interactively review and update its staff attorney responsibilities on a bi-annual basis.
7. In order to be electronically more responsive to Freedom of Information requests, OHCA should establish a secure holding area on the website titled “Recent FOI Requests” to provide temporary content for such that requestors could download large files and reduce paper responses.

VI. Financial and Utilization Data

1. In order to improve public understanding of the hospital industry and its trends, OHCA should quarterly post short website informational documents extracted from its reports

which focus on key findings and conclusions drawn from this data, such as the Hospital Dashboards.

2. In order to enhance work products, OHCA should continue to find meaningful areas on which to research and report to the industry and policy makers using its financial and utilization data, as well as, other available resources.
3. In order to enhance work products, propose legislation to require limited unaudited financial data by individual hospital on a six-month (bi-annual) basis (*see quarterly hospital data reports in Washington State and Massachusetts*).
4. In order to improve workflow, propose legislation to require acute care hospitals to post their full current pricemasters (Chargemasters) on their own websites.

VII. Economic Development and Community Benefits

1. In order to be more proactive and promote health care development, the legislature should reconfirm its commitment to state health planning and recognize CON as an implementation tool, as well as a steward of cost, access and quality.
2. In order to provide opportunities for health care economic development in areas of unmet need, OHCA should update the CON regulated portions of the Statewide Health Care Facilities and Services Plan to include methodologies to define specific needs for facilities, equipment and services by type, volume and location.
3. In order to motivate the submission of CON applications to address areas of unmet need, the CON Program should establish a bi-annual “Request For Application” process (*see examples in Virginia, Maryland and North Carolina*).
4. In order to assist in and motivate the development of new and expanded facilities, equipment and services in unmet need areas, the legislature should establish a special “Health Care Development Fund” for qualified healthcare providers.
5. In order to stimulate community benefits, selected conditions should be placed on approved CON applications related to charity care, unreimbursed costs for means-tested government programs, subsidized health services, community health improvement services and benefits operations, research, healthcare professional education, community health needs assessments, and contributions to community groups (*see examples in New York, Michigan, Maryland and North Carolina*).
6. In order to assure full compliance with the intent of not-for-profit status, the legislature should mandate minimum hospital community benefit programs, financial assistance policies, and community health needs assessments (*see New York, Maryland and Rhode Island for examples*).
7. In order to fully represent the views of providers, consumers, business, payers, and others, OHCA should augment its update of the Statewide Health Care Facilities and Services Plan with a statewide invitation to stakeholders to provide comments and recommendations on how to improve the scope and content of Connecticut’s CON process (*see New York State Public Health and Health Planning Council*).

Detailed Responses to Scope of Assessment



1. Financial Data Reporting Program

A. Documents and information reviewed:

DPH/ Hospital Filings.webarchive
Report 450 & 485 Examples.pdf
HRS Reports Quarterly Data Dashboards.pdf
Financial and Health Data Descriptions.pdf
Financial Status of Connecticut's Short Term
Acute Care Hospitals for Fiscal Year 2012
Website listings

Impressions from review:

- ◆ Connecticut Hospital Financial Data on OHCA's website includes information for all hospitals including annual reporting filings, 12-month actual filings, audited financial statements, financial dashboard, and frequently requested data reports (2009 to 2012), plus current hospital Chargemasters.
- ◆ Annual financial statements are also provided for nine specialty hospitals (2009 to 2012).
- ◆ Broadly detailed reports include everything from hospital finances to Medicare cost reports, corporate structure, officers and directors, hospital utilization reports, policies and procedures, hospital salaries and benefits, and much more.
- ◆ Reports 450 and 485 also provide hospital inpatient and outpatient data, other services aggregate utilization and FTEs, plus hospital outpatient surgical, endoscopy and emergency room services by location.
- ◆ Financial status report is a captivating 146-page review of financial performance, profiles and other analytical reports of 29 hospitals in 2012 providing a comparative analysis depicting the trends in health of the Connecticut hospital industry.
- ◆ Connecticut compared well with other hospital data programs (*see Appendix C*).

B. Site Visit Observations

Perceptions from First Visit Interviews:

- ◆ Excellent data collection systems yielding informative reports, and also need a more frequent streamlined hospital status dashboard to timely monitor health of hospitals.
- ◆ Media likes financial stability reports and CEO salaries for hospitals, which are important leads into other important information.

Perceptions from Second Visit Interviews:

- ◆ Financial Team and Utilization Team meet periodically, coordinate through staff.
- ◆ Comparison of quality vs. performance is difficult to do, but important consideration.
- ◆ There is a "story behind the data", and staff should consider what the reader needs to know and include a summary of key points.
- ◆ Readmission rates are important to monitor and evaluate.
- ◆ Outpatient Data Workgroup started considering additional data about a year ago.

C. Conclusions

The financial data reporting program appears to be very well grounded. The staff is experienced and knowledgeable about the tasks that they have before them. The information that they collect and reports that are produced appear to be a good fit, skillfully reflecting the hospital systems in Connecticut, with the potential to keep many better informed.

Most of the emphasis is on hospital data, with some efforts underway to gain more outpatient data. Long-term care data is handled in the Department of Social Services.

D. Recommendations

1. In order to improve public understanding of the hospital industry and its trends, OHCA should quarterly post short website informational documents extracted from its reports which focus on key findings and conclusions drawn from this data, such as the Hospital Dashboards.
2. In order to enhance work products:
 - a. OHCA should continue to find meaningful areas on which to research and report to the industry and policy makers using its financial and utilization data, as well as, other available resources; and
 - b. Propose legislation to require limited unaudited financial data by individual hospital on a six-month (bi-annual) basis (*see quarterly hospital data reports in Washington State and Massachusetts*).
3. In order to improve workflow, propose legislation to require acute care hospitals to post their full current pricemasters (Chargemasters) on their own websites.

2. Certificate of Need Program

A. Documents and information reviewed:

DPH CON Kaizen Final Presentation.pptx
Public Health Committee Forums video
Michigan Presentation of CT CON.ppt
OHCA Policy and Procedures.pdf
Certificate of Need summary.docx
CON Process Side-By-Side Comparison.doc
CON Application Summary 2012.pdf
Summary of Certificate of Need Activity in Calendar 2013.xlsx
Mock Exercise Script - proposal & compliance.pdf
Huge Application Example 12_31788_con.pdf
Example of Well-Written Application
HSS 31780 Decision Example.pdf
Denial Example Econ Dev impact 31799.pdf
CON rev manual (OLD).doc
CT AHPAdir / notes / matrix / directory.pdf
CON folder of forms / website
NEWYORK tips_for_submitting_complete_con_application.pdf
OHCA decision 31837 writing style.pdf
OHCA 101 video

Impressions from review:

- ◆ Michigan presentation of CON in Connecticut is a wonderful public relations overview that was last updated in 2010.
- ◆ Kaizen presentation for CON program improvement produced in mid-2013 captures a variety of well thought-out activities and procedures to streamline the internal process.
- ◆ Public Health Committee presentation online is an hour-long video which describes the roles of OHCA and the Attorney General's office in review of proposed conversions of not-for-profit to for-profit status of hospitals under CON in accordance with the statutes plus Q&A, including the views of the Connecticut Hospital Association at a second two-hour committee forum.
- ◆ OHCA policies and procedures is a 231-page procedures manual to assist staff in their daily operations including information on customer assistance, CON review process, detailed process flow charts, application questions and forms by type of service, hospital reporting system instructions, patient bill review, fee acceptance process, and CON compliance procedures.
- ◆ CON summary prepared by OHCA describes how CON is administered in other states.
- ◆ Process side-by-side comparisons illustrate the detailed before and after effects of new Statute 19a-638 changes in 2010.
- ◆ Brief 2012 report showing 33 applications, 39 determinations, seven CON modifications.
- ◆ Summary 2013 report showing 31 applications, 40 determinations, four modifications and one reconsideration.

- ◆ Mock exercise script was the dialogue used by OHCA staff to present the CON proposal process plus the CON compliance process.
- ◆ Various CON applications were examined to show a well-written complete application (over 1,325 page affiliation application), typical decision narrative (MRI application), preferred decision writing style example (behavioral health application) and a denial example (outpatient plastic surgery application).
- ◆ Reviewed the outdated CON analysis training manual which was used before OHCA was assimilated into DPH; it was intended to assist analysts with the CON procedure checklist, review process improvements, hearing specifications, and critical review concepts (no longer in use).
- ◆ Various charts, notes, tables and other information were reviewed from the American Health Planning Association national directory.
- ◆ Numerous forms were reviewed which are used by applicants to apply for each of the categories of CON review were downloaded from the website, as well as various checklists and overviews of process.
- ◆ New York State CON tips for submitting a complete application providing guidance to applicants to ensure the best possible submissions were reviewed.
- ◆ Recent OHCA 101 hour-long video which provided the succinct presentations by staff as an overview of OHCA activities designed for a public audience was reviewed.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ “Public need” begs definition due to variety of competing interpretations.
- ◆ Extensive legal support supplied to applications, with electronic and paper submission.
- ◆ Long-term care CON is in the Department of Social Services (DSS), OHCA CON is very detailed and protracted process.
- ◆ Need a single source of information for one-stop-shopping to aid staff, applicants, planners, legislators, media, public, and others.
- ◆ Opportunities for flexibility and community benefit through “agreed settlements”.
- ◆ Population information can be acquired from any source without state verification.
- ◆ Service areas are defined by the applicant without consistent objective standards.
- ◆ Very few face-to-face applicant meetings with staff to learn about process or trends.
- ◆ Draft decision goes from analyst to supervisor to attorneys to director to deputy commissioner, and occasionally to Attorney General’s office.
- ◆ Attorney General’s office said, regarding not-for-profit to for-profit conversions of hospital assets, they are charged with assuring the preservation of charitable funds and that the transfer of assets was the result of a fair, diligent and balanced transaction, they are counsel to OHCA for administrative proceedings, they defend all the appeals on behalf of OHCA, and have final say on statutory interpretations (*see listing of interviewees in Appendix G*).
- ◆ Provider-driven CON review system with little scheduling control for OHCA, complex system which has evolved over many years and could benefit from streamlining.

Perceptions from Second Visit Interviews:

- ◆ DPH staff wants clear definitions for terms like “expedited” and “termination” to improve process, legislative changes may be needed.
- ◆ Many concerned about long length of overall CON review time, now over a year compared to historical average of six to nine months, as well as decisions not being rendered by statutory deadline of 90 days.
- ◆ 30-day completeness cycle is taking longer and could often be completed in 20 days.
- ◆ Improved accountability needs to be enforced to meet deadlines, reduce repeat drafts.
- ◆ Usually about 30 projects per year for six analysts doing CON part-time.
- ◆ Restoration of legislative decision deadline may be needed to reduce review length.
- ◆ Some expect more potential denials and conditions in the future with new standards.
- ◆ Legally supported position necessary via findings of fact, but applicant representatives have concerns about timing of review knowing it should be shorter with more applicant communication needed.
- ◆ Templates are needed with emphasis on style and content in view of recent changes.
- ◆ Quality of reviews are not good due to problems with accuracy, too many repeat drafts, inadequate communication at all levels, inconsistent templates, no formal training, and editing changes; standardized templates needed for tables/letters/analysis/forms.

C. Conclusions

OHCA’s administration of the Connecticut Certificate of Need Program is well described and presented in a variety of venues. The staff is obviously passionate in their attitude, and the administration is supportive in their management. The documents reviewed illustrate a knowledgeable depth of operations seasoned by many years of experience and dedication.

The changes that have occurred over the past six years due to health care reform, statutory streamlining efforts, and integration into the Department of Public Health have been laudable in their objectives, but the results have fallen short of their intentions due to loss of staff capacity, expertise and morale, plus a decided shortage of resources.

In spite of previous efforts, the Connecticut Certificate of Need Program still appears complex and opaque. Critical terms such as “public need” and “termination” beg for definition and clarification, while the application and review processes seem overly complicated and unnecessarily time-consuming. While the website and public information opportunities may be effective for the experienced user, the lack simplicity and ease-of-use for the general public and new applicants are time-consuming and confusing.

In an attempt to be objective, consistent and complete, the overall process is overly burdensome for CON applications of obvious merit and probable approval. Yet some information requirements are left to broad interpretation, such as service areas and population statistics. The loss of the Letter of Intent preview process and mandated decision dates has restricted OHCA staff’s ability to efficiently schedule and manage the review process. The extensive tiers of review and repeated cycling of analyses delay the final decision beyond statutory guidelines creating frustration for the applicants and staff.

Recent public information efforts are an excellent step toward improving knowledge and understanding of OHCA's efforts, but other presentation tools and website information are outdated and sometimes misleading. The multitude of statutes, regulations, policies and procedures, guidelines, charts, tables, flowcharts, and other information can indeed be found on the website, but are spread out and not consolidated into a single resource document for easy access and review.

Although intended to be a helpful "recipe" for applicants, the online sets of application questions by category of review have evolved over the last 40 years to become unnecessarily complicated, often resulting in incomplete applications. Efforts are underway to simplify and realign these questions with the 10 statutory criteria, but these have been delayed by diversified workload, lack of adequate communication, and issues of accountability.

Because the CON process is a "provider-driven" system whereby applications of all sorts are filed without any predictability or patterns, scheduling and workload is difficult to manage, often with competing priorities with other OHCA projects. Batching by type of review, expedited review processes, and predefined review cycles are successful techniques used in other states, but not yet established in Connecticut CON regulation.

The analytical process of reviewing CON applications toward the development of a draft decision is burdened by inconsistency, insufficient templates, inadequate writing styles, repeated editing at multiple levels, unclear expectations, inefficient use of resources, lack of specialization, difficult coordination, and limited communication. The review guidance manual is antiquated and unused, while changes in authorship and guidance have led to confusion, frustration and delays. OHCA's recent "Kaizen" opportunity for improvement "problem statement" accurately proposes that *"Certificate of Need (CON) Decision writing can be improved to be more efficient in terms of time spent adequately analyzing applications, determining appropriate completeness questions to be asked of the applicant, drafting well-written relevant, findings of fact and discussions."* The objectives and improvement ideas set forth in this team effort are an excellent first step toward resolving many review issues and should be pursued further.

D. Recommendations

1. In order to improve the CON analytical process:
 - a. Add four new staff positions including a lead planning analyst (a generalist with exceptional editing, management, analytical and motivational skills) to supervise CON reviews, an associate research analyst (data, survey, report writing, and communication skills) to meet this increasing workload, a health care analyst (writing, analytical, multi-tasking skills) to conduct reviews, and an office assistant (detail-oriented, copying, filing, correspondence, and communication skills) to provide general support services, all of whom are critically needed due to the rapidly expanding workload, increasing complexity of reviews, growing demand for detailed financial and utilization reports of regulated services, pressing need for multiple planning updates, and new research priorities pursuant to health reform activities (*Note: this only reflects current need, but even more analysts should be added if legislative changes, such as new conversion statutes, require more planning standards, CON analysis and data reports*).
 - b. Create a new Review Manual which includes styles, punctuation, templates, tables, format, legal expectations, and time frames;

- c. Establish a team approach to overall CON application review processes (while maintaining individual analysis) building on the objectives and ideas defined in the Kaizen approach, and building into it a firm implementation schedule complete with feedback and quarterly updates; and
 - d. Post a revised set of questions based on the ten CON criteria and customized by individual review category.
2. In order to enhance the decision-making process:
- a. Establish a CON Advisory Panel appointed by the DPH Commissioner with ten volunteer members representing the healthcare industry, medical professions, business, insurance, and community who share their expertise about whether a CON proposal should be approved, conditions added, or denied (*based on examples such as Hawaii, New Jersey, New York, Rhode Island, Tennessee, and Vermont*);
 - b. Utilize conditions on CON approvals through “agreed settlements” to promote more extensive CON applicant involvement in health planning activities such as State Health Improvement Plan, Statewide Health Care Facilities and Services Plan, and Community Health Needs Assessments, as well as funding local economic development efforts; and
 - c. Provide streamlining incentives such as abbreviated applications and shorter review times for joint ventures among health providers for unique proposals such as new and emerging technologies, existing equipment acquisition, and equipment replacement.
3. In order to better manage workload, workflow and priorities, in statutes:
- a. Institute a quarterly system of review cycles for at least the general categories of Ownership Change, Imaging, Termination, Cardiac and Behavioral Health (*such as Missouri, Michigan, and North Carolina*);
 - b. Require a Letter of Intent at least 30 days before application submission;
 - c. Implement a statutory decision due date for 90 days after an application has been deemed complete after which a CON application would be automatically approved if a decision is not otherwise rendered; and
 - d. Establish an Expedited CON review process to reduce the time and detail required for certain types of review such as existing equipment acquisition, replacement equipment, and compliant non-controversial applications (*such as in Rhode Island, New Jersey and North Carolina*).
4. In order to add clarity and distinction to CON review, the following terms should be defined in statute as:
- a. “Public Need” . . . Health care services and facilities necessary for the people of Connecticut as a whole as specifically measured by the applicable standards of the Statewide Health Care Facilities and Services Plan, as well as consideration of other statutory certificate of need guidelines and principles;
 - b. “Termination” . . . The operational discontinuance or elimination by a health care facility (excluding affiliates) as defined by Subsection (10) of Section 19a-630, C.G.S of a health care service (not including a temporary suspension lasting six months or less) with the exception of the merger, transfer or relocation of health care services which are located up to five miles apart in an urban area;
 - c. “Expedited” . . . An abbreviated certificate of need process requiring only basic application forms and a decision within 45 days after deemed complete, after which a

- CON application would be automatically approved if a decision is not otherwise rendered, for facility and equipment replacement applications;
- d. “Service Area” . . . The geographic area, usually comprised of census tracts, in which the health care facility or service is located from which approximately 80% of their patients currently originate or reside, or are expected to originate;
 - e. “Healthcare Quality” . . . The extent to which health services provided to individuals and patient populations improve desired health outcomes whereas the care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision-making (*see Institute of Medicine*); and
 - f. “Healthcare Access” . . . The ability of a person to receive necessary health care services, which is a function of availability of personnel and supplies, and the ability to pay for those services (*see McGraw-Hill Dictionary of Modern Medicine*).
5. In order to balance the level of services reviewed, add by statute the review category of new hospital inpatient and outpatient services.
 6. In order to restore alignment with statutory criteria and ensure an improved completeness process, the CON review forms should be revised to build on the current ten statutory criteria, ensure consistency of format among all forms, tables and charts, and simplify the CON application process.
 7. In order to assist CON applicants and improve the review process, a high priority should be committed to the completion and implementation of regulations for the criteria and standards in the Statewide Health Care Facilities and Services Plan.
 8. In order to better manage workload and because it requires legal interpretation, inquiries into potential CON projects and requests for CON determinations should be conducted by OHCA legal counsel, with assistance from CON and compliance staff, a transition which has already begun.
 9. In order to better manage workflow, requests for extensions beyond the second year CON end date should be moved from the CON Analyst to the Compliance Analyst.
 10. In order to encourage the development of new facilities and services in areas of unmet need as defined in the Statewide Health Care Facilities and Services Plan, provide incentives such as creative conditions (relocation of proposals, transportation of patients, exception to standards), expedited review and waived process to CON applicants.
 11. In order to reduce delays and keep OHCA informed of an applicant’s steps toward project completion, brief periodic progress reports should be electronically submitted by the applicant every six months after CON approval until a final report upon completion.
 12. In order to improve public understanding of CON:
 - a. Update annually the OHCA PowerPoint presentation and post on CON website;
 - b. Update annually the OHCA 101 video and add a step-by-step online training webinar for CON applicants; and
 - c. Create and post a CON Guidebook (*see Appendix H as an attached example*) on the website, as well as a paper version, for distribution to potential applicants, media, planners, legislators and other interested persons.

3. Health Data Reporting Program

A. Documents and information reviewed:

IP & ED Source Data Layout_10032013.xlsx
OHCA IP ED Data Files Layout_2013.xls
OSC Source Data Layout_10032013.xlsx
DPH- Outpatient Data Work Group.webbloc
Preventable Hospitalizations.pdf
Utilization Chart Book.pdf
Report_QTRLY_Example.xls
Quarterly Data Proposal & Support Info.pdf
CT DPH OHCA Inpatient Data Dictionary FY2013.pdf
OHCA Data Dictionary.pdf
Data Elements in Chime ED Database.pdf
Financial and Health Data Descriptions.pdf

Impressions from review:

- ◆ The layouts for inpatient and emergency department data files, IP and ED source data, and OSC source data are consistent with national guidelines, plus the inpatient and hospital discharge data dictionaries and Chime ED data elements, very detailed and informative by nature.
- ◆ Outpatient Data Workgroup met for a year and a half developing specifications in preparation for a pilot data gathering exercise leading to a fully operational system by the year 2015, and excellent progress has since been made.
- ◆ Comprehensive 44-page Databook was produced in 2010 by OHCA for Preventable Hospitalizations in Connecticut spanning the years 2004-2008.
- ◆ Colorful and Educational 37-page Chartbook released by OHCA in 2011 concerning the 2010 Availability and Utilization of Health Care Services at Acute Care Hospitals and Federally Qualified Health Centers loaded with interesting charts, graphs, tables and descriptions related to the performance of 30 hospitals at that time.
- ◆ Website description of Connecticut hospital financial data, health utilization data, 12-month filings, and annual dashboard provides a broad spectrum of valuable hospital information.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Excellent data collection systems yielding numerous informative reports.
- ◆ Need a streamlined quarterly hospital status dashboard which can better track the health of individual hospitals and assure communities of continued stability.

Perceptions from Second Visit Interviews:

- ◆ Financial Team and Utilization Team meet periodically, coordinate through staff.
- ◆ Comparison of quality vs. performance is difficult to do, but an important feature.

- ◆ DPH staff believes there is a “story behind the data”, should consider what the reader needs to know and should include a summary of key points.
- ◆ Readmission rates are important to monitor and evaluate.
- ◆ Outpatient Data Workgroup considered additional data about a year ago; this outpatient surgical data is needed to eventually expand the OHCA data set.

C. Conclusions

OHCA’s health data reporting system is particularly well tailored to the Connecticut hospital system and provides excellent reports to the public. The ability to draw hospital executive salaries from these reports is particularly attractive to the media.

Efforts to gather more data from outpatient settings appears to be working in an acceptable pace with probable rewards in 2015. Such data and more should eventually cover all CON reviewed services outside of hospital settings.

D. Recommendations

1. In order to improve public understanding of the hospital industry and its trends, OHCA should quarterly post short website informational documents extracted from its reports which focus on key findings and conclusions drawn from this data, such as the Hospital Dashboards (*also posted in Financial Data section*).
2. In order to enhance work products, OHCA should continue to find meaningful areas on which to research and report to the industry and policy makers using its financial and utilization data, as well as, other available resources (*also posted in Financial Data section*).

4. Compliance Program

A. Documents and information reviewed:

OHCA Policy and Procedures.pdf
Mock Exercise Script - proposal & compliance.pdf
CON Compliance Letter Examples.pdf

Impressions from review:

- ◆ OHCA's CON Compliance Procedure Manual carefully outlines the step-by-step process highlighted by flowcharts related to filing, missing information and two-year CON expiration notifications.
- ◆ All procedures were presented by staff in a well-executed Mock Exercise following a detailed step-by-step script.
- ◆ Although a description of the procedural steps was not found, examples of CON determination letters provided articulate illustrations of the attention to detail and respectful handling of potential enforcement inquiries.
- ◆ Numerous examples were also reviewed of enforcement letters to ensure compliance with conditions and modifications of approved CONs.
- ◆ Carefully stipulated orders of agreed settlements were reviewed.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Progressive pre-application investigatory process with three-part CON followup process illustrates a well-defined and orderly procedure.
- ◆ Early CON determination process informs potential applicant as to need to get a CON.
- ◆ Compliance after CON approval examines initial submission by applicant, review of missing information, and two-year duration of CON.
- ◆ Conditions are carefully examined for wording and intent to ensure defensibility of the final decision, and understanding for the applicant .
- ◆ There is a potential civil penalty for non-compliance (seldom needed).
- ◆ Systems lacks periodic progress reports after CON issued and prior to completion.
- ◆ CON is not statutorily required before licensure, but it is communicated as an administrative courtesy between sections.
- ◆ 82% of CON decisions have no conditions, but is changing due to health care reform.
- ◆ CONs are not transferrable or reassignable, but can be modified later.
- ◆ Terminations are one of the biggest pre-CON issues.
- ◆ Conditions are triggered by issues found during review, and are not standardized due to unique nature of each application, and must be meaningful in content.

Perceptions from Second Visit Interviews:

<no additional information gained>

C. Conclusions

The CON compliance activities are largely focused on pre- and post-application oversight. The process appears well thought-out, carefully documented in guidance materials, and faithfully implemented on a timely basis.

It appears unusual that DPH licensure sections do not require evidence of a CON prior to processing. Additional information periodically submitted after CON approval, but before project completion, would be very helpful in order to track project implementation.

D. Recommendations

1. In order to reduce delays and keep OHCA informed of an applicant's steps toward project completion, brief periodic progress reports should be electronically submitted by the applicant every six months after CON approval until a final report upon completion *(also posted in Certificate of Need Program section)*.
2. In order to avoid confusion and promote industry cooperation, a statutory provision should be established requiring that the pre-requisite CON be included as part of the licensure application process for those facilities and services requiring CON.

5. Statewide Health Care Facilities and Services Plan

A. Documents and information reviewed:

OHCA Statewide Facilities and Services.pdf

Impressions from review:

- ◆ Executive Summary provides an excellent four-page overview of plan.
- ◆ Introduction to Statewide Health Care Facilities and Services Plan (SHCFSP) provides extensive foundation, purpose, guidance, structure and linkages to Healthy People 2020, state health planning, CON and popular issues.
- ◆ Overarching Issues handily depicts contemporary concerns with accuracy and extensive references by describing key elements of information technology and workforce.
- ◆ Acute Care chapter graphically illustrates locations, utilization, CON need, and planning areas for acute-care hospitals, emergency departments, cardiac services, and cancer treatment centers using well-placed maps tables and highlighted definitions (Division of Emergency Management and Homeland Security (DEMHS) regions are referenced but not shown on the maps).
- ◆ Outpatient Surgery chapter discusses ambulatory surgery procedures, outpatient surgery facilities, surgeries in outpatient settings, standards/guidelines, and current issues including descriptions of certification, licensure, ownership, and definitions.
- ◆ Imaging and New Technology chapter describes the imaging environment, inventory, standards/guidelines for MRI, CT, PET, PET-CT and new technology including extensive definitions and review criteria.
- ◆ Other Health Care Services and Facilities chapter wraps up the second section to describe long-term and rehabilitative care services including skilled care, custodial care, medical rehabilitative care, nursing home care, long-term acute care, residential care, hospice inpatient care, assisted living service agencies, continuing care retirement communities, congregate living, adult day care, and home health (nursing homes require a CON from DSS).
- ◆ Persons at Risk and Vulnerable Populations extensively describes inequities and disparities, the dimensions of vulnerable populations, unmet health care need, methods for evaluation, programs and plans for unmet need and gaps in services related DSS programs, and health insurance exchange.
- ◆ Behavioral Health Care details the various points of access to services, recovery and resilient systems, behavioral health environment, service definitions and locations, other initiatives information sources, and relationship to primary care.
- ◆ Primary care chapter focuses particularly on safety net services by providing an overview, facility settings, service gaps and unmet need, avoidable emergency department visits, and primary care initiatives.
- ◆ Next Steps and Recommendations chapter is a collection of thoughtful explorations, examinations, investigations, studies, considerations, and review affecting acute-care and ambulatory surgery, behavioral health, and primary care.

- ◆ Data Sources and Limitations chapter references the primary sources of information including OHCA's Acute Care Hospital Inpatient Discharge Database, their Hospital Reporting System, and 2011 surveys plus Department of Public Health licensure information, Primary Care Office data, Department of Children and Families licensure data, Connecticut Hospital Association ChimeData, and U.S. Census Bureau noting limitations of some of these data sets.
- ◆ This is followed by an exhaustive glossary of terms, abbreviations and acronyms.
- ◆ 21 Appendices describe the pertinent statute, lists the members of the advisory body and subcommittees, and provides inventories of healthcare practitioners, towns, focus groups, emergency department visits, and maps of surgical facilities, MRIs, CTs, PETs and PET-CTs, health status and services priorities, DPH programs, psychiatric information, and mental health authorities.
- ◆ Plan is culminated by an Inventory of Health Care Facilities, Services and Equipment which in 28 tables provides a listing of towns, hospitals, surgical facilities, imaging equipment, long-term care facilities, mental health facilities, health centers, and clinics by location, services and other details.
- ◆ Within its 334 pages of detailed information, colorful illustrations, exacting descriptions, and thoughtful deliberations, this Plan largely focuses on services and facilities related to CON review, plus other useful information.
- ◆ Standards/Guidelines for individual services and facilities reviewed by CON are buried in each related chapter, but are not summarized for easy reference nor volumetric in nature or geographic area.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Recently completed CON-focused SHCFSP with standards which need updating for clarity and measurability of need.
- ◆ Great potential for a CON promotion document for one-stop-shopping to aid staff, applicants, planners, legislators, media, public and others.
- ◆ State Health Improvement Plan is different from the SHCFSP, and done as an overall DPH initiative along with other branches and sections (and other health-related departments).
- ◆ SHCFSP was created by three specific subcommittees and one general advisory committee, and will probably be updated with similar input.
- ◆ Criteria standards are intended to be used by CON review once in regulation.
- ◆ Inventory of services was difficult to do using mostly licensure sources.
- ◆ Hope to include community needs assessments at a later time.

Perceptions from Second Visit Interviews:

<no additional information gained, update to Plan by Oct 2014, more research needed>

C. Conclusions

The Statewide Health Care Facilities and Services Plan (SHCFSP) is a well-prepared result of over two years of effort. In terms of a plan as a guidance document for CON, it provides an in-depth look at all the services which are reviewed and establishes operational standards accordingly (even though these standards are not summarized in one location). This Plan also goes on to address many other services and issues of great importance to Connecticut which are not covered by CON.

Although addressed generically, the Plan does not go on to specify specific areas of unmet need. The DEMHS regions are not illustrated on the included maps. The inventories of services and programs are helpful in describing what is available, but the lack of numeric methodologies to predict the volume and location of CON reviewed facilities and equipment limits OHCA's ability to predict public need or promote attention to areas of unmet need.

D. Recommendations

1. In order to better measure the public quantitative need for CON reviewed facilities, equipment and services, the CON standards and guidelines in the Statewide Health Care Facilities and Services Plan should be expanded to include population-based predictive formulas, unmet needs and surpluses (*see Missouri CON standards for simplicity, the New York and Michigan CON standards for well-researched details, and the North Carolina State Medical Facilities Plan for statistical methodologies and conclusions*).
2. In order to facilitate the updating of CON rules, add a new part to the executive summary of the Statewide Health Care Facilities and Services Plan which highlights the recommended standards for each facility and service category reviewed by the CON program.
3. In order to better link potential CON conditions with the Statewide Health Care Facilities and Services and State Health Improvement Plans, establish a new chapter showing facilities and services opportunities to meet unmet need or gaps in services.
4. In order to illustrate the Division of Emergency Management and Homeland Security regions, if used in future editions, the boundaries of these regions should be shown on key maps showing the locations of various facilities.

6. General Work Flow Conducted by OHCA Staff

A. Documents and information reviewed:

Step by Step 1.docx

Template for Decision Tables.docx

LEAN Government Services

Continuous Improvement in State Government 10-23-13.pdf

Impressions from review:

- ◆ The step-by-step instructions for adding, editing, and updating the docket system for recording and tracking individual CON applications is well constructed and appears to adequately meet the needs of OHCA staff.
- ◆ Basic template for tables showing applicant's service area, historical and projected utilization, proposed capital expenditures, projected revenue and expenses, and payer mix provides an excellent example for consistent analytical writing (these are part of a new template for decisions being developed so analysts can more easily determine what is missing in completeness reviews and to make decisions look uniform).
- ◆ LEAN Government Services for the past 10 years has provided definitive guidance in how to reduce waste, improve productivity, and promote efficiency which OHCA has used in helping its management activities.
- ◆ OHCA achievements in efficiency and effectiveness were reported in October 2013 OPM report on Continuous Improvement in State Government showing OHCA funding assessment improvements and better access to hospital chargemasters.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Mock Exercise presentation illustrated a long, detailed, provider-driven, legally-intensive process without Letter of Intent or adequate progress reports.
- ◆ Multiple levels of analytical review appears to unnecessarily delay the process.

Perceptions from Second Visit Interviews:

- ◆ Workflow could be improved if some of the projects are prioritized and streamlined or expedited, such as equipment replacement, SPECT-CT, and others.
- ◆ Increased enforcement is needed of review process cut-off and end-dates because currently there are few penalties if deadlines are missed.
- ◆ The ability to focus on individual tasks is often distracted by many other assignments.
- ◆ Accountability continues to be a concern within OHCA's staff structure due to diversified workload, mixed expectations and occasional languid attitude.
- ◆ Completeness reviews are now longer because full data is needed for all applications, but projects like mergers and conversions which are non-controversial could be reduced to 45 days, instead of 90 or more.

- ◆ Review process could be made more predictable by using quarterly application deadlines, batching projects by type, expedited applications on a monthly basis, and better management of reviews.
- ◆ Behavioral health review could be improved if the Department of Mental Health and Addiction Services could become more actively involved in CON reviews.
- ◆ Review procedures, manuals and templates appear outdated and unused, but could be a valuable tool to build consistent, complete, timely and defensible draft decisions.

C. Conclusions

OHCA staff is experienced, diversified, talented and dispirited. In spite of numerous tools, detailed instructions, efficiency efforts, periodic meetings, and sincere attitude, OHCA workflow seems ponderous and convoluted with concerns about mixed expectations, unclear direction, and mismatched skillsets relative to responsibilities. Longevity for some may be a hinderance rather than a strength.

This is a skilled office which is out of balance due to limited resources, insufficient specialization, and a propensity for taking on too many tasks without more time and assets. Accountability for action (or inaction) is challenging with frequently missed deadlines, multiple assignments with conflicting priorities, and inadequate motivation. Professional growth opportunities seem not to be attractive nor sufficiently embraced for some.

There appears to be the idea that staff are using their skills to perform a defined function or set of tasks. This task-oriented mindset leads people to believe that, if they perform their duties, then they've done what they're supposed to do, whether or not the desired result was achieved. The dichotomy is "doing the job" versus "achieving the result".

D. Recommendations

1. In order to spark more staff interest and enthusiasm:
 - a. Establish a Culture of Accountability beginning with clearly defined results, mandated deadlines, designated responsibility for achievement, committed team spirit, attractive incentives, sincere recognition, and sustained feedback (*educational documents, training packages, webinars, videos, regional seminars and onsite workshops are available from resources such as www.partnersinleadership.com and www.ozprinciple.com . . . also posted in the [General Work Flow section](#));*
 - b. Expand professional development opportunities by requiring attendance at innovative training and skills building sessions throughout the year; and
 - c. Promoting health industry field trips to improve knowledge of how regulated health care facilities and services are evolving and the changes that are necessary.
2. In order to better align skills and experience with defined results management and future opportunities, OHCA staff should be reorganized into the basic disciplines of data, planning, and analysis teams with articulated cross-team advisory responsibilities.
3. In order to better manage workflow, requests for extensions beyond the second year CON end date should be moved from the CON Analyst to the Compliance Analyst (*also posted in [Certificate of Need Program section](#)*).

7. OHCA Staff Skill Sets

A. Documents and information reviewed:

Staff Division Class Specs.pdf
Employee Lists & Trng Job Specs.pdf
OHCA Staff Class Specifications.pdf
OHCA PS YTD Expenses as of Check Date 12.13.13.xls

Impressions from review:

- ◆ OHCA class specifications include 28 pages of descriptions for director of operations, principal healthcare analyst, healthcare analyst, associate healthcare analyst, research analyst, associate research analyst, lead planning analyst, planning specialist, administrative assistant, office assistant, information technology analyst, economist, career trainee and staff attorney . . . showing in great detail the purpose, supervision, duties, qualifications, and experience for each position.
- ◆ Review of staff salaries indicates compensation is more reflective of longevity than responsibility with some disparity between positions with seemingly equivalent duties, but overall is consistent with regional rates.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Educated and passionate staff, overwhelmed by increasing workload, reduced staff, and multi-tasking, while reallocation of duties appears to be needed to match skills and interests more appropriately with positions and responsibilities.
- ◆ Some staff are better writers, others are better researchers (everyone is expected to do everything), may need to reassess skills vs. functions.
- ◆ “Cut-and-paste” analysis done sometimes instead of researched information.
- ◆ Staff direction and guidance needs to be simpler and clearer, questions about rewards for good work which might include financial and recognition incentives.
- ◆ “Jack of all trades” problem now counterbalance to previous “job silo” specialization.
- ◆ Health care reform emphasizes pricing versus regulation’s focus on volume.
- ◆ Additional staff potential for lead planning analyst (generalist), associate research analyst (data skills), a health care analyst (reviews), and a office assistant (support).
- ◆ Perception that more communication is needed between OHCA director, CON Team and legal services to improve work flow and desired results.

Perceptions from Second Visit Interviews:

<no additional information gained, emphasis on staff increases>

C. Conclusions

With over 220 years of experience among 17 staff members, a tremendous bank of talent has been assembled into this one office. Experience can be a wonderful asset, as well as a heavy anchor, when change and innovation are being contemplated. Health reform streamlining,

legislative redirection, and DPH assimilation have reduced staff capacity by 30% and sacrificed critical knowledge and supervisory experience as a consequence.

Although it would appear that staff compensation is a little out of balance with individual responsibilities, the real concern has more to do with the quantity and quality of work. Consistent and comprehensive authorship skills are paramount to the success of draft decisions prepared by the analytical staff in order to avoid recurring rewrites and critical editorial oversight. There is also a perception of continually changing guidelines for writing style and legal defensibility of the decisions. On the other hand, the data teams appear to be producing publications that are well-written, timely-produced and well-received.

Supervision of strategic data and analytical activities is adequate, but not inspiring or motivating to staff activities. Efforts to encourage additional leadership training and improve management skills have not been met with enthusiasm, nor do the supervisors feel well-equipped to oversee their activities. Consequently, due to these and other factors, staff morale and sense of empowerment is substantially depressed. Unfortunately, even with extensive skills and talent, the energy and enthusiasm to use it to its fullest potential is compromised.

D. Recommendations

1. In order to restore staff capacity and skill levels, four new staff positions should be added including a lead planning analyst (a generalist with exceptional editing, management, analytical and motivational skills) to supervise CON reviews, an associate research analyst (data, survey, report writing, and communication skills) to meet this increasing workload, a health care analyst (writing, analytical, multi-tasking skills) to conduct reviews, and an office assistant (detail-oriented, copying, filing, correspondence, and communication skills) to provide general support services, all of whom are critically needed due to the rapidly expanding workload, increasing complexity of reviews, growing demand for detailed financial and utilization reports of regulated services, pressing need for multiple planning updates, and new research priorities pursuant to health reform activities *(Note: this only reflects current need, but even more analysts should be added if legislative changes, such as new conversion statutes, require more planning standards, CON analysis and data reports . . . also posted in Certificate of Need Program section)*.
2. In order to spark more staff interest and enthusiasm, establish a Culture of Accountability beginning with clearly defined results, mandated deadlines, designated responsibility for achievement, committed team spirit, attractive incentives, sincere recognition, and sustained feedback *(educational documents, training packages, webinars, videos, regional seminars and onsite workshops are available from resources such as www.ozprinciple.com and www.partnersinleadership.com . . . also posted in General Work Flow section)*.
3. In order to improve the CON analytical process:
 - a. Create a new Review Manual which includes styles, punctuation, templates, tables, format, legal expectations, and time frames;
 - b. Establish a team approach to overall CON application review processes (while maintaining individual analysis) building on the objectives and ideas defined in the Kaizen approach, and building into it a firm implementation schedule complete with feedback and quarterly updates;
 - c. Post a revised set of questions based on the ten CON criteria and customized by individual review category *(also posted in Certificate of Need Program section)*; and
 - d. Request that Department of Administrative Services reassess OHCA's skills and functions.

8. Workload, Staffing Levels within OHCA

A. Documents and information reviewed:

OHCA Resource Reorganization original, revised 2 and 3.xlsx

Sample CON Status Report.pdf

CON Application Summary 2012.pdf

Summary of Certificate of Need Activity in Calendar 2013.xlsx

Impressions from review:

- ◆ OHCA resource alignment charts cross-index 17 staff members with 33 distinct activities (not including supervision) which is detailed and ambitious, but somewhat confusing as it attempts to capture tasks and responsibilities in one table, and illustrates the consequences of well-intentioned multi-tasking; it also demonstrates a management style that is more task-oriented rather than results-oriented.
- ◆ With CON 2012-2013 annual workload average of 32 applications, 35 determinations, and 6 modifications, plus the data and special projects activities (*no measurement device was found for non-CON workload*), it would seem that staff is very busy.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Potential communication issues and organizational mismatches which are hindering production time, quality outcomes and satisfaction with process.
- ◆ Transitional staff issues still prevail due to downsizing and DPH integration.

Perceptions from Second Visit Interviews:

- ◆ Several years ago overall government cutbacks reduced the OHCA staff from 24 to 17 losing extensive knowledge and expertise, followed by integration into the Department of Public Health which decreased autonomy and access to customers.
- ◆ Staff perceives workload as requiring that everyone do everything with many competing priorities, but shortages of time and communication.
- ◆ Specialists by type of service could become advisors to other projects.
- ◆ The distinctive separation of financial team from utilization team may be unnecessary, even with differing skills, cross-over functions are valuable for new reports.
- ◆ It appears that more staff resources are needed for CON review and general support activities, particularly as more special projects emerge and health care changes.
- ◆ Focus should be on empowering rather than delegating staff resources.
- ◆ Staff sees too much emphasis on “priority of the moment”; ad hoc activities takes time.
- ◆ Supervision and change impeded by slow government reclassification process.
- ◆ Staff concerns expressed about research vs health care analyst job descriptions.
- ◆ Analysts sometimes feel powerless, yet need more consensus among themselves.
- ◆ Analysts prefer to be involved earlier in communication process, want better draft decision written guidance/feedback, and need to keep them in the loop.

C. Conclusions

OHCA is a complex and busy office within the Department of Public Health with principal responsibilities for certificate of need review, hospital and related data, and episodic research. Staff size and morale have diminished over the past five years, while the workload has changed and become more complicated. Attempts to move from the previous perception of “siloes” work assignments to a multi-tasking cross-trained discipline has instead led to discontent, delays, and resistance to change.

While the quantity of workload appears to not have increased substantially, the quality of results has suffered. Insufficient ownership and responsibility for work product and deadlines has resulted in protracted reviews, repeated rewrites, inadequate communication, and lack of agreement among team members and staff overall.

D. Recommendations

1. In order to restore staff capacity and skill levels, four new staff positions should be added including a lead planning analyst (a generalist with exceptional editing, management, analytical and motivational skills) to supervise CON reviews, an associate research analyst (data, survey, report writing, and communication skills) to meet this increasing workload, a health care analyst (writing, analytical, multi-tasking skills) to conduct reviews, and an office assistant (detail-oriented, copying, filing, correspondence, and communication skills) to provide general support services, all of whom are critically needed due to the rapidly expanding workload, increasing complexity of reviews, growing demand for detailed financial and utilization reports of regulated services, pressing need for multiple planning updates, and new research priorities pursuant to health reform activities *(Note: this only reflects current need, but even more analysts should be added if legislative changes, such as new conversion statutes, require more planning standards, CON analysis and data reports . . . also posted in Certificate of Need Program section).*
2. In order to accommodate OHCA’s “can do” attitude and maintain a consistent workload, the response to requests for new activities and priorities must be met with “yes, if” answers such that considerations of time, resources and competing priorities must accompany the acceptance of additional workload.
3. In order to spark more staff interest and enthusiasm:
 - a. Establish a Culture of Accountability beginning with clearly defined results, mandated deadlines, designated responsibility for achievement, committed team spirit, attractive incentives, sincere recognition, and sustained feedback *(educational documents, training packages, webinars, videos, regional seminars and onsite workshops are available from resources such as www.partnersinleadership.com and www.ozprinciple.com . . . also posted in the General Work Flow section);*
 - b. Expand professional development opportunities by requiring attendance at innovative training and skills building sessions throughout the year; and
 - c. Promoting health industry field trips to improve knowledge of how regulated health care facilities and services are evolving and the changes that are necessary *(also posted in General Work Flow section).*

9. Internal Communications within OHCA and External Communications with Department Administration, Programs, Other Agencies, and Customers that Utilize OHCA's Services

A. Documents and information reviewed:

Sample CON Status Report.pdf
J Dempsey Hosp 10-bed addtn Notice.pdf
Inter-agency communications ~ licensure.pdf
DPH and DMHAS MoA.pdf
DPH and DSS MoA.pdf
Key Contacts in State Government.docx
OHCA phone numbers.doc
Key Contacts for Health Care Organizations.docx
Various Articles.pdf
RE_ OHCA 101 video

Impressions from review:

- ◆ Reports on the website such as CON status, pending applications, decisions and determinations are very helpful with eight years of history.
- ◆ An example of a prior CON decision which lacked clarification needed by licensure as to bassinets vs regular bed distinction demonstrated some communication issues.
- ◆ Memorandums of Agreement and Understanding between DPH and Department of Mental Health and Addiction Services, as well as between DPH and the Comptrollers Office, illustrate cooperative and collaborative communication related to reports, security, Medicaid information and compliance monitoring.
- ◆ Discussions with licensure sections and OPM indicate that more communication and fewer delays are expected from OHCA staff, particularly the analysts.
- ◆ Examples of news articles show the value of for-profit hospitals, financial health and hospitals, hospital sales, hospital battles, and hospital affiliations showing OHCA as a positive source of information in these stories.
- ◆ OHCA 101 public information presentation was a good first step in what could be a series of educational spots to improve legislative and media understandings.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Communication channels may be blurring, with changing work priorities an issue.
- ◆ New techniques are needed for inter-agency communication, particularly with analysts.
- ◆ DPH staff sees more and more emphasis on behavioral health; staff occasionally works with Department of Mental Health and Addiction Services, and envisions more collaboration with Department of Social Services.
- ◆ Occasional meetings appear to be held with DMHAS about CON.

- ◆ DPH also occasionally meets with the Department of Children and Family Services.
- ◆ Strong CON shift to access for Medicaid population with more legislative criteria.
- ◆ Rebalancing of staff and resources needed in OHCA due to current limitations.
- ◆ All Payers Claims database could be promising for Connecticut in the future (note experience in Massachusetts).
- ◆ Legislature often supports CON, but concerned about how to protect workforce (particularly labor).
- ◆ Licensing and behavioral health sections would like to increase communication with OHCA analysts (excellent already with leadership), but are concerned about issues of emergency departments vs urgent care (outpatient centers).
- ◆ Residential care facilities, assisted living facilities, and home health services were deregulated in early 2000, and no longer a concern for CON.

Perceptions from Second Visit Interviews:

- ◆ DPH staff meets frequently with CON analysts, OHCA director, and CON supervisor to monitor the CON review process.
- ◆ Staff interviewed from the Governor's office and OPM are concerned about lengthy and unresponsive review process, too many extensions of time, believes it would be useful to talk to representatives of applicants such as attorneys and consultants to get their perspective.
- ◆ CON staff is concerned that communication and access to customers is insufficient.
- ◆ Staff used to do tours of applicant proposals, but now limited, yet needed in order to better understand context, changing venues, and health reform trends.
- ◆ Many believe that early intervention is important before an application is filed, which would provide an improved relationship with industry to update knowledge with the rapid changes in healthcare delivery.
- ◆ OPM interested in CON program assessment of effectiveness to inform the health care delivery system and alignment with health care reform, feasibility of considering economic development, and best practices with other similar states; they raised concerns about communication, overly broad review, process complexity, time-consuming.

C. Telephone Interviews:

- ◆ ***Alan Kaye, MD, Chairman, Legislative Committee, Radiological Society of Connecticut President, Advanced Radiology Consultants, 3 Enterprise Drive, Shelton, CT 06484***
 - Overall OHCA grade of B or B+ due to changing healthcare environment. Area for improvement would be in timeliness of decisions (see below).
 - In terms of timeframe, they are slow to act, probably restricted by issues of limited staffing, and very opaque in the last two years. Overall, however, their caution is understandable, in view of the consolidation of providers and the pressures they are under from industry and attorneys.

- Healthcare economics are changing quickly with hospital acquisitions of medical practices including a major effort with respect to imaging, thus producing concerns about concentration into small number providers who would control the market.
- Radiologists are concerned about ownership change. Many want to be able to sell as needed. There needs to be, however, the long-term concern about the acquisition of physician practices.
- The situation is not black and white but rather complex, and OHCA needs to be cautious because they create uncertainty in the industry; thus, they are “appropriately hesitant” and need to be consistent in their decisions; they have a tough job with staffing problems.
- Connecticut and Massachusetts have comparatively low utilization due to CON, so it should not be done away with.
- Opinion is that CON should be preserved, transfer of ownership should be monitored, and all lawfully acquired equipment should be placed on an equal footing with no exemptions (CON approved, determination no CON required, and acquired lawfully without determination or CON). There is equipment that has CON that gets little use, and equipment that was purchased below the old threshold that is at or above capacity. It does not make sense that the former would be exempt and the latter not.
- Common presumption is that OHCA takes a long time to make a decision due to previous staff reductions and their move into the Department of Public Health.
- As for data distribution, it should be kept as this or expanded, the Imaging Task Force showed the value of the data, should have information about all services that are regulated but OHCA already has their hands full now with good dedicated people.
- The federal Stark provisions previously attempted to restrain physician-owned equipment, but the loopholes became a floodgate.
- Four main points: OHCA does a great job, important job because of industry change, must be prepared for consequences, and needs to promote an even playing field.

◆ **James Iacobellis**, *Senior Vice President, Government and Regulatory Affairs
Connecticut Hospital Association, 110 Barnes Road Wallingford, CT 06492*

- CON is supported by the hospital industry, and OHCA is generally effective and efficient.
- Hospitals support CON; it is absolutely necessary even though there is disagreement about what should be under review.
- The CON process could run more smoothly; at times its reviews take too long. This may be an unintended consequence of when OHCA was merged into DPH, adding an additional layer of review.
- OHCA does not have a default decision deadline, though it previously did. As such, the process at times is not completed on a timely basis.
- Healthcare is changing quickly and it’s hard for the staff to keep pace with the dynamic changes of healthcare reform. Staff is not to blame. Perhaps ways to address the issue

would include allowing the staff to take advantage of continuing education opportunities regarding current healthcare trends or regularly spending time in the field to understand changes across the continuum of care.

- Unfortunately, CON dialogue seems to be confined to legal/lawyer conversations rather than policy conversations. There is a need to talk earlier, and have earlier intervention about what is covered by CON. Generally, more conversation and advice to applicants would be appreciated.
- The definition of “Termination of Services” is too inclusive and should be modernized. There should be a short track review for terminations.
- There has been a great focus lately on imaging. Imaging equipment that has previously undergone CON review because of a change of ownership should be exempt from review.
- The recent legislative changes to the OHCA statutes, with respect to conversions from not-for-profit to for-profit, involved discussions surrounding clinics, with a focus on behavioral health providers.
- The CON review process should be shorter. Healthcare changes are dynamic and decisions need to balance the policy objective of appropriate regulatory oversight with need for decisions to be issued in a timely fashion.
- The OHCA staff and director run a remarkably efficient organization, but are probably understaffed for the volume they receive. That causes a backlog, which in turn hurts care access and care planning overall.

◆ **Ken Ferrucci**, *Senior Vice President of Government Affairs*

Matthew Katz, *Executive Vice President and Chief Executive Officer*

Connecticut State Medical Society (CSMS)

127 Washington Ave, East Building, North Haven, CT 06473

Steven B. Levine, M.D., *ENT & Allergy Assoc LLC, 160 Hawley Lane, Trumbull, CT 06611*

Michael M. Krinsky, M.D., *Neurologist, 580 Cottage Grove Road, Bloomfield, CT 06002*

- Last session the Governor vetoed a bill that would have allowed for profit hospitals (one exists and 3 more potentially this year through pending legislation) to use CSMS medical foundation statute to allow for-profit hospitals to purchase physician offices. This relates to what was transpiring in Connecticut with the transformation of health care.
- Concern was raised that if for-profit hospitals were in fact able to purchase physician offices and the hospitals struggled financially, would they eliminate the remote physician offices first. If so, what would impact be on the physicians and the community as a whole.
- There is an inherent conflict when CON is funded by the hospital industry.
- Small entities have a hard time, CON creates barriers to market entry – more and more private practices are being acquired by hospitals which leads to monopoly which leads to potential abuse.
- According to CSMS estimates, the number of actively practicing physicians in Connecticut has decreased.
- In a comprehensive discussion of CON and its impact on health care, we need to include a state statute that requires any entity including physician offices to obtain a CON and a facility license when using moderate and deep sedation. It has made it

difficult for physicians and smaller practice to compete in open up facilities to provide office based services.

- CON pits haves vs. have-nots, the simple cost alone favors hospitals instead of physicians offices. Hospitals have access to more capital than small physician offices.
- Attorney General has expressed concern about extra hospital facility fees on outpatient services provided in hospital owned facilities.
- CON is one, but a significant reason that has made it harder to attract and retain interns to Connecticut, 80% go elsewhere, procedures can often be done for 1/3 the price in private physician practices.
- CON is inconsistent with the free market.
- CON is costly because it requires attorneys, lots of data, lots of time with no guarantee of a successful outcome.
- When a CON is denied, the reported information is often nebulous, with no guiderails for repeat applications, denials are not sufficiently specific, no clarity on why.
- In other states, most surgery has been moved from hospitals to outpatient settings, but not in Connecticut, because of the restrictions of CON.
- When hospitals merge or purchase other hospitals or facilities, how the CON is determined becomes problematic; the same standards for the original CON seem to apply instead of a different set based on an established used piece of equipment.
- It is hard to recruit and retain primary care physicians, but even more difficult to recruit and retain medical specialists and sub specialists; the CON process makes it much more difficult to recruit and retain, because they can use and purchase this equipment in other states while in Connecticut they need to go through an expensive CON process, then still may not get to use. The question is, why come to Connecticut and practice if what you were trained to use certain equipment, which is not possible in Connecticut.
- CON is not the only negative factor because liability insurance and a confluence of issues are also problems, it would have been better if OHCA had empowered small practices in the first place in the early days of health planning and regulation.
- Best economic development would be to get rid of CON.
- Medicine is in a crisis. CSMS has looked at every aspect and option to recruit and retain physicians including use of the Department of Community and Economic Developments Small Business Express Program for physicians to obtain grants and loans for equipment and personnel. However, the CON process would still be needed first for certain things.
- Another solution would be to eliminate CON for cone-beam CT scanners, or even better would be to remove CON for CT and MRI equipment acquisitions.
- Since surgery centers and office based surgeries already require state licensure and federal certification, why is CON needed on top of that?
- Don't often intersect with CON, but are concerned about cone-beam CT scanners which are okay in the hands of dentistry, but require a CON for physicians.
- This discriminates against Ear, Nose and Throat specialists and favors hospitals.
- Hospitals are acquiring many physician practices, which has made it hard to recruit new physicians as evidenced by the experience of a physician brought from Virginia.

- CON is an inappropriate abuse of government trust (CT example).
- Had experience in 1979–80 when CT was new which was a battle between big vs. small hospitals, instead of appropriate need expansion and enhancement of private physicians in the community, which is what it should have been.
- In spite of testimony provided at public hearings, comments on regulations and more, the results did not reflect what was of the concern to physicians.
- The issue transcends many administrations with no change in 30 years.
- Was able to get a CT scanner into neurology through the back door in early 1980s.
- Hospitals have been very successful, even though costs are lower in clinics and outpatient settings than in hospitals, but hospitals are getting less and less competition.
- Connecticut is facing a manpower crisis in specialties, the average age in neurology is 55-65, very few new physicians, often prohibited from competing with hospitals.
- Public policy for CON is working against the welfare of the people.

◆ **Lisa Winkler**, *Executive Director, Connecticut Ambulatory Association of Surgical Centers*
22 Avalon Drive, Avon, CT 06001

- OHCA is trying to do a lot more with a lot less, they have accomplished much with limited resources, particularly with the loss of staff members.
- Healthcare reform concerns many people and makes them nervous, but there is a strong interest in streamlining CON.
- Attorneys and applicants have expressed concern about communication with OHCA, since they used to be able to call informally and get guidance before applying into the costly and lengthy CON process; they appreciated the give-and-take through informal conversation and direction because everyone is trying to do the same thing in achieving better access and higher-quality at a lower price; but, this doesn't happen anymore and hasn't happened for the last few years.
- Many terrific people at OHCA agency, but being downsized may have limited communication, not sure why, but maybe a policy in DPH.
- Timing is another issue because review takes too long, like a recent change of ownership application that went to the AG's office which took much longer than the statutory timeframe, apparently because of the out-of-state ownership when a portion of a private practice was being sold.
- Connecticut has a real mix of surgery center sizes, both big and small, and some decisions are shortsighted because the same criteria was applied to everyone.
- Moving an existing surgery center to a new building in the same community is supposed to be easier than it used to be, but is still time-consuming, and costly. Improving quality should be the focus.
- Malpractice climate in Connecticut is very difficult, so many private practices are being bought by hospitals, a few surgery centers are being bought, but the emphasis is on more joint ventures with hospitals.
- CON has certainly controlled the number and kind of services in Connecticut.
- With respect to other areas in the health system, there appears to be an urgent care facility explosion which is definitely having an impact on the health care delivery

system. While there are many hybrid medical facilities developing which are not being regulated, other facilities like “med spas” and vein clinics, that are doing surgical procedures, are completely unregulated. This needs more study.

- Except for the legal community, the challenging nature of CON offers very few opportunities for economic development.
- Perhaps more health providers could be encouraged to set up services in shortage areas like Northeast Connecticut if expedited CONs were provided.
- It seems unusual that government would be interested in finding ways to meet unmet needs, when they are considering cutting funding for LifeStar and other support.
- Government should be interested more in addressing the malpractice situation to reverse the trend which shows many medical practitioners leaving the state.
- Some health care providers are giving free services such as free colonoscopies, but need someone else to help coordinate support services like child care and transportation to ensure they keep appointments, etc.
- CON should provide more positive assistance instead of being punitive. OHCA should be looking for ways to improve access, enhance services and quality.
- Data requirements for surgery centers have been very costly and difficult, particularly when reported data was previously not used; but, discussions are underway with OHCA director to do more in the future as medical records are changing with technology. APCD might be the way to go rather than gathering facility level data.

D. Conclusions

Communications within OHCA are friendly and efficient, but not always effective. Guidance provided from the top down is based on extensive experience and knowledge, but receptivity from the bottom up falls short of expectations. Intermediate management has not been a dependable two-way bridge with production.

Dialogue between the heads of various sections within DPH appears to be frequent and informative. Issues have been expressed concerning clear communication between analysts and members of other sections. Consistent meetings and mechanisms for exchange of information appears to be insufficient.

Correspondence between departments appears well articulated in memorandums of agreement and understanding for specific issues. It is unclear as to the volume of exchange of reports.

It is readily apparent from many outside sources that communication between OHCA staff and elements of the public, particularly CON applicants, has been suffering for at least the last three years. Numerous concerns are also expressed about the extensive length of reviews well beyond statutory limits. Information on the website is extensive, but dated and often difficult to easily access with a structure that is overly technical and somewhat convoluted.

E. Recommendations

1. In order to accomplish CON decisions on a timely basis, OHCA should improve its operations by streamlining workflow to include statutory decision deadlines, expedited application review, analyst review manual, and disciplined staff oversight.
2. In order to encourage early planning, improve application completeness and promote coordination with OHCA, require that prospective CON applicants meet with a review analyst prior to submission of their CON application.
3. In order to improve customer relations and public receptiveness, OHCA staff should be empowered and trained in effective communication, particularly with CON applicants and the media, emphasizing early intervention, continual information exchange, and effective delivery of public information.
4. In order to improve connections with licensure section in DPH, the assigned analyst for a CON application should notify this section by telephone with the specifics of the application, notify the same sections by email when a final decision is rendered, and all analysts should hold at least quarterly meetings with these sections in order to provide CON status reports.
5. In order to improve public knowledge and simplify electronic access to OHCA information, the CON portion of the website should be restructured similar to the Facilities Plan page which sequences Goal, Background, Issues, Outcomes and Content (*worthy examples of other state CON websites include Massachusetts, Georgia, Missouri, and Maine*).
6. In order to reduce inefficiencies, maintain effective coordination, and enhance relations with legal services for the CON program and other activities, OHCA should interactively review and update its staff attorney responsibilities on a bi-annual basis.
7. In order to avoid confusion and promote industry cooperation, a statutory provision should be established requiring that the pre-requisite CON be included as part of the licensure application process for those facilities and services requiring CON (*also posted in Compliance Program section*).
8. In order to better align skills and experience with defined results management and future opportunities, OHCA staff should be reorganized into the basic disciplines of data, planning, and analysis teams with articulated cross-team advisory responsibilities (*also posted in General Work Flow section*).
9. In order to better manage workload, workflow and priorities, in statutes:
 - a. Institute a quarterly system of review cycles for at least the general categories of Ownership Change, Imaging, Termination, Cardiac and Behavioral Health (*such as Missouri, Michigan, and North Carolina*);
 - b. Require a Letter of Intent at least 30 days before application submission;
 - c. Implement a statutory decision due date for 90 days after an application has been deemed complete after which a CON application would be automatically approved if a decision is not otherwise rendered; and

- d. Establish an Expedited CON review process to reduce the time and detail required for certain types of review such as existing equipment acquisition, replacement equipment, and compliant non-controversial applications (*such as in Rhode Island, New Jersey and North Carolina . . . also posted in Certificate of Need Program section*).
10. In order to recognize state-of-the-art medical practice and streamline equipment acquisitions, remove computerized tomography (CT) and cone-beam imaging equipment in any setting from review (*consistent with two-thirds of the other CON states*).
11. In order to assure a level playing field for all CON review facilities and services, an independent study should be conducted concerning the CON implications of the urgent care facility, hybrid medical facility (such as “med spas” and vein clinics) and other new service proliferations which conduct surgical procedures.
12. In order to encourage the development of new facilities and services in areas of unmet need as defined in the Statewide Health Care Facilities and Services Plan, provide incentives such as creative conditions (relocation of proposals, transportation of patients, exception to standards), expedited review and waived process to CON applicants (*also posted in Certificate of Need Program section*).

10. OHCA's Organizational Structure and Operations

A. Documents and information reviewed:

OHCA org chart.pdf
DPH org chart revised 7-12-12.pdf
OHCA office layout.pdf

Impressions from review:

- ◆ OHCA staff organizational charts show a director with two assistants plus a HRS data/compliance supervisor with five analysts and a CON/discharge data supervisor with six analysts, with the director reporting to the Deputy Commissioner directly under the Commissioner of the Department of Public Health.
- ◆ OHCA office suite on the third floor of the DPH building shows staff generally aligned across the front of the building, not clustered by team, with supervision, meeting and support functions at the opposite end (*layout is somewhat outdated for specifics*).

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Post-DPH-integration impact of reduced staff and talent warrants corrective action.
- ◆ Add third supervisory position plus more staff, but inability to promote to higher level.
- ◆ Need more analytical expertise and staffing since now doing more complex financial analysis and planning than research, responsibilities are shifting, and data reports are becoming more complicated.
- ◆ OHCA called upon to do a wide variety of additional special activities beyond the data and usual CON responsibilities of the past.

Perceptions from Second Visit Interviews:

- ◆ Staff structure appears to be convoluted and misaligned based on experience, ability, motivations, and available resources.
- ◆ Staff is definitely out of balance with needs for supervisory change; gaps in functional staffing, with perception of inconsistency of direction.
- ◆ Ability to achieve staffing changes has been slow and frustrating.

C. Conclusions

The streamlining and integration efforts of the past five years have resulted in a loss of capacity and expertise which have been demoralizing and disabling for staff. The reorganized structure attempted to realign and cross-train employees for more efficient and effective operations. But, contrary to intent, OHCA's staff resources are now generally out of balance, out of focus, and out of motivation.

The OHCA staff offices are appropriately near the front of the Department of Public Health building, but are not arranged by function. Meeting spaces are not conveniently located close to these offices or supervisors, making team gatherings for coordination more difficult.

D. Recommendations

1. In order to restore staff capacity and skill levels, four new staff positions should be added including a lead planning analyst (a generalist with exceptional editing, management, analytical and motivational skills) to supervise CON reviews, an associate research analyst (data, survey, report writing, and communication skills) to meet this increasing workload, a health care analyst (writing, analytical, multi-tasking skills) to conduct reviews, and an office assistant (detail-oriented, copying, filing, correspondence, and communication skills) to provide general support services, all of whom are critically needed due to the rapidly expanding workload, increasing complexity of reviews, growing demand for detailed financial and utilization reports of regulated services, pressing need for multiple planning updates, and new research priorities pursuant to health reform activities *(Note: this only reflects current need, but even more analysts should be added if legislative changes, such as new conversion statutes, require more planning standards, CON analysis and data reports . . . also posted in CON Program section).*
2. In order to better align skills and experience with defined results management and future opportunities, OHCA staff should be reorganized into the basic disciplines of data, planning, and analysis teams with articulated cross-team advisory responsibilities *(also posted in General Work Flow section).*
3. In order to maximize the team concept and facilitate continual communication and coordination, redesign the office arrangements such that the staff cubicles are clustered close to their functional area supervisors, and include strategic open assembly areas to encourage productive intermittent meetings, while maintaining current building location.
4. In order to spark more staff interest and enthusiasm:
 - a. Establish a Culture of Accountability beginning with clearly defined results, mandated deadlines, designated responsibility for achievement, committed team spirit, attractive incentives, sincere recognition, and sustained feedback *(educational documents, training packages, webinars, videos, regional seminars and onsite workshops are available from resources such as www.partnersinleadership.com and www.ozprinciple.com . . . also posted in General Work Flow section);*
 - b. Expand professional development opportunities by requiring attendance at innovative training and skills building sessions throughout the year; and
 - c. Promoting health industry field trips to improve knowledge of how regulated health care facilities and services are evolving and the changes that are necessary *(also posted in General Work Flow section).*

11. Sufficiency of Available Resources within OHCA

A. Documents and information reviewed:

OHCA Budget and salaries.pdf
Resource Reorg.pdf
OHCA Resource Alignment Charts.xlsx
OHCA Fund Process-presentation_Final.pptx

Impressions from review:

- ◆ Budget/salary info for Fiscal Year 2014 includes office expenses of about \$151,900, salaries of about \$1,691,900, and estimated employee benefits of over \$800,000.
- ◆ Total Fiscal Year 2012 budget was \$2,561,333.86 according to the OHCA Fund Process which allocates reimbursement from all Connecticut acute care hospitals.
- ◆ Comparative review of 16 staff positions relative to 33 work categories revealed complexity and frustration about allocations of time across a broad spectrum of activities which fall short of management expectations (*see Appendix E*).

B. Site Visit Observations:

Perceptions from First Visit Interviews:

<Some gaps perceived, but too early for comment>

Perceptions from Second Visit Interviews:

- ◆ More staff education is needed to improve their knowledge of health services and changing trends to assist in better preparation of CON reviews and data reports.
- ◆ PDF creation and manipulation software in short supply and needed for all staff.

C. Conclusions

A tremendous amount of knowledge, expertise and experience reside within OHCA which, if properly focused and motivated, have great potential to achieve excellent results. But, although the overall budget of OHCA exceeds \$2.5 million annually, it falls short of the necessary funds needed for additional staff to meet the expanding workload.

The building space provided for OHCA's activity appears sufficient, but lacks adequate design and functional layout to encourage team identity, communication and supervision. Modern technology for information processing, electronic communication, and integrated storage appear to meet staff needs, although some tools for presentations and PDF processing are in short supply.

Although data collection and distribution cycles are well-established and predictable, time management is very difficult to achieve in the CON regulatory process. Because this is a provider-driven portion of the OHCA workload, most CON operating systems tend to be reactive rather than proactive when attempting to achieve timely and high-quality results.

D. Recommendations

1. In order to fund the necessary additional staff and support expenses, at least \$300,000 plus fringe benefits and operational expenses should be added to OHCA's annual budget.
2. In order to maximize the team concept and facilitate continual communication and coordination, redesign the office arrangements such that the staff cubicles are clustered close to their functional area supervisors, and include strategic open assembly areas to encourage productive intermittent meetings, while maintaining current building location. *(also posted in Organizational Structure section).*
3. In order to better manage workload, workflow and priorities, in statutes:
 - a. Institute a quarterly system of review cycles for at least the general categories of Ownership Change, Imaging, Termination, Cardiac and Behavioral Health *(such as Missouri, Michigan, and North Carolina)*;
 - b. Require a Letter of Intent at least 30 days before application submission;
 - c. Implement a statutory decision due date for 90 days after an application has been deemed complete after which a CON application would be automatically approved if a decision is not otherwise rendered; and
 - d. Establish an Expedited CON review process to reduce the time and detail required for certain types of review such as existing equipment acquisition, replacement equipment, and compliant non-controversial applications *(such as in Rhode Island, New Jersey and North Carolina . . . also posted in Certificate of Need Program section).*

12. Mechanisms to Monitor Ongoing Compliance

A. Documents and information reviewed:

OHCA Policy and Procedures.pdf
CON Compliance Letter Examples.pdf

Impressions from review:

- ◆ OHCA's CON Compliance Procedure Manual carefully outlines the step-by-step process highlighted by flowcharts related to filing, missing information and two-year CON expiration notifications, all of which was presented by staff in a Mock Exercise following a detailed step-by-step script.
- ◆ Numerous examples were also reviewed of enforcement letters to ensure compliance with conditions and modifications of approved CONs, as well as carefully stipulated orders of agreed settlements.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Intermediate progress reports would help track applicant's efforts and scheduling of activities toward project completion.

Perceptions from Second Visit Interviews:

- ◆ The two major mechanisms for enforcement of CON compliance are the CON approvals with conditions (agreed settlements to which the applicants have signed their names) and the civil penalty law under 19a-653 of the CT statutes (a monetary penalty for anyone willfully disobeying a statute, regulation or order).

C. Conclusions

The CON compliance activities are largely focused on pre- and post-application oversight. The process appears well thought-out, carefully documented in guidance materials, and faithfully implemented on a timely basis. Additional information after CON approval, but before project completion, would be very helpful.

D. Recommendations

1. In order to better manage workload and because it requires legal interpretation, inquiries into potential CON projects and requests for CON determinations should be conducted by OHCA legal counsel, with assistance from CON and compliance staff, a transition which has already begun (*also posted in Certificate of Need Program section*).
2. In order to better manage workflow, requests for extensions beyond the second year CON end date should be moved from the CON Analyst to the Compliance Analyst (*also posted in Certificate of Need Program section*).
3. In order to reduce delays and keep OHCA informed of an applicant's steps toward project completion, brief periodic progress reports should be electronically submitted by the applicant every six months after CON approval until a final report upon completion (*also posted in Certificate of Need Program section*).

13. Applicable Statutes and Regulations

A. Documents and information reviewed:

OHCA CON Statutes (current).pdf
Certificate_of_Need_Regulations (current).pdf
CON Statutes 19a-638 ~ 19a-641.pdf
2013HB-06705-R00-HB.pdf
CON Rules 19a-61.pdf
Public Act No. 10-179.pdf
OHCA Policy and Procedures.pdf
Policies Procedures for Public Act 10-179 final 10-25-10.pdf

Impressions from review:

- ◆ A review of the various iterations of the public acts and statutes over the past four years, plus the policies, procedures, rules and regulations that implement them, illustrates an attempt to streamline CON review by removing provisions such as the Letter of Intent, capital expenditure thresholds and some categories of review.
- ◆ These changes also emphasized review of terminations, sale of nonprofit hospitals, and Medicaid considerations, but did not define important terms such as “termination” or “public need”, which invites confusion and misinterpretation.
- ◆ CON is required for termination (removed then reinstated in statute) of inpatient/ outpatient services in a hospital, surgical services in an outpatient surgical facility or hospital, emergency department in a hospital, inpatient outpatient services in a Medicaid or Medicare hospital or other facility.
- ◆ Considerable space is devoted to the sale of nonprofit hospitals (six pages), but there has only been one conversion to a for-profit hospital (another in review process now).

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Numerous changes via health care reform, new SHCFS Plan improves criteria.
- ◆ Use of SHCFS Plan standards delayed by extensive regulation development process.

Perceptions from Second Visit Interviews:

- ◆ Recent updates focus on access for Medicaid recipients.
- ◆ Hospital representative said prior emphasis on review of not-for-profit to for-profit hospital conversions not motivated by hospitals but by private practice concerns.

C. Conclusions

The statutes related to OHCA and CON have undergone considerable transition in response to various political motivations and attempts at deregulation. Unfortunately, regulation is still too extensive in some areas such as imaging and terminations, while opportunities to promote economic development and community benefits are being overlooked. Regulations to implement updated criteria and standards have been very slow in development.

D. Recommendations

1. In order to better manage workload, workflow and priorities, in statutes:
 - a. Institute a quarterly system of review cycles for at least the general categories of Ownership Change, Imaging, Termination, Cardiac and Behavioral Health (*such as Missouri, Michigan, and North Carolina*);
 - b. Require a Letter of Intent at least 30 days before application submission;
 - c. Implement a statutory decision due date for 90 days after an application has been deemed complete after which a CON application would be automatically approved if a decision is not otherwise rendered; and
 - d. Establish an Expedited CON review process to reduce the time and detail required for certain types of review such as existing equipment acquisition, replacement equipment, and compliant non-controversial applications (*such as in Rhode Island, New Jersey and North Carolina . . . also posted in Certificate of Need Program section*).
2. In order to add clarity and distinction to CON review, the following terms should be defined in statute as:
 - a. “Public Need” . . . Health care services and facilities necessary for the people of Connecticut as a whole as specifically measured by the applicable standards of the Statewide Health Care Facilities and Services Plan, as well as consideration of other statutory certificate of need guidelines and principles;
 - b. “Termination” . . . The operational discontinuance or elimination by a health care facility (excluding affiliates) as defined by Subsection (10) of Section 19a-630, C.G.S of a health care service (not including a temporary suspension lasting six months or less) with the exception of the merger, transfer or relocation of health care services which are located up to five miles apart in an urban area;
 - c. “Expedited” . . . An abbreviated certificate of need process requiring only basic application forms and a decision within 45 days after deemed complete, after which a CON application would be automatically approved if a decision is not otherwise rendered, for facility and equipment replacement applications;
 - d. “Service Area” . . . The geographic area, usually comprised of census tracts, in which the health care facility or service is located from which approximately 80% of their patients currently originate or reside, or are expected to originate;
 - e. “Healthcare Quality” . . . The extent to which health services provided to individuals and patient populations improve desired health outcomes whereas the care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision-making (*see Institute of Medicine*); and
 - f. “Healthcare Access” . . . The ability of a person to receive necessary health care services, which is a function of availability of personnel and supplies, and the ability to pay for those services (*see McGraw-Hill Dictionary of Modern Medicine . . . also posted in Certificate of Need Program section*).
3. In order to promote various aspects of health reform, consider in statute a change from CON review of “transfer of ownership” to a public notification process, except for hospital conversions which affect tax status, such as not-for-profit to for-profit.

4. In order to recognize state-of-the-art medical practice and streamline equipment acquisitions, remove computerized tomography (CT) and cone-beam imaging equipment in any setting from review (*consistent with two-thirds of the other CON states*).
5. In order to balance the level of services reviewed, add by statute the review category of new hospital inpatient and outpatient services (*also posted in Certificate of Need Program section*).
6. In order to avoid confusion and promote industry cooperation, a statutory provision should be established requiring that the pre-requisite CON be included as part of the licensure application process for those facilities and services requiring CON (*also posted in Certificate of Need Program section*).
7. In order to assure predictable, consistent and accurate statistical information, amend the statutes to require that population projections for CON applications be obtained from the Department of Public Health (*also posted in Certificate of Need Program section*).
8. In order to assure a level playing field for all CON review facilities and services, an independent study should be conducted concerning the CON implications of the urgent care facility, hybrid medical facility (such as “med spas” and vein clinics) and other new service proliferations which conduct surgical procedures (*also posted in Certificate of Need Program section*).
9. In order to clarify how termination review would be applied and articulate clearly statutory intent, the legislature should define the term “healthcare service” including the specific types of health care facility resources to be affected (*also posted in Certificate of Need Program section*).
10. In order to enhance the decision-making process:
 - a. Establish a CON Advisory Panel appointed by the DPH Commissioner with ten volunteer members representing the healthcare industry, medical professions, business, insurance, and community who share their expertise about whether a CON proposal should be approved, conditions added, or denied (*based on examples such as Hawaii, New Jersey, New York, Rhode Island, Tennessee, and Vermont*);
 - b. Utilize conditions on CON approvals through “agreed settlements” to promote more extensive CON applicant involvement in health planning activities such as State Health Improvement Plan, Statewide Health Care Facilities and Services Plan, and Community Health Needs Assessments, as well as funding local economic development efforts; and
 - c. Provide streamlining incentives such as abbreviated applications and shorter review times for joint ventures among health providers for unique proposals such as new and emerging technologies, existing equipment acquisition, and equipment replacement (*also posted in Certificate of Need Program section*).
11. In order to enhance work products, propose legislation to require limited unaudited financial data by individual hospital on a six-month (bi-annual) basis (*see quarterly hospital data reports in Washington State and Massachusetts . . . also posted in Financial Data section*).
12. In order to improve workflow, propose legislation to require acute care hospitals to post their full current pricemasters (Chargemasters) on their own websites (*also posted in Financial Data section*).

14. Facilities, Equipment and Services Currently Subject to CON Review

A. Documents and information reviewed:

CON Cheat Sheet 4-12-13.docx
CON Review Criteria_October 15_2012.xls
CON Statutes 19a-638 ~ 19a-641 (extract).pdf
CON matrix 020414.pdf

Impressions from review:

- ◆ The recent emphasis on review of terminations, sale of nonprofit hospitals, and Medicaid considerations are complicated by the lack of definition for important terms such as “termination” or “public need”.
- ◆ A comparison of Connecticut to other CON states in terms of what is reviewed illustrates a ranking of 16th among 35 active CON programs with the unusual provision that all named facilities and services require review regardless of cost.
- ◆ Connecticut is the only CON state that reviews long-term care services (nursing homes in particular) in a completely separate department and agency from other CON regulated categories (some observers believe that this may relate to the location of Medicaid funding).
- ◆ States within a 300 mile proximity of Connecticut range in CON reviewability from Pennsylvania (no review) to Vermont (most categories reviewed in the United States).
- ◆ Different from Connecticut, many states also review home health, neo-natal intensive care, organ transplants, and rehabilitation units, which is why two out of three neighboring states rank significantly higher on the reviewability matrix.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Post-reform statutory changes solved a number of concerns but created others.
- ◆ Terminations need clear definitions, along with other terms in common use.
- ◆ Statutory changes reduced items to be reviewed, eliminated financial thresholds for review, and eliminated Letter of Intent (this is a concern).

Perceptions from Second Visit Interviews:

<no additional information except more concerns about definition of “termination”>

C. Conclusions

When reviewing in context what the Connecticut CON program reviews, with 13 of 30 generally recognized review categories (*see Appendix A*) listed in statute regardless of cost, this effort ranks squarely in the middle of all CON regulatory programs nationally. There are legitimate concerns about reviewing terminations too broadly, and some imaging equipment unnecessarily.

D. Recommendations

1. In order to balance the level of services reviewed, add by statute the review category of new hospital inpatient and outpatient services (*also posted in Certificate of Need Program section*).
2. In order to promote various aspects of health reform, consider in statute a change from CON review of “transfer of ownership” to a public notification process, except for hospital conversions which affect tax status, such as not-for-profit to for-profit (*also posted in Statutes and Regulations section*).
3. In order to recognize state-of-the-art medical practice and streamline equipment acquisitions, remove computerized tomography (CT) and cone-beam imaging equipment in any setting from review (*consistent with two-thirds of the other CON states . . . also posted in Statutes and Regulations section*).
4. In order to add clarity and distinction to CON review, defined in statute the term “Termination” as the operational discontinuance or elimination by a health care facility (excluding affiliates) as defined by Subsection (10) of Section 19a-630, C.G.S of a health care service (not including a temporary suspension lasting six months or less) with the exception of the merger, transfer or relocation of health care services which are located up to five miles apart in an urban area (*also posted in Certificate of Need Program section*).

15. Criteria, Standards and Methods Used to Determine “Need” and “Access”

A. Documents and information reviewed:

CON Cheat Sheet 4-12-13.docx
CON Review Criteria_October 15_2012.xls

Impressions from review:

- ◆ CON criteria includes consistency with policies and regulations, relationship to Facilities Plan, clear public need, financial impact statewide, demonstrated improvement of quality/access/cost-effectiveness, patient population, payer mix, population and need, utilization of existing providers, and duplication of services.
- ◆ Recent legislation added criteria for improvement of quality/access/cost-effectiveness, access to services, and whether an applicant has demonstrated good cause for failing to provide access for Medicaid recipients and indigent persons.
- ◆ Customized CON application forms are available for hospitals (increase in license bed capacity, equipment acquisition, new technology equipment, freestanding emergency department, new cardiac services, outpatient surgical facility or operating room increase), physicians and practitioners (equipment acquisition, outpatient surgical center), behavioral health services (new behavioral health or substance abuse), outpatient services facilities (equipment acquisition, outpatient surgical center), and transfer of ownership, termination or relocation of any above in PDF or Word format.
- ◆ New standards will be available from the Statewide Health Care Facilities and Services Plan once new regulations have been completed, also the Plan will be updated in October 2014.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Criteria based on new SHCFS Plan appear appropriate, but standards need refreshing.
- ◆ Focus on access very good, but should promote more to address unmet needs.
- ◆ Determining financial feasibility is easier than before, with more timely data now available.
- ◆ CON review process does not see the whole picture or context even though staff works hard to keep the public informed, but communication is very limited with applicants, even though staff used to be involved with applicants much earlier in the process.
- ◆ Policy and culture are more punitive with review at arm’s-length process, more protracted review process with more legal defensibility emphasis.
- ◆ Batching should be considered, volumetric need needs much more attention, and a definition of “public need” should be established.
- ◆ Mergers use standardized financial review forms which help standardize process.

Perceptions from Second Visit Interviews:

- ◆ Renewed emphasis on ten basic criteria including new Medicaid additions from last year.
- ◆ Concerns expressed about delays in completing new regulations for Plan standards.

C. Conclusions

Written standards and criteria continue to be the basic foundation of the analysis of CON need and access review. Two years of effort have been invested in the development of an updated Statewide Health Care Facilities and Services Plan which has largely focused on the improvement of standards for CON, but the regulations necessary to implement the standards are extremely slow in development. Efforts are underway to update this plan by the end of 2014, but more emphasis needs to be placed on the establishment of population-based methodologies to help define the volume and location of CON-reviewed facilities, equipment and services, as well as identifying areas of unmet need.

The 2012 nine statutory criteria for CON review, amended by 2013 Medicaid provisions, are certainly well-grounded and comparable to review criteria in most other CON states. But, the CON review forms have over many years become so customized to individual categories of review that they have become overly complex, comparatively inconsistent, generally burdensome, and somewhat disconnected from the base criteria. Efforts to resolve the situation were initiated this past year but continue to be delayed by other priorities.

D. Recommendations

1. In order to restore alignment with statutory criteria and ensure an improved completeness process, the CON review forms should be revised to build on the current ten statutory criteria, ensure consistency of format among all forms, tables and charts, and simplify the CON application process (*also posted in Certificate of Need Program section*).
2. In order to assist CON applicants and improve the review process, a high priority should be committed to the completion and implementation of regulations for the criteria and standards in the Statewide Health Care Facilities and Services Plan (*also posted in Certificate of Need Program section*).
3. In order to facilitate the updating of CON rules, add a new part to the executive summary which highlights the recommended standards for each facility and service category reviewed by the CON program (*also posted in Facilities and Services Plan section*).
4. In order to better measure the public quantitative need for CON reviewed facilities, equipment and services, the CON standards and guidelines in the Statewide Health Care Facilities and Services Plan should be expanded to include population-based predictive formulas, unmet needs and surpluses (*see Missouri CON standards for simplicity, the New York and Michigan CON standards for well-researched details, and the North Carolina State Medical Facilities Plan for statistical methodologies and conclusions . . . also posted in Facilities and Services Plan section*).

16. CON Standards and Guidelines in the Statewide Health Care Facilities and Services Plan

A. Documents and information reviewed:

OHCA Statewide Facilities and Services.pdf

Impressions from review:

- ◆ Standards/Guidelines for individual services and facilities reviewed by CON are buried in each related chapter, but is not summarized for easy reference . . . the following are extracted from the Plan for ease of comparison:

- Acute Care Hospital bed need criteria

1. Bed utilization is based on patient days and is calculated using data from three consecutive Federal Fiscal Years (FFYs). Patient days are broken down by DEMHS region, hospital, service category (Medical/Surgical, Maternity, Psychiatric, Rehabilitation and Pediatric) and age group (0-14, 15-44, 45-64, 65+) – the Pediatric category uses different age groups (0-19, 20+) to better utilize population estimate age ranges.
2. Patient days are divided by 365 (days) to calculate Average Daily Census (ADC) for each year of the three years.
3. A Weighted ADC is calculated, giving the greatest weight to the most current year and the least weight to the oldest year. $\text{Weighted avg. daily census} = (\text{Year1} + \text{Year2} \times 2 + \text{Year3} \times 3)/6$
4. The Weighted ADC is multiplied by a population growth/attrition factor for each DEMHS region (based on projected population estimates for 2010 and 2015, provided by the Connecticut State Data Center) to produce the Projected Average Daily Census.
5. The Projected ADC is divided by the Target Occupancy factors provided by the Acute Care/ Ambulatory Surgery Subcommittee to determine the number of beds needed.
6. “Beds Needed” is summed by service/age category and totaled by individual hospital.
7. The sum of “Beds Needed” is deducted from a hospital’s total number of licensed beds (excluding bassinets) to determine the number of excess or additional licensed beds that are required (Excess (-)/ Deficit (+)).
8. Individual hospital utilization and licensed bed data can be summed by the region in which hospitals are located to produce regional results. Statewide capacity is calculated using data from all 30 acute care hospitals.

The following criteria into may also be taken into consideration during its review of an application:

1. Observation Days; or
2. An average weekday occupancy rate/census for two separate and distinct periods of 30 calendar days for the most recent twelve month period at or above 80% of total licensed beds, it may qualify to add acute care beds. Those qualifying hospitals may seek a CON to add up to 10% of licensed bed capacity (not to exceed 50 beds), or alternatively up to 30 beds, whichever is greater. A hospital seeking to add beds under this exception must not have been granted a bed increase in the past 12 months and must have been licensed for at least one year.
3. Particular innovations, changes in care delivery models or modalities, resources (including physical resources and building facilities) needed to treat specific diseases or conditions
4. Quality or patient safety concerns

OHCA’s acute care bed need planning uses the Connecticut Department of Emergency Services and Public Protection, Division of Emergency Management and Homeland Security (DEMHS) regions which divide the state into five planning areas, comprising the Eastern, Western, North Central, South Central and Southwestern parts of the state. The DEMHS regions may be considered as part of the assessment under CGS 19a-639, specifically subsections (2) and (5), but are not necessarily considered the service area of the applicant.

- Emergency Departments need criteria

<none provided>

- Cardiac Services need criteria

Percutaneous Coronary Intervention (PCI): Primary PCI

1. Based on ACC and AHA, Primary PCI for STEMI should be performed by experienced operators who perform more than 75 elective PCIs per year and, ideally, at least 11 PCI procedures for STEMI per year. Ideally, these procedures should be performed in institutions that perform more than 400 elective PCIs per year and more than 36 primary PCI procedures for STEMI per year.

2. A report by the American College of Cardiology/American Heart Association Task Force on practice guidelines, referring to Class II b, suggests that Primary PCI for patients with STEMI might be considered in hospitals without on-site cardiac surgery provided that appropriate planning for program development has been accomplished and includes: experienced physician operators (more than 75 total PCIs and, ideally, at least 11 primary PCIs per year for STEMI); an experienced catheterization team on a 24 hours per day; 7 day per week call schedule; a well-equipped catheterization lab with digital imaging equipment; a full array of interventional equipment; intra-aortic balloon pump capability; and a proven plan for rapid transport to a cardiac surgery operating room in a nearby hospital with appropriate hemodynamic support capability for transfer. Primary PCI should be limited to patients with STEMI or MI with new or presumably new LBBB on ECG and should be performed in a timely fashion (goal of balloon inflation within 90 minutes of presentation) by persons skilled in the procedure (at least 75 PCIs per year) and at hospitals that perform a minimum of 36 Primary PCI procedures per year. (Level of Evidence: B - Limited populations evaluated. Data derived from a single randomized trial or nonrandomized studies).

Elective PCI

1. Elective/urgent PCI should be performed by operators with an acceptable annual volume (>75 procedures) at high volume centers (> 400 procedures) with on-site cardiac surgery (Level of Evidence: C)
2. Elective/urgent PCI should be performed by operators and institutions whose current risk-adjusted outcome statistics are comparable to those reported in contemporary national data registries, (Level of Evidence: C)
3. It is reasonable that low volume operators (< 75 PCI procedures per year) perform elective/urgent PCI at high volume centers (> 400 PCI procedures per year) with on-site cardiac surgery. Ideally, operators with an annual procedure volume of fewer than 75 procedures per year should only work at institutions with an activity level of more than 600 procedures per year. Operators who perform fewer than 75 procedures per year should develop a defined mentoring relationship with a highly experienced operator who has an annual procedural volume of at least 150 procedures per year. (Level of Evidence C)
4. It is not recommended that elective/urgent PCI be performed by low volume operators (< 75 PCI procedures per year) at low volume centers (200 to 400 procedures per year) with or without on-site cardiac surgery. An institution with a volume of fewer than 200 procedures per year, unless in a region that is underserved because of geography, should carefully consider whether it should continue to offer this service. (Level of Evidence: C)
5. The 2005 PCI Guideline does not establish an explicit minimum hospital volume threshold for elective PCI; there are multiple references in the context of operator and institutional competency to “centers” performing 200 – 400 elective PCI procedures per year.
6. The 2011 PCI Guideline states that operator and hospital volume recommendations have been maintained from the ACC/ AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention. PCI in Hospitals without On-Site Surgical Back-up is in the Class IIb category. Elective PCI might be considered in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished and rigorous clinical and angiographic criteria are used for proper patient selection (Level of Evidence: B). Any hospital considering elective PCI without on-site-cardiac surgery must meet the criteria set forth in the 2011 ACCF/AHA/SCAI PCI Guideline, Section 4.8., PCI in Hospitals Without On-Site Surgical Backup: Recommendations (see link below): <http://circ.ahajournals.org/content/124/23/e574.full.pdf+html>. Any hospital not meeting the 2011 ACCF/ANA/SCAI PCI Guideline criteria will be considered to be in Class III. Primary and elective PCI should not be performed in hospitals without on-site cardiac surgery capabilities without a proven plan for rapid transport to a surgery operating room in a nearby hospital or without appropriate hemodynamic support capability for transfer. (Level of Evidence: C)

Quality and Performance Considerations for PCI Programs:

Based on the 2011 American College of Cardiology Foundation/American Heart Association/Society for Cardiovascular Angiography and Interventions Guidelines for PCI:

1. Every PCI program should operate a quality improvement program that routinely:
 - a) reviews quality and outcomes of the entire program;
 - b) reviews results of individual operators;
 - c) includes risk adjustment;
 - d) provides peer review of difficult or complicated cases; and
 - e) performs random case reviews (Level of Evidence: C)
2. Every PCI program should participate in a regional or national PCI registry for the purpose of benchmarking its outcomes against national norms. (Level of Evidence: C)

Open Heart Surgery

1. Guidelines for Standards in Cardiac Surgery developed by the Advisory Council for Cardiothoracic Surgery and approved by the American College of Surgeons' Board of Regents in October 1996 – Bulletin of the American College of Surgeons, Vol. 82, No. 2, February 1997:
 - a) An annual volume of at least 100 to 125 open heart procedures per hospital is necessary from a quality compared with those doing a high volume
 - b) At least 200 procedures per year are necessary in order for a program to function efficiently

- c) A team approach with a minimum of 2 qualified cardiac surgeons is recommended to provide adequate and continuous perioperative care as well as assistance in the OR
2. The following conditions must be met to initiate a new OHS program:
 - a) The annual caseload of other programs w/in the proposed PSA shall not that one seems to have trouble getting on and out you never started out turn off my Wi-Fi access is turned back on in connection for a while and then you come by later is severe I need to do and not to install building all I don't know and is access to is only done to special Connections on the my computer and I and not really wasn't him him again Mac crazy and rop below 350 procedures
 - b) Epidemiological evidence of conditions for which OHS is appropriate w/in the PSA or demonstrates a significant unmet need in the PSA for these procedures
 - c) Existing program(s) in the service area are performing at least 350 open heart surgeries annually
 - d) Evidence demonstrating the performance of a minimum of 200 open heart surgeries annually within the first three years of the start of the new Open Heart Surgery program

Other factors for consideration:

Supplemental to the current guidelines and principles, as listed in Section 19a-639, CGS, proposed service areas may also be considered that include patients from those states that border Connecticut, i.e., Massachusetts, New York and Rhode Island, when reviewing a Certificate of Need request.

• Linear Accelerator need criteria

<none provided>

• Outpatient Surgery Facility need criteria

1. When an Applicant proposes to establish a new multi-specialty OSF, the case volume of single-specialty OSFs dedicated solely and exclusively for endoscopy may be excluded from the existing; volumes when establishing need for the multi-specialty OSF as required by Sec. 19a-639 (3), CGS.
2. Unless otherwise established by the Applicant and supported with documentation:
 - The capacity of the proposed facility will be based on eight (8) hours per day, five (5) days per week fifty (50) weeks per year for a total of 2,000 hours per year;
 - The optimal utilization for an operating room in an OSF is 80%;
 - The average time for an outpatient case will be sixty (60) minutes; and
 - Thirty (30) minutes will be allocated to cleanup between cases;
3. Unstaffed operating rooms are considered as available and shall be included in any calculations for capacity and utilization;
4. Delivery rooms for Caesarean sections and operating rooms specifically reserved for cardiac cases shall be excluded from calculations for capacity and utilization;
5. Proposed new OSFs must have written policies concerning access to care by persons who are underinsured or uninsured;
6. The Applicant must demonstrate the financial feasibility of the OSF within the first three (3) years of operations or within a reasonable time based on factors reported and supported by the Applicant;
7. The proposed new OSF will have in place at start of operations a transfer agreement with an acute care general hospital;
8. The Applicant must have in place at the start of operations a quality Assessment and Performance Improvement Program and be certified by Medicare or a national accrediting body for which CMS grants status to accredit ambulatory surgery centers;
9. The applicant must have in place at the start of operations a contract with a patient safety organization as defined at CGS § 19a-127o.

Other factors for consideration:

Supplemental to the current guidelines and principles, as listed in Section 19a-639, CGS, OHCA may consider the following factors when reviewing a Certificate of Need request:

1. Changes in technology and changes in medical treatment specialties;
2. Proposed service areas that include patients from those states that border Connecticut, i.e., Massachusetts, New York and Rhode Island;
3. Physician referral patterns;
4. Underserved populations;
5. Unique populations, specific clinical needs or performance of procedures more lengthy in nature;
6. Limited specialty programs where access to surgical services is limited; and
7. Atypical barriers to care based on cost, quality, financial access or geographic access.

• Imaging and New Technology need criteria:

Magnetic Resonance Imaging

1. Information Supporting Need Analysis:
 - a. Identify the Primary Service Area;
 - b. Identify existing services (i) of the applicant, and (ii) of other providers in Primary Service Area;
 - c. Provide capacity of existing services identified in subsection (1)(b), if available;
 - d. Explain the likely impact on existing services identified in subsection (1)(b);
 - e. Provide actual and proposed hours of operation for services;
 - f. Provide 3-year projection of utilization, with reasonable assumptions on MRI scan volume and capacity; and
 - g. Demonstrate need as described in 2 and 3 below.

2. Need Analysis – Statewide Benchmark and Assumptions:
 - a. “Utilization Rate per Capita” means the number of scans/1,000 population as determined by data collected and published by the Office of Health Care Access division of the Department of Public Health through its data collection and survey processes. If such data is not available from the Office, the applicant is responsible for including reliable statistics, with citations, to establish the utilization rate;
 - b. “Utilization Rate” means procedure per year for the PSA calculated by multiplying the Utilization Rate per Capita by the population in the PSA using the most recently available census data;
 - c. “Current Estimated Capacity” means 4,000 scans/year multiplied by the number of scanners in the PSA at the time of the application; and
 - d. “Percent Utilization of Current Capacity” means the “Utilization Rate/Current Estimated Capacity.” For current estimated capacity to remain in effect, it must be updated and such update published by the Office of Health Care Access not less than every two years based on the Statewide Facilities and Services Plan. If the Office does not publish an update, the applicant may present reliable capacity estimates for consideration by OHCA to establish the capacity.
3. Need Methodology (either of following):
 - a. The applicant is expected to demonstrate that the Percent Utilization of Current Capacity in the Primary Service Area exceeds 85%.
 - b. If the applicant has an MRI scanner in the Primary Service Area, the applicant is expected to demonstrate that its Percent Utilization of Current Capacity exceeds 85%. If the applicant is unable to demonstrate a clear public need for the proposed scanner based upon the assumptions and need methodology in subsection (3)(a) and the requirements of subsection (3)(b) have been met, the Applicant may rely upon any other relevant factors, including those described in subsection 7, to demonstrate need among the population it intends to serve.
4. Quality and Accessibility:
 - a. Hospital applicants shall be accredited by the Joint Commission on Accreditation of Healthcare Organizations or certified by Medicare directly or through a deeming agency;
 - b. Non-hospital facilities shall obtain accreditation from the American College of Radiology within eighteen months of the date on which imaging activities are first conducted;
 - c. A full-time board certified radiologist, who is a member in good standing with the American College of Radiology, shall be responsible for managing the operation of the MRI scanner and for the written interpretation of the MRI scan;
 - d. Personnel shall be trained, consistent with guidance of the American College of Radiology, in the use of the MRI scanner and the safety procedures to follow in the event of an emergency;
 - e. When imaging is performed a physician must be available either on-site or with immediate access to remote viewing of images as they are acquired. The physician in this case must be qualified to interpret images, make adjustments to imaging parameters or protocols, make decisions regarding magnetic field strength risks, and consult with the technologists on technical factors related to the study acquisition. This physician must be board certified to perform and interpret the examinations so produced;
 - f. When contrast is administered, a physician capable of addressing any contrast reactions or adverse events must be on site and immediately physically available to assist in the imaging suite. This physician must be in proximity such that he/she can respond immediately if called. This is not intended to require the physical presence of a physician in the room or suite at all times;
 - g. The facility or provider must have a policy that explains what steps will be taken to respond in the event of a medical emergency for patients undergoing MRI scans, including the plan for responding to allergic reactions related to contrast media or other drugs or biologicals used in connection with the scan; and
 - h. The facility or provider shall not deny MRI scanner services to any individual based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients.
5. Financial criteria:

The Applicant shall demonstrate that it has sufficient capital to finance the project and provide projections concerning the revenue and expenses for the first three years of the proposal.
6. Other Factors for Consideration:
 - a. The capabilities of the proposed CT scanner as compared to existing scanners;
 - b. The ability of the applicant to serve an underserved population and not jeopardize the financial viability of the project;
 - c. The impact on existing services, including avoiding delays in timely diagnosis or treatment;
 - d. The use of the scanner for clinical research;
 - e. The history of the applicant in running accredited, financially successful facilities;
 - f. The applicant’s ability to make radiation dose exposure decisions; and
 - g. For hospital applicants only, unique patient populations or specific clinical needs for specialty scanners or specific clinical applications, including scanners with multiple use applications; complexity of scanning procedures, including the impact on available scanner access due to lengthy procedures; necessity for back-up and redundant equipment to meet the needs of emergency departments.

CT scanning

1. Information Supporting Need Analysis:

- a. Identify the Primary Service Area;
 - b. Identify existing services (i) of the applicant, and (ii) of other providers in the Primary Service Area;
 - c. Provide capacity of existing services identified in subsection (1)(a), if available;
 - d. Explain the likely impact on existing services identified in subsection (1)(b);
 - e. Provide actual and proposed hours of operation for services;
 - f. Provide 3 year projection of utilization, with reasonable assumptions on CT scan volume and capacity; and
 - g. Demonstrate need as described in 2 and 3 below.
2. Need Analysis – Statewide Benchmark and Assumptions:
- a. “Utilization Rate per Capita” means the number of scans/1,000 population as determined by data collected and published by the Office of Health Care Access, a division of the Department of Public Health through its data collection and survey processes. If such data is not available from the Office, the applicant is responsible for including reliable statistics, with citations, to establish the utilization rate;
 - b. “Utilization Rate” means the procedure per year for the PSA calculated by multiplying the “Utilization Rate per Capita” by the population in the PSA using the most recently available census data.
 - c. “Current Estimated Capacity” is 12,000 scans per year multiplied by the number of hospital based scanners in the PSA at the time of the application for the acquisition of a hospital based scanner and 3,700 scans per year multiplied by the number of outpatient scanners in the PSA at the time of the application for the acquisition of an outpatient scanner; and
 - d. “Percent Utilization of Current Capacity” means “Utilization Rate/Current Estimated Capacity”. For current estimated capacity to remain in effect, it must be updated and such update published by the Office of Health Care Access not less than every two years based on the Statewide Facilities and Services Plan. If the Office does not publish an update, the applicant may present reliable capacity estimates for consideration by OHCA to establish the capacity.
3. Need Methodology (either of following):
- a. The applicant is generally expected to demonstrate that the Percent Utilization of Current Capacity in the Primary Service Area exceeds 85%.
 - b. If the applicant has a CT scanner in the Primary Service Area, the applicant is expected demonstrate that its Percent Utilization of Current Capacity exceeds 85%. If the applicant is unable to demonstrate a clear public need for the proposed scanner based upon the assumptions and need methodology in subsection 3(a) and subsection 3(b) have been met, the Applicant may rely upon any other relevant factors, including those described in subsection (7), to demonstrate need among the population it intends to serve.
4. Quality and Accessibility:
- a. Hospital applicants shall be accredited by The Joint Commission or certified by Medicare directly or through a deeming agency;
 - b. Non-hospital facilities shall obtain accreditation from either the American College of Radiology or the Intersocietal Commission on the Accreditation of Computed Tomography Laboratories within eighteen months of that date on which the imaging activities are first conducted;
 - c. The CT unit shall be operated safely by trained physicians and/or radiologic technologists who are licensed in Connecticut and who meet the minimum criteria set forth by the appropriate accrediting organization including but not limited to the American College of Radiology, the American Registry of Radiologic Technologists, and the American Registry of Clinical Radiography;
 - d. All applicants must employ or contract with a radiation physicist to review the quality and safety of the operation of the CT scanner;
 - e. When imaging is performed a physician must be available either on-site or with immediate access to remote viewing of images as they are acquired. The physician must be qualified to interpret images, make adjustments to imaging parameters or protocols, make decisions regarding radiation dose, and consult with the technologists on technical factors related to the study acquisition. This physician must be board certified to perform and interpret the examinations so produced;
 - f. When contrast is administered, a physician capable of addressing any contrast reactions or adverse events must be on site and immediately physically available to assist in the imaging suite. This physician must be in proximity such that he/she can respond immediately if called. This is not intended to require the physical presence of a physician in the room or suite at all times;
 - g. The facility or provider must have a policy that explains what steps will be taken to respond in the event of a medical emergency for patients undergoing CT scans, including the plan for responding to allergic reactions related to contrast media or other drugs or biologicals used in connection with the scan; and
 - h. The facility or provider shall not deny CT scanner services to any individual based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients.
5. Financial criteria:
The Applicant shall demonstrate that it has sufficient capital to finance the project and provide projections concerning the revenue and expenses for the first three years of the proposal.
6. Other Factors for Consideration:
- a. The capabilities of the proposed CT scanner as compared to existing scanners;
 - b. The ability of the applicant to serve an underserved population and not jeopardize the financial viability of the project;

- c. The impact on existing services, including avoiding delays in timely diagnosis or treatment;
- d. The use of the scanner for clinical research;
- e. The history of the applicant in running accredited, financially successful facilities;
- f. The applicant's ability to make radiation dose exposure decisions; and
- g. For hospital applicants only, unique patient populations or specific clinical needs for specialty scanners or specific clinical applications, including scanners with multiple use applications; complexity of scanning procedures, including the impact on available scanner access due to lengthy procedures; necessity for back-up and redundant equipment to meet the needs of emergency departments.

PET and PET/CT Scanning

1. Information Supporting Need Analysis:
 - a. Identify the Primary Service Area;
 - b. Identify existing services (i) of the applicant, and (ii) of other providers in the Primary Service Area;
 - c. Provide capacity of existing services identified in subsection 1(b), if available;
 - d. Explain the likely impact on existing services identified in subsection 1(b);
 - e. Provide actual and proposed hours of operation for services;
 - f. Provide 3 year projection of utilization, with reasonable assumptions on PET or PET-CT scan volume and capacity; and
 - g. Demonstrate need as described in 2 and 3 below.
2. Need Analysis – Statewide Benchmark and Assumptions:
 - a. "Utilization Rate per Capita" means the number of scans/1000 population as determined by data collected and published by the Office of Healthcare Access Division of the Department of Public Health through its data collection and survey processes. If such data are not available from the Office, the applicant is responsible for including reliable statistics, with citations, to establish the utilization rate;
 - b. "Utilization Rate" means procedure per year for the PSA calculated by multiplying the Utilization Rate Per Capita by the population in the PSA using the most recently available census data;
 - c. "Current estimated capacity" means 700 scans per year multiplied by the number of scanners in the service area; and
 - d. "Percent Utilization of Current Capacity" means "Utilization rate/Current Estimated Capacity." For current estimated capacity to remain in effect, it must be updated and such update published by the Office of Health Care Access not less than every two years based on the Statewide Facilities and Services Plan. If the Office does not publish an update, the applicant may present reliable capacity estimates for consideration by OHCA to establish the capacity.
3. Need Methodology:
 - a. The applicant is expected to demonstrate that the Percent Utilization of Current Capacity in the Primary Service Area exceeds 85%.
 - b. If the applicant has a PET or PET/CT scanner in the Primary Service Area, the applicant is expected to demonstrate that its Percent Utilization of Current Capacity exceeds 85%. If the applicant is unable to demonstrate a clear public need for the proposed scanner based upon the assumptions and need methodology in subsection 3(a) and subsection 3(b) have been met, the Applicant may rely upon any other relevant factors, including those described in subsection 7, to demonstrate need among the population it intends to serve.
4. Quality and Accessibility:
 - a. Hospital applicants shall be accredited by the Joint Commission or certified by Medicare directly or through a deeming agency;
 - b. Non-hospital facilities shall obtain accreditation from either the American College of Radiology or the Intersocietal Commission on the Accreditation of Nuclear Laboratories within eighteen months of the date on which imaging activities are first conducted;
 - c. A physician who is board-certified, shall be available during service hours;
 - d. Qualified engineering and physics personnel with training in the operation and maintenance of PET equipment shall be available to the facility during service hours;
 - e. Qualified radiation safety personnel with training and experience in the handling of short-lived position emitting nuclides shall be available during services hours;
 - f. The facility must have a policy that explains what steps will be taken to respond in the event of a medical emergency for patients undergoing PET or PET-CT scans, including the plan for responding to allergic reactions related to contrast media or other drugs or biologicals used in connection with the scan; and
 - g. The facility or provider shall not deny PET or PET-CT scanner services to any individual based upon the ability to pay or source of payment, including uninsured, underinsured and Medicaid patients.
5. Financial Criteria:

The Applicant shall demonstrate that it has sufficient capital to finance the project and provide projections concerning the revenue and expenses for the first three years of the proposal.
6. Other Factors for Consideration:
 - a. The capabilities of the proposed PET or PET-CT scanner as compared to existing PET or PET-CT scanners;

- b. The ability of the applicant to serve an underserved population and not jeopardize the financial viability of the project;
 - c. The impact on existing services, including avoiding delays in timely diagnosis or treatment;
 - d. The use of the PET or PET-CT scanner for clinical research;
 - e. The history of the applicant in running accredited, financially successful facilities;
 - f. The applicant's ability to make radiation dose exposure decisions; and
For hospital applicants only, unique patient populations or specific clinical needs for specialty scanners or specific clinical applications, including scanners with multiple use applications; complexity of scanning procedures, including the impact on available scanner access due to lengthy procedures; necessity for back-up and redundant equipment to meet the needs of emergency departments.
7. Replacement of PET scanners:
- a. A facility or provider may replace a PET scanner with a PET-CT scanner, without obtaining a CON, provided that the CT scanner will not be used independently of the PET component of the PET-CT scanner.
 - b. A facility or provider may replace a mobile PET scanner or PET/CT scanner, without obtaining a CON, with a fixed PET or PET/CT scanner.

New Technology

1. The applicant shall document that the proposed new technology is efficacious;
2. The applicant shall document that the equipment is certified for its proposed use by the United States Food and Drug Administration (FDA);
3. If applicable, preference shall be given to proposals that involve multi-institutional arrangements by contract, agreement, ownership, or other means between two (2) or more agencies to coordinate services, share support services, or provide services on a geographically integrated basis. A party to a multi-institutional arrangement shall not establish its own service or participate in another arrangement for the service until the original service is operating at sufficient capacity for adequate efficiency and quality of care. If the projected use of the new service includes expected referrals from others, the referring parties should be included in the multi-institutional arrangement, if possible;
4. If applicable, preference shall be given to proposals that place the new technology in a medical school or other teaching or research facility. New technology designed for pediatric use or proposed for use by pediatric patients shall be approved only in pediatric teaching facilities which have the availability of physician specialty support and specialized ancillary support services;
5. Before acquiring new technological equipment, applicants shall have complementary diagnostic and treatment services available to support the new program;
6. In cases where specific professional standards have not yet been formulated, applicants shall demonstrate that personnel who will staff the new technology are qualified and adequately trained. The applicant shall specify how personnel will be trained in the use of the specific equipment and safety procedures to follow in the event of an emergency. The institution providing the new services shall document its plan for providing continuing education for referring physicians and institutions in the use of the new technology; and
7. Applicants acquiring new technological equipment shall report utilization and demographic data necessary to evaluate the technology and to facilitate State planning.

• Behavior Health and Substance Abuse need criteria:

<none provided>

- ◆ Considerable criteria is devoted to staffing, credentialing, policies, and experience, with basic need calculations distilled down to bed need (80% occupancy, *but Target Occupancy factors not found*), PCI (400 procedures per year), Open Heart (200 procedures per year), Outpatient Surgery (80% use rate), MRI (4,000 scans per year), CT (12,000 per year), and PET (700 per year); population-based methodologies were not in evidence.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

<Insufficient time to study, too early for comment>

Perceptions from Second Visit Interviews:

<limited discussion, SHCFS Plan to be updated by October 2014>

C. Conclusions

Based on projections derived from the acute care bed need model, Connecticut has sufficient acute care inpatient bed capacity with a surplus of 1,581 beds, overall. However, further study is necessary to determine if regional gaps in service exist by service line/department (such as psychiatric, maternity, and medical/surgical). Although every hospital has its own emergency department, there do not appear to be any conclusions about whether there is an unmet need or surplus of free-standing emergency departments. There appears to be an unmet need for inpatient cardiac services in DEMHS Regions 4 and 5, presuming these include cardiac surgery services.

No conclusions could be found about an unmet need or surplus of outpatient surgical facilities, behavior health or substance abuse centers, linear accelerators, MRIs, CTs, or PET/CTs. References are made to long-term and rehabilitative services, but CON review for nursing homes is done in the Department of Social Services, which currently has a moratorium on new beds (with some exceptions).

The CON Standards and Guidelines in the Statewide Health Care Facilities and Services Plan provide an excellent description of what currently exists and how the CON reviewed services are generally utilized, but falls short of being able to predict the extent and locations of facility, equipment and service surpluses and unmet needs (except for hospital beds). Instead, much of the focus is currently on “how they should be operated” rather than on “how much is needed.”

D. Recommendations

1. In order to better measure the public quantitative need for CON reviewed facilities, equipment and services, the CON standards and guidelines in the Statewide Health Care Facilities and Services Plan should be expanded to include population-based predictive formulas, unmet needs and surpluses (*see Missouri CON standards for simplicity, the New York and Michigan CON standards for well-researched details, and the North Carolina State Medical Facilities Plan for statistical methodologies and conclusions . . . also posted in Facilities and Services Plan section*).
2. In order to balance the level of services reviewed, add by statute the review category of new hospital inpatient and outpatient services (*also posted in Certificate of Need Program section*).
3. In order to recognize state-of-the-art medical practice and streamline equipment acquisitions, remove computerized tomography (CT) and cone-beam imaging equipment in any setting from review (*consistent with two-thirds of the other CON states . . . also posted in Communications section*).

17. Effectiveness of the CON Program to Inform the Health Care Delivery System and Alignment with Health Care Reform

A. Documents and information reviewed:

Sample CON Status Report.pdf
Final CON Reform.pdf
CON Process Side-By-Side Comparison.doc
CON Info Forum.ppt
CERTIFICATE OF NEED REFORM.DOC
Memo PHC CON Reform.pdf
Public Act No. 10-179.pdf
CON_Reform_Brief.pdf
DPH/OHCA/CON websites
OHCA 101 video

Impressions from review:

- ◆ Early documents concerning proposed CON reform provide clear evidence that the proposed changes were successful in streamlining the CON program.
- ◆ 2010 legislative changes reflected major policy shifts of the new CON law including the elimination of all capital expenditure thresholds, the removal of the “additional function or service” requirement, the elimination of CONs for “termination of services” (later legislation restored it), discontinuance of the Letter of Intent, and otherwise simplified much of the CON language.
- ◆ Federal health care reform contemplates moving from a “volume-driven” system to a patient-centered system. As reimbursement and patients’ insurance coverage begin to shift in response to health care reform efforts, the CON process became realigned away from previous volume-driven behavior toward more value-driven outcomes.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Freedom of Information (FOI) request system impressive and responsive to inquiries.
- ◆ Website content progressing well, but have concerns about website navigation.
- ◆ DPH has numerous educational opportunities for website audiences such as general public, media, legislators, potential applicants, and others.
- ◆ A new FAQ section would be very beneficial (being developed).
- ◆ More staff contact information would be helpful online.
- ◆ This website was reorganized in 2011 but based on 14-year-old software (looking for examples of great websites), website has limited interactivity and no tabbing.
- ◆ Current website includes many informational databases, OHCA has 75% of website services, information maintained in Windows, databases use SQL host.
- ◆ Hospital Reporting System (HRS) data collected by OHCA, discharge data comes from Connecticut Hospital Association (CHA), outpatient data to be expanded in 2015 via efforts already underway.

- ◆ A secure holding area could be activated on the website to provide temporary content for freedom of information requests to be titled “Recent FOI Requests”.
- ◆ OHCA has an obligation to respond to the media and needs more education accordingly.
- ◆ Media response emphasis should be concise responses which also include reports.
- ◆ Authors must consider for whom reports are developed and why they are available in response to more changes which means that more information is needed.
- ◆ Media response should “stay in our lane” and not comment outside of the topic knowing that DPH communications office can help facilitate education and training.
- ◆ Tremendous potential for video presentation and webinars, but responding to requests by saying that “it’s on the website” should not be the first answer.
- ◆ An all-in-one publication with all pertinent CON guidance information appears needed.
- ◆ Previous CON reform was instituted by prior OHCA Commissioner, while streamlining efforts were motivated by threat of CON sunset.
- ◆ Health care reform intent was to make the system more patient-centered.
- ◆ Concerns again expressed about termination vs transfer whereas both need definition.
- ◆ Questions raised about why an ending (termination) should be reviewed if the beginning doesn’t require a CON?
- ◆ “Character and competence” review is potentially important (often done in other states).
- ◆ There is a need to preserve the safety net, and CHA may offer definitions, but generally want them to be kept flexible.

Perceptions from Second Visit Interviews:

<more information was later gleaned from telephone interviews with health industry *which are shown in the Internal and External Communications Section*>

C. Conclusions

By most accounts, OHCA has been very effective in communicating its CON program descriptions and activities. Their websites have successfully provided opportunities to learn more about CON applications, the review process, hospital and other data, and historical documentation of prior CON decisions and other information (some attention is needed to improve the ability to efficiently navigate these electronic pages and topics).

Many people have also complimented DPH and OHCA leadership about being responsive to inquiries. The Freedom of Information (FOI) response system appears to work fairly well, although access via the website could be improved. OHCA’s late-2013 public information forum appears to have been well received and very informative. Unfortunately, the failure to provide open, early and frequent communication between applicants and CON analysts has raised the concerns of many from the healthcare industry, Governor’s office and OPM interviews.

As for health care reform, the 2010 Patient Protection and Affordable Care Act includes two key provisions that will probably impact all CON programs:

- an increase in the insured population that will demand more services, which may call for increased provider capacity; and
- provider payment reforms, which may restore some of the market constraint on expansion seen in the 1990s.

On one hand, communities that had previously sought expansions may prepare for payment reform by increasing efficiency and find that they have adequate capacity and can absorb

increased demand without difficulty. This may be true for the number of inpatient facilities, but outpatient services have changed significantly, and efficiencies are being sought through mergers and terminations, physician-practice acquisitions, and not-for-profit conversions.

On the other hand, communities with a high proportion of currently uninsured people and truly inadequate capacity in key areas (such as rural areas) might use the CON process to assist with state health planning. Another aspect to consider is whether maintaining or loosening CON regulations will benefit other goals of health care reform, such as the creation of integrated health systems, medical homes and accountable care organizations, as some have suggested.

Connecticut's legislative realignment of the CON process away from previous volume-driven behavior toward more value-driven outcomes was well-intentioned, but has caused confusion about dimensions of public need and frustration about interpretation of what should, or should not be reviewed. More transparency and flexibility is needed, as well as clear information and guidance about how to communicate and cooperate with health planning and regulatory efforts.

D. Recommendations

1. In order to be electronically more responsive to Freedom of Information requests, OHCA should establish a secure holding area on the website titled "Recent FOI Requests" to provide temporary content for such that requestors could download large files and reduce paper and CD responses.
2. In order to improve public knowledge and simplify electronic access to OHCA information, the CON portion of the website should be restructured similar to the Facilities Plan page which sequences Goal, Background, Issues, Outcomes and Content (*worthy examples of other state CON websites include Massachusetts, Georgia, Missouri, and Maine . . . also posted in Communications section*).
3. In order to improve customer relations and public receptiveness, OHCA staff should be empowered and trained in effective communication, particularly with CON applicants and the media, emphasizing early intervention, continual information exchange, and effective delivery of public information (*also posted in Communications section*).
4. In order to better measure the public quantitative need for CON reviewed facilities, equipment and services, the CON standards and guidelines in the Statewide Health Care Facilities and Services Plan should be expanded to include population-based predictive formulas, unmet needs and surpluses (*see Missouri CON standards for simplicity, the New York and Michigan CON standards for well-researched details, and the North Carolina State Medical Facilities Plan for statistical methodologies and conclusions . . . also posted in Facilities and Services Plan section*).
5. In order to clarify how termination review would be applied and articulate clearly statutory intent, the legislature should define the term "healthcare service" including the specific types of health care facility resources to be affected (*also posted in Certificate of Need Program section*).
6. In order to enhance the decision-making process, provide streamlining incentives such as abbreviated applications and shorter review times for joint ventures among health providers for unique proposals such as new and emerging technologies, existing equipment acquisition, and equipment replacement (*also posted in Certificate of Need Program section*).

18. Feasibility of Considering Economic Development and Benefits to the State as Part of the CON Process

A. Documents and information reviewed:

Gov Malloy Regulatory Review Opportunities for Economic Growth
Gov Letter about Reg Review

Impressions from review:

- ◆ Gov. Malloy's Executive Order (October 16, 2013) was aimed at streamlining state regulations and holds great promise for improving efficiency, expanding transparency and motivating the CON program to be more responsive. One of the expressed key principles when drafting updated regulations is to account for the anticipated impact on economic growth.
- ◆ Immediately after this (October 23, 2013) an 84-page report to the Governor called "Continuous Improvement in Connecticut State Government" demonstrated a large number of achievements in efficiency and effectiveness including the OHCA fiscal assessment mechanism of acute care hospitals for OHCA's expenses using the "Plan, Do, Check, Act" quality improvement process to streamline the process, reduce staff time, and improve user-friendly operations. In a different accomplishment, OHCA has posted hospital chargemasters on their website in a successful effort to improve transparency of the hospital pricing information.
- ◆ LEAN Government Services also assists government offices (and others) in streamlining their work processes resulting in significant cost and resource savings (this is a process which the OHCA staff is attempting to apply to their CON process and other activities).
- ◆ CON is considered by many to be anti-development. Justice Department's Antitrust Division has said: "market forces improve the quality and lower the cost of healthcare services ... CON laws are a classic government-erected barrier to entry. As such, they are anathema to competitive markets." South Carolina Governor Nikki Haley recently vetoed a bill to fund her state's CON, and said: "the [CON] program is an intensely political one through which bureaucratic policymakers deny new healthcare providers from offering treatment. We should allow the market to work rather than politics."
- ◆ On the other hand, CON supporters say the process is meant to balance cost, access and the quality of health care. According to Bret Jackson, executive director of the Economic Alliance for Michigan, "Certificate of need not only helps control capital costs but utilization of services ... Health care doesn't operate in a free market," he said. "About half of patient care is paid for by the government through Medicare and Medicaid." Patients, unless they are going in for an elective procedure, typically don't shop around, they just go to their doctor and do what is recommended.
- ◆ The South Carolina Hospital Association's position is: "CON provides a public safety net so that citizens in rural areas and the medically underserved will have access to health care facilities, including emergency medical services. The existence of financially strong hospitals provides stable employment opportunities and supports long term economic development. Maintaining a fair state health planning process is in the best interests of South Carolinians and their communities."

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Connecticut is close to the bottom for economic development (46th in economic performance, according to the *2013 Alec-Laffer State Economic Competitiveness Index*, which negatively affects CON perception.
- ◆ Early indications that “yes, if...” conditions provide flexible promotional opportunities via “agreed settlements” that could create economic opportunities for unmet needs.

Perceptions from Second Visit Interviews:

<no additional information gained, more research needed>

C. Conclusions

It is very obvious that state government efforts in Connecticut have been very sincere in trying to simplify and streamline its interactions with “customers”. OHCA has evidenced numerous successes in achieving greater efficiency and effectiveness in some of its operations, and is clearly striving to accomplish more.

Meanwhile, economic and political pressures continue to press for improved development opportunities and community benefits. Historically across the country, CON has represented a regulatory process intended to carefully evaluate proposed providers’ ability to ensure quality and access at a reasonable cost. Indeed, OHCA’s prime Mission is “to ensure that the citizens of Connecticut have access to a quality health care delivery system”.

In order for Connecticut’s CON program to consider economic development and community benefits as part of its process, OHCA must step forward from a mostly reactive role to become much more proactive and promotional in its mission, operations and intended results. Conceptually, health care issues appear to have come full circle back 40 years to the initial emergence of the National Health Planning and Resources Development Act of 1974 (Public Law 93-641) when “Congress (made) the following findings:

- (1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.
- (2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.
- (3) The many and increasing responses to these problems by the public sector (Federal, State, and local) and the private sector have not resulted in a comprehensive, rational approach to the present—
 - (A) lack of uniformly effective methods of delivering health care;
 - (B) maldistribution of health care facilities and manpower; and
 - (C) increasing cost of health care.
- (4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.
- (5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of

- the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels.
- (6) Large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health services,

In recognition of the magnitude of the problems described (above) and the urgency placed on their solution, it is the purpose of this Act to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy.”

The Connecticut legislature could reasonably make the same findings today in order to rebuild its efforts to facilitate new state health planning policy, augment community and state planning, and authorize funding for such economic development. Thereafter, OHCA could then use its Statewide Health Care Facilities and Services Plan and the State Health Improvement Plan to articulate the need for health facilities, equipment and services, and the CON Program to promote development in areas of unmet need through “agreed settlements”.

In short, the Plans would illustrate how much of what is needed where by when. Then, regulation would become the tool (for which it was originally intended) to promote and motivate implementation of the Plans. The results would thus achieve the much-needed economic development (quantitative and qualitative financial improvements) and community benefits (ensured health care access and improved health status) that are expected.

The classic anti-competition argument of health care entrepreneurs is inconsistent with the health and welfare of consumers. State efforts to ensure reasonable cost, equitable access and high quality of health care is akin to regulating water purity, highway safety, and quality education. Because the free market is fiction for health care due to health insurance standards, government payments, and provider guidance, government oversight is imperative, particularly since health services are not a commodity. The assurance of public safety nets, rural and medically underserved access, emergency medical services availability, financially stable hospitals and reliable freestanding services does promote long term economic development, if based on fair state health planning and regulatory processes.

D. Recommendations

1. In order to be more proactive and promote health care development, the legislature should reconfirm its commitment to state health planning and recognize CON as an implementation tool, as well as a steward of cost, access and quality.
2. In order to provide opportunities for health care economic development in areas of unmet need, OHCA should update the CON regulated portions of the Statewide Health Care Facilities and Services Plan to include methodologies to define specific needs for facilities, equipment and services by type, volume and location.
3. In order to motivate the submission of CON applications to address areas of unmet need, the CON Program should establish a bi-annual “Request For Application” process (*see examples in Virginia, Maryland and North Carolina*).
4. In order to assist in and motivate the development of new and expanded facilities, equipment and services in unmet need areas, the legislature should establish a special “Health Care Development Fund” for qualified healthcare providers.

19. Feasibility of Including Strategies of Aligning Community Benefits Programs as Part of the CON Process

A. Documents and information reviewed:

*Caution On For-Profit Hospital Conversion Trend In CT
Hosp Community Benefits.pdf
The Hilltop Institute- Hospital Community Benefit Program
Hospitals Spend Little on Health of Community*

Impressions from review:

- ◆ Courant.com editorial (November 25, 2013) stated that “National for-profit corporations are looking to Connecticut to acquire nonprofit community hospitals. And both for-profit and nonprofit hospitals appear increasingly intent on acquiring previously independent doctors' practices . . . Hospital-affiliated practices can negotiate higher rates than independent physician practices, charge separate "facility fees," drive out competition in particular markets and provide care in areas where more patients are covered by higher-paying commercial health insurance policies. These trends undoubtedly have resulted in higher health care costs . . . Connecticut's current laws simply did not contemplate the realities of today's marketplace . . . The Office of Health Care Access has some authority to ensure continued quality care and access, but those tools may prove insufficient and outdated . . . Other states go further in reviewing hospital mergers and acquisitions: Tennessee requires more stringent conditions to ensure health care access and quality. Massachusetts permits regulators to require for-profit hospitals to fund independent monitors who periodically report on community health care access. And Rhode Island empowers regulators to consider issues of workforce retention and collective bargaining rights.”
- ◆ According to researchers Gary Young, PhD, of Northeastern University in Boston, and colleagues, they wrote in the April 18 *New England Journal of Medicine* that tax-exempt hospitals spend only a very small fraction of their operating expenses on improving community health. In 2009, of the mean 7.5% of operating expenses set aside for community benefits by tax-exempt hospitals, an average of 5% of that very small slice was used to improve health in the community. The majority of fiscal community benefit resources – 85% – were used for charity care and other care-related services, while the remaining 10% was used for education, research, and community group contributions. Because of this, a provision in the Affordable Care Act (ACA) requires hospitals to assess community needs at three-year intervals and “develop an implementation strategy to address identified needs.” Seven community benefits were used in the study, including charity care, unreimbursed costs for means-tested government programs, subsidized health services, community health improvement services and benefits operations, research, healthcare professional education, and contributions made to community groups.
- ◆ The Hilltop Institute last year assessed hospital community benefits and produced state profiles across the country through an effort funded by the Robert Wood Johnson Foundation. This Hospital Community Benefit Program is a central resource created specifically for state and local policymakers who seek to ensure that tax-exempt

hospital community benefit activities are responsive to pressing community health needs. A comparison of Connecticut to other Northeastern states (*see Appendix D*), such as Maryland, New York and Rhode Island, in eight hospital community benefit categories, found that they all had community benefit reporting requirements and limitations on charges/billing/collections; but unlike the others, Connecticut does not expressly require community benefits, health needs assessments, community benefits plans, financial assistance policies or dissemination (none of them had a mandatory minimum community benefit). Connecticut does require hospitals that do voluntarily develop community benefit programs to satisfy specific reporting requirements such as filing annually with the state Office of Health Care Access their policies on charity care and reduced cost services to the indigent. DPH statutes were also added in 2005 to require each hospital to submit a report to the Healthcare Advocate of whether they have a community benefits program in place.

- ◆ Community Health Needs Assessments are required by federal law, and the data is collected by OHCA in collaboration with the Connecticut Hospital Association.

B. Site Visit Observations:

Perceptions from First Visit Interviews:

- ◆ Concerns expressed by DPH staff about provider need vs. business need vs. public need (cross-state competition for New Technology).
- ◆ What are community benefits, issues related to for-profit changes of ownership.

Perceptions from Second Visit Interviews:

<no additional information gained, more research needed>

C. Conclusions

Not-for-profit hospitals are granted tax-exempt status based on qualifying as charitable organizations through “providing services and otherwise engaging in activities that they fully or partially subsidize.” However, whether these hospitals provide adequate community benefits to earn such status is a controversial topic with opportunities for assistance when they make proposals to the CON Program.

D. Recommendations

1. In order to stimulate community benefits, selected conditions should be placed on approved CON applications related to charity care, unreimbursed costs for means-tested government programs, subsidized health services, community health improvement services and benefits operations, research, healthcare professional education, community health needs assessments, and contributions to community groups (*see examples in New York, Michigan, Maryland and North Carolina*).
2. In order to assure full compliance with the intent of not-for-profit status, the legislature should mandate minimum hospital community benefit programs, financial assistance policies, and community health needs assessments (*see New York, Maryland and Rhode Island for examples*).

20. Aforementioned Items in Conjunction with Best Practices and Other Similar States

A. Documents and information reviewed:

Other states Termination Regs_Statutes_Definitions.docx
CON white pages file.onepkg
CON States with Review Board - White paper.xlsx
A Regional Perspective on the CON Process (NY).pdf

Impressions from review:

- ◆ CON approval is required prior to health service termination in six states including Connecticut, Hawaii, Illinois, Maryland, Rhode Island, and West Virginia
- ◆ Repeated research has shown that there is little consistency in the definition of “termination” (only Florida, Iowa and West Virginia even defined the term) with only the Florida definition coming close to application in Connecticut: “Termination of an inpatient health service means the cessation of a health service which currently requires a certificate of need. It does not include the temporary cessation of a service lasting six months or less.”
- ◆ Nine states require a written notification of discontinuance or termination of service (no CON approval required) including Alaska, Florida, Georgia, Iowa, Kentucky, Maine, Missouri, New York, and Oklahoma.
- ◆ Of the 35 CON regulated states, seven have Boards that make the final decisions, six have Advisory Boards who make recommendations, and 28 have an agency or department head who makes the final decision.
- ◆ When comparing the relative scope and review thresholds of state CON programs, today Connecticut ranks 16th of 35 as compared to five years ago when it ranked sixth of 37 (Wisconsin has since discontinued CON, and South Carolina has been defunded).
- ◆ From 1974 to 1987, most CON programs nationwide operated in the same fashion due to Federal guidelines, but during the past 27 years, local priorities and politics have dramatically changed and (in many cases) deregulated these CON processes (often diminishing or eliminating state health plans) which has made relative comparisons between state CON programs more and more difficult.
- ◆ Due to regressive budget cutbacks and efforts to deregulate, most state CON programs have lost valuable staff and almost eliminated out-of-state travel which has all but curtailed communication and information sharing.
- ◆ “Best Practices” achievement for health care is one of the building blocks of CON as it seeks assurances in its plans and applications that the proposed services will be properly staffed, use minimal performance levels to maximize quality, sufficient provisions to maintain access, and financial stability of the state health care system.
- ◆ Best Practices achievement for the CON process is being re-examined in many states such as next door where health planning and regulation began 50 years ago, and the New York State Public Health and Health Planning Council has been asking stakeholders to provide comments and recommendations on the scope and content of their CON process in response to five key questions including:

“How can the CON process be refined to respond appropriately to new models of care, new ways of structuring relationships among health care providers, new technologies and migration of services to outpatient settings?” and
“Are there types of projects that should no longer be subject to CON review or projects that are not subject to review, but should be?”

- ◆ Numerous responses have come from organized consumer planning groups, as well as diverse health care associations including:

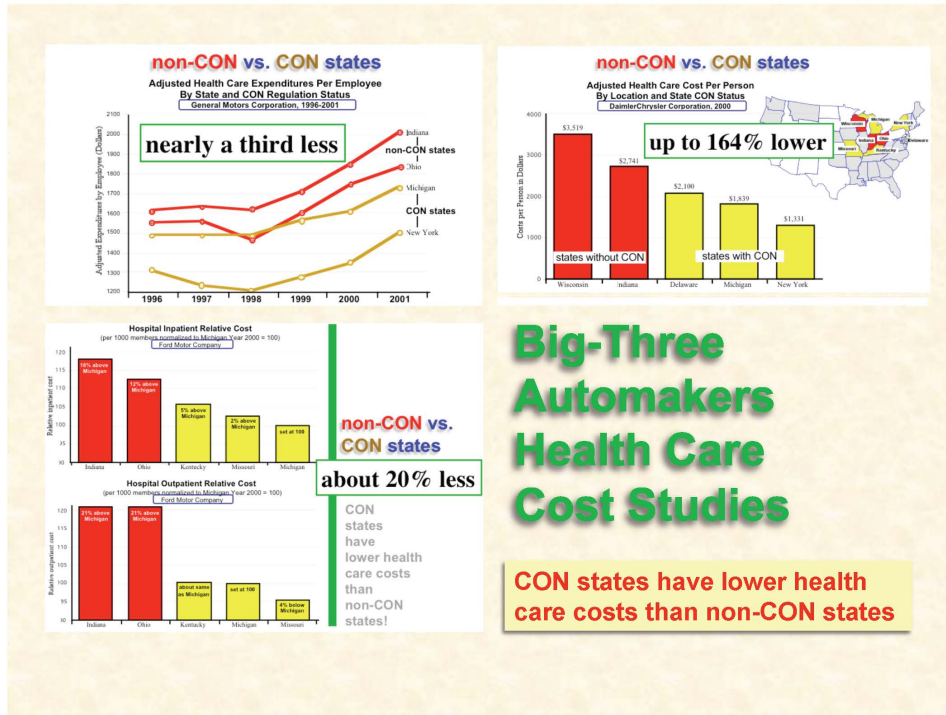
“Greater New York Hospital Association (GNYHA) firmly believes that New York State’s certificate of need (CON) program requires substantial reform to ensure that the State can best meet its overarching goal of improving health and health care while also controlling costs.

Given the extraordinary evolution of the health care system since the State’s CON program was created in 1964, its value and role in promoting cost control, quality, and access have diminished significantly. Many aspects of the program are unnecessarily complicated, expensive, and lengthy; it is both over- and under-inclusive; and it is dated in terms of the categories of projects it reviews and its methodologies.”

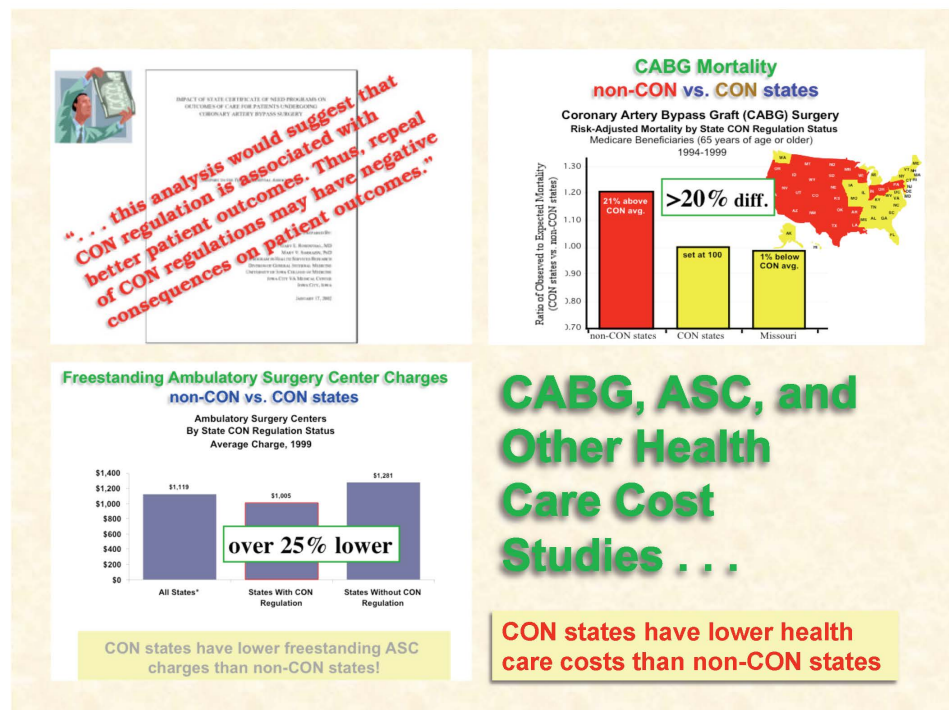
- ◆ Even deregulated states like Texas, Arizona, Indiana, Kansas and others have attempted to bring CON back in response to out-of-control health care costs. As an example, Pennsylvania in 2010 debated House Bill 247 (with over 40 sponsors) which would have reintroduced the CON process, a move that was called “*critical to helping rein in the escalating costs of health care . . . one of the significant health care cost drivers is unnecessary duplication of expensive medical technology and services.*” Supporters asserted that the removal of CON requirements had sparked a costly and unnecessary “*technological arms race*” among Pennsylvania’s healthcare providers. Since the State’s CON program expired in 1996, the number of licensed ambulatory surgical centers in Pennsylvania increased by 400%, from 44 to more than 230. Echoing the sentiments of every state who wanted to bring CON back, the sponsor said the purpose of the bill was to “*...reconfigure our health care system by considering community health care needs on a regional basis so that capital expenditures on medical technology can be prioritized for certain areas but limited where the market is already saturated....Opponents of CON will tell you that the duplication of these health care services is about ‘choice’ and ‘competition.’ I believe it’s about profit. We need to recognize that competition is not always the solution; sometimes it’s the problem. And in this case, it’s driving people who need health insurance out of the marketplace.*” This effort did not succeed, nor has any other (Indiana deregulated 1994, restored 1996, ended 1998, while Wisconsin deregulated 1987, restored 1992, ended 2013, [see state CON durations chart in Appendix F](#)).
- ◆ When reviewing “best practices” among CON regulated states, Michigan repeatedly emerged as the example of objective and effective operations. According to the National Institute for Health Care Reform (NIHCR), Michigan requires “providers to document the community need for all regulated services regardless of cost, while others do not require CON approval for any project under certain cost thresholds.” They went on to say that “Michigan has the most systematic approach to evaluating and updating CON requirements. The appointed state CON commission evaluates the review standards for modification on a three-year rotating schedule and has the authority to recommend revisions to the list of covered clinical services subject to

CON review . . . the Economic Alliance for Michigan, a nonprofit statewide business-labor coalition, strongly supports CON, saying the process helps lower overall health care cost growth by restricting providers' geographic expansion, making market entry more difficult for specialty and for-profit hospitals, and keeping excess bed capacity to a minimum . . . In Michigan, CON applications recently shifted to an electronic filing system, and the response to this was overwhelmingly positive because of increased transparency and efficiency of the process overall. While state budget problems may foreclose additional funding for now, investments in strengthening CON programs might help decrease health care costs down the line."

- ◆ In recent testimony before a legislative budget committee, the Economic Alliance of Michigan (together with 16 business and consumer associations, 6 labor organizations, and 51 hospitals and health systems, collectively known as the "Friends of Certificate of Need") stated that "Michigan CON has been supported by all Republican and Democratic governors in the last 40 years. The program is a recognized national leader in avoiding duplicative and thus very costly hospitals, surgical programs, other health facilities and advanced health services (e.g., imaging, open heart surgery, and other advanced services). CON is one of the key reasons why per capita health costs are generally lower in Michigan than elsewhere in the Great Lakes region and in other states with significant competitors for Michigan businesses. For example, repeated studies by Chrysler, Ford and GM have shown that their per capita health costs are lower in strong CON states, like Michigan . . . The three US auto companies and the UAW have cooperated on periodic analyses of their combined health cost data for all employees. They consistently found that per capita health costs in states with a significant auto presence were lower in strong CON states (Michigan's has the lowest costs of all auto states) . . . States that repealed CON often had a proliferation of unneeded/duplicative facilities and services, especially in high income areas, already amply served: for example, when Ohio and Pennsylvania repealed their CON laws, there was an explosion of spending on unneeded and duplicative specialty facilities." . . . in Ohio, the next four years saw an increase of 19 new hospitals, a 137% surge in outpatient dialysis stations, and a 600% increase in ambulatory surgical centers; in Pennsylvania, they saw a dramatic growth in open heart surgery programs, which increased from 35 to 62 . . . "This threatened the financial viability of existing hospitals and health programs, critical for citizens' access to basic and emergency services. That also generated significant cost increases."
- ◆ Reported by the National Conference of State Legislatures, "a study conducted by the 'big-three' automakers claims lower health care costs in CON states than in non-CON states." They undertook separate systematic analysis of their health care costs in states where they have large numbers of employees and insured dependents. This empirical experience was recorded only in states where they had at least 10,000 employees and comparable health benefit programs. DaimlerChrysler Corporation showed that their employees in CON states enjoyed health care costs which were up to 164% lower than in the non-CON regulated states. General Motors analyzed health care use and expense data four states where it has large numbers of insured showing that they spent nearly a third less in CON states for health care expenses per employee than in non-CON states (with over a million employees, it spends \$4.2 billion each year on health care benefits for its employees, retirees and their dependents). In comparing MRI and CABG services, health care costs were found to be from 11 to 39% lower in CON states (*see comparative charts and graphs on next page for illustrations of these statistics*).



SMG Solutions, a national surgery monitoring organization, showed that ambulatory surgery center charges in CON states were over a quarter lower than in non-CON states. A nationwide study of Medicare patients concluded that “. . . CON regulation is associated with better patient outcomes.” Comparing the results of CON states to non-CON states, coronary artery bypass graft (CABG) mortality rates were found to be over 20% lower in CON states (*see comparative charts and graphs below*).



B. Site Visit Observations:

First Visit:

- ◆ Staff presentation developed by staff about other states with review boards (New York, Missouri and Michigan have good examples of differential types).

Second Visit:

<no additional information gained, more research needed>

C. Conclusions

Comparisons to CON programs in other states has become progressively more difficult since discontinuance of Federal mandates and funding 27 years ago. Each state's manner of operations, categories of review, and appetite for enforcement have drifted apart and diminished in scope and importance. As pioneered by its early planning and regulatory efforts, the northeastern United States still has the most comprehensive CON review (in spite of significant deregulation in Massachusetts, Maryland and Delaware).

Best practices in health care are usually defined as "... activities, disciplines and methods that are available to identify, implement and monitor the available evidence in health care ..." (*see National Institutes of Health*). The most objective remaining tool that has continued to monitor health planning and certificate of need programs for the past 23 years is the "National Directory of State Certificate of Need Programs and Health Planning Agencies" published annually by the American Health Planning Association. Even this document has lost much of its prior importance due to survey delays and differential reporting. Intermittent and consistent contact with CON program directors has also produced disappointing results because of staff turnovers and dramatic budget cutbacks.

As prescribed in the 1974 National Health Planning and Resources Development Act, the premier "best practice" guide is a definitive state health plan with CON standards.

D. Recommendations

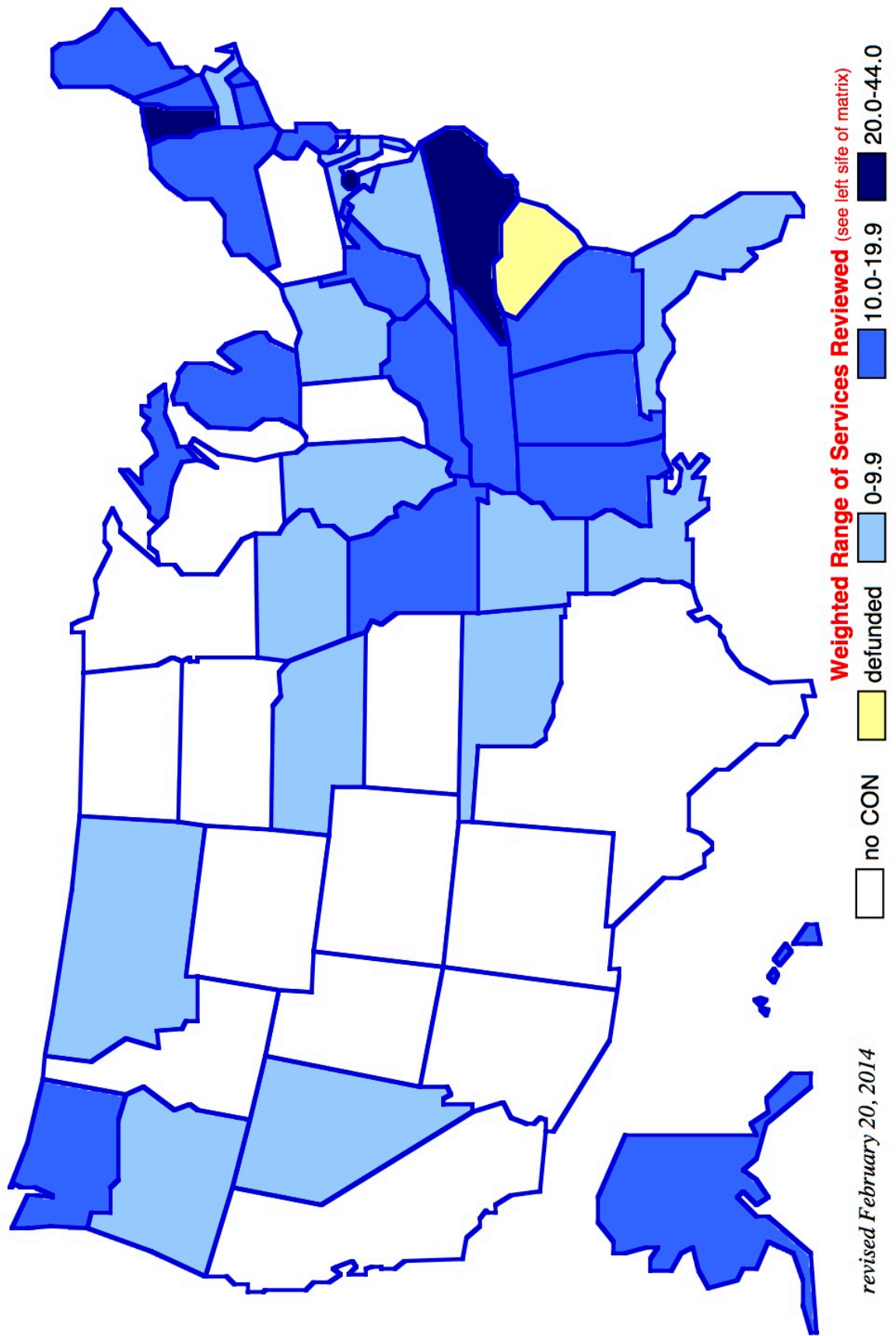
1. In order to fully represent the views of providers, consumers, business, payers, and others, OHCA should augment its update of the Statewide Health Care Facilities and Services Plan with a statewide invitation to stakeholders to provide comments and recommendations on how to improve the scope and content of Connecticut's CON process (*see New York State Public Health and Health Planning Council*).
2. In order to add clarity and distinction to CON review, define "Termination" in statute as the operational discontinuance or elimination by a health care facility (excluding affiliates) as defined by Subsection (10) of Section 19a-630, C.G.S of a health care service (not including a temporary suspension lasting six months or less) with the exception of the merger, transfer or relocation of health care services which are located up to five miles apart in an urban area (*also posted in Statutes and Regulations section*).
3. In order to better measure the public quantitative need for CON reviewed facilities, equipment and services, the CON standards and guidelines in the Statewide Health Care Facilities and Services Plan should be expanded to include population-based predictive formulas, unmet needs and surpluses (*see Missouri CON standards for simplicity, the New York and Michigan CON standards for well-researched details, and the North Carolina State Medical Facilities Plan for statistical methodologies and conclusions . . . also posted in Facilities and Services Plan section*).

Appendices



Appendix B

2014 Map of Certificate of Need Regulation by State Relative Scope and Review Thresholds (a geographic illustration of the CON matrix)



Appendix C

State Patient Level Hospital Data Collection Programs						
2011						
Jurisdiction	Authority		Collection Agency Type			Notes
	Mandated Collection	Voluntary Collection	State Agency	Hospital Association	Other Private Organization	
Alabama (6)		X				Quarterly Survey of Discharges
Alaska (2)		X		X		No Public Release
Arkansas (1)	X		X			
Arizona	X		X			
California (1)	X		X			
Colorado (2)		X		X		
Connecticut (4)	X		X			
Delaware (1)	X		X			
District of Columbia	X			X		
Florida (1)	X		X			
Georgia (3)	X			X		
Hawaii (2)		X			X	
Idaho						No Program
Illinois (4)	X		X			
Indiana (3)	X			X		Limited Public Release
Iowa (3)	X			X		Limited Public Release
Kansas (5)	X			X		
Kentucky (1)	X		X			
Louisiana (1)	X		X			
Maine (1)	X		X			Collects Payer Claims Data
Maryland (1)	X					Collects Outpatient Claims Data
Massachusetts (1)	X		X			
Michigan (2)		X		X		Limited Public Release
Minnesota (5)		X		X		Limited Public Release
Mississippi (1)		X	X			Quarterly Survey of Discharges
Missouri (4)	X		X			Limited Public Release
Montana (2)		X		X		No Public Release
Nebraska (2)		X		X		
Nevada (1)	X		X			
New Hampshire (1)	X		X			
New Jersey (1)	X		X			
New Mexico (1)	X		X			
New York (1)	X		X			
North Carolina (3)	X			X		
North Dakota (1)	X		X			
Ohio (2)		X		X		No Public Release
Oklahoma (1)	X		X			
Oregon (1)	X		X			
Pennsylvania (1)	X		X			
Rhode Island (1)	X		X			
South Carolina (1)	X		X			
South Dakota (2)		X		X		
Tennessee (3)	X			X		
Texas (1)	X		X			
Utah (1)	X		X			
Vermont (4)	X		X			
Virginia (3)	X				X	Virginia Health Information
Washington (1)	X		X			
West Virginia (1)	X		X			
Wisconsin (3)	X			X		
Wyoming (2)		X		X		
Totals	38	10	29	17	2	

Source: National Association of Health Data Organizations (NAHDO), 2011.

(1) Mandate: State agency or state-affiliated agency collects and distributes data under mandate.
 (2) Voluntary: Hospital Association or other private agency collects data without state mandate, with voluntary participation by hospitals.
 (3) State mandate with delegated authority to nonstate agency: State agency contracts with independent private agency to implement mandate.
 (4) Two systems: Both the state and the hospital association collect hospital discharge data statewide.
 (5) State mandate not implemented--hospital association collects membership data voluntarily.
 (6) Collect quarterly a representative sample of discharges for a set of DRGs.

Appendix D



The Hilltop Institute

analysis to advance the health of vulnerable populations

Hospital Community Benefit Program

Community Benefit State Law Profiles Comparison

State Community Benefit Requirements and Tax Exemptions for Nonprofit Hospitals

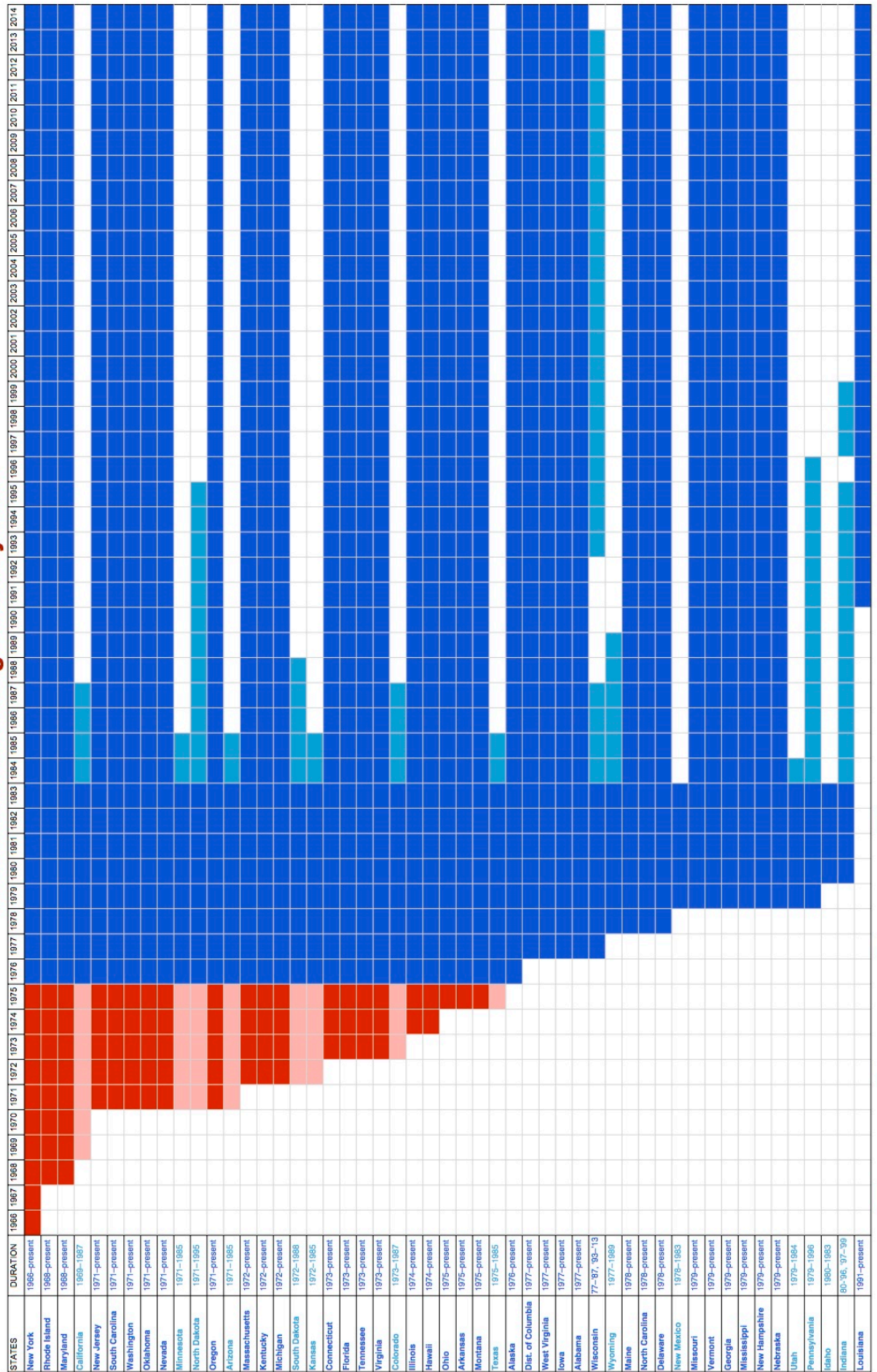
Select All States		To see which states have a particular requirement, click on a symbol in the top (yellow) row. For detailed information about the requirement of a particular state, click on the symbol in the field at the intersection of the state's row and the requirement's column. For example, to read about Alabama's financial assistance policy dissemination requirement, click on the square in the field at the intersection of the Alabama row and the Financial Assistance Policy Dissemination column to open a new browser window showing the relevant text in the Alabama profile.										<input type="checkbox"/> State tax exemption <input checked="" type="checkbox"/> No state tax exemption Blank = State does not impose this tax	
Compare	State	Community Benefit Requirement	Mandatory Minimum Community Benefit Requirement	Community Benefit Reporting Requirement	Community Health Needs Assessment	Community Benefits Plan/Implementation Strategy	Financial Assistance Policy	Financial Assistance Policy Dissemination	Limitations on Charges, Billing, and Collections	Income Tax Exemption	Property Tax Exemption	Sales Tax Exemption	
	Select:	<input type="radio"/> <input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input checked="" type="checkbox"/>	
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<input type="checkbox"/>	Florida	<input checked="" type="radio"/>								<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Georgia			<input checked="" type="checkbox"/>						<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Hawaii									<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Idaho			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
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<input type="checkbox"/>	Virginia	<input type="radio"/>		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Washington	<input checked="" type="radio"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
<input type="checkbox"/>	West Virginia	<input type="radio"/>		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Wisconsin			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Wyoming									<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

Appendix E

OHCA RESOURCE ALIGNMENT CHART																	
-> Staff (supervisor) -> V- Function -V	Alla (Kaila R.)	Aminur (Kim M.)	Brian (Kaila R.)	Carmen (Karen R.)	Gloria (Karen R.)	Jack (Karen R.)	Kaila R. (Kim M.)	Karen R. (Kim M.)	Kevin (Kim M.)	Kim (DC Davis)	Laurie (Kaila R.)	Olga (Kaila R.)	Paolo (Kaila R.)	Ron (Karen R.)	Srini (Kim M.)	Steve (Kaila R.)	Tillman (Karen R.)
Requests from Kim (primarily, but could be others) for research, pulling info, creating replies, attending meetings, etc.							15%	11%									
Duties related to supervision of staff, HR matters, approve timesheets, hold staff and one-on-one meetings							10%	9%									
CON Process questions & general facilitation	Trains to be secondary 10%						Secondary in Steve's absence 10%								IT Support primary		PRIMARY (for liaison purposes)
CON Apps - Basic Terminations							2%						PRIMARY (60%)		IT Support primary		
CON Apps - Imaging	PRIMARY 30%						18%					Secondary 10%			IT Support primary		
CON Apps - Mergers & Affiliation (not 486)			PRIMARY 10%				5%	4%						Financial Analysis as assigned (10%)	IT Support primary		PRIMARY (15%)
486 process				Financial Analysis as assigned 10%			2%							Financial Analysis as assigned (10%)	IT Support primary		PRIMARY (for liaison purposes w/ consultants & AGs) (20%)
CON Apps - Behavioral Health	As needed by Laurie 10%						14%				PRIMARY 60%		As needed by Laurie (10%)		IT Support primary		
CON Apps - Transfers of Ownership	As needed for Imaging To CONs 10%						4%	1%						PRIMARY (10%)	IT Support primary		
CON Apps - Cardiac			PRIMARY 10%				2%					Secondary 5%			IT Support primary		
CON Apps - Other major (i.e., increases in beds)			PRIMARY 10%	10%			3%					As needed during 2014 10%			IT Support primary		
CON Compliance						PRIMARY 36% as of 1/1/2014		11%					Continues through 12/31 st (closes)		IT Support primary		
CON Determinations									PRIMARY 40%						IT Support primary		
OHCA Initiated Inquiries							Primary through 3/1/2014 10%		PRIMARY as of 4/1/2014						IT Support primary		
CON Modification									PRIMARY 10%						IT Support primary		
Plan Bed Need, Unmet Need Primary Care and Inpatient Services			PRIMARY 10%				10%						PRIMARY 10%		IT Support primary		
Mapping					Secondary 5%						PRIMARY (10%)				IT Support primary		
Inventory					Secondary 15%			PRIMARY 13%			Assist (<1%)				IT Support primary		
FOI Coordination						Transitions to Jack as PRIMARY see next line									IT Support primary		Primary until streamlining project with Srini is
CON and Financial FOI's					Secondary (for	PRIMARY 36%									IT Support primary		
Data FOI's					PRIMARY 15%										IT Support primary		
Medical Foundations						PRIMARY 3%		0.5%							IT Support primary		
OHCA Funding				PRIMARY as of Mid-January 2014 15%				6%							IT Support primary		Secondary after Mid-January 2014 (20%)
Outpatient Data Work Group												PRIMARY 10%			IT Support primary		
Inpatient Discharge								LEAD 18%					LEAD (also data QC) 20%		IT Support primary		
Non-FOI Data Reports and Requests	Assist (after SPSS training) 10%	Assists										Assist (30%)	PRIMARY 15%		IT Support primary		
Regulations							1%	3%	PRIMARY (with Tillman)				5%		IT Support primary	Assist Kevin with CON	PRIMARY (with Kevin)
Public Use Files					PRIMARY 15%		1%					Secondary 5%			IT Support primary		
Pricemasters					Secondary 10%			6%							IT Support primary		PRIMARY (25%)
Consumer Assistance				PRIMARY 5%	Assist 10%	Assist 10%		2%							IT Support primary		
Specialty Hospitals							PRIMARY 15% (as of December)	0.5%							IT Support primary		Secondary to Jack as of December (5%)
Website															IT Support primary		
Community Health Needs Assessments			PRIMARY 10%									5%			IT Support primary		
HRS	Assigned 30%			Assigned 60% (and train as backup to Ron in HRS process and system)	Assigned 20%								Assigned (20%)	PRIMARY (50%)	IT Support primary		Assigned (30%)
Financial Stability Report			Back up to Ron after training 1%				1%	5%							IT Support primary		

Appendix F

Duration of CON Regulation by State



Legend: ■ Voluntarily-continued ■ Voluntarily-terminated ■ Mandatory-continued ■ Mandatory-terminated

(from 1966 to 1975, 30 states voluntarily started CON before it was a nationally mandated by P.L. 93-641; of those, 6 terminated CON after the end of these mandates; 5 of the remaining 20 mandatory CON programs also terminated after mandates ended)

updated: February 27, 2014

Appendix G

List of CON Assessment Interviewees

First Visit (November 18-22, 2013)

Department of Public Health Executive Office

Commissioner Jewel Mullen
Deputy Commissioner Lisa Davis
Bill Gerrish, Director, Office of Communications
Elizabeth Keyes, Executive Asst to Commissioner
Jill Kentfield, Legislative Liaison

Office of Health Care Access Staff

Kimberly R. Martone, Director of Operations
Barbara K. Olejarz, Administrative Assistant
Leslie M. Greer, Office Assistant

Kaila J. Riggott, Planning Specialist
(CON and HRS Data Supervisor)
Olga Armah, Associate Research Analyst
Laurie K. Greci, Associate Research Analyst
Brian A. Carney, Associate Research Analyst
Steven W. Lazarus, Associate Health Care Analyst
Jack A. Huber, Health Care Analyst
Alla M. Veyberman, Health Care Analyst

Karen E. Roberts, Principal Health Care Analyst
(Financial Data Supervisor)
Ronald A. Ciesones, Associate Health Care Analyst
Tillman Foster, Associate Health Care Analyst
Paolo Fiducia, Associate Health Care Analyst
Gloria P. Sancho, Associate Health Care Analyst
Carmen G. Cotto, Associate Health Care Analyst

Aminur Rahman, IT Analyst 3
Srinivasa Chalikonda, IT Analyst 3

DPH Legal Services

Marianne Horn, Director of Public Hearing Office
Kevin T. Hansted, Staff Attorney 2

DPH Licensing Section

Sandra Bauer, Behavioral Health
Rose McClellan, Hospital & Surgery Center Licensure

Attorney General's Office

Henry A. Salton, Assistant Attorney General
Rosemary M. McGovern, Assistant Attorney General

Second Visit (December 17-18, 2013)

Governor's Office

Luke Bronin, General Counsel

Office of Policy and Management

Anne Foley, Undersecretary for Policy
Development and Planning
Joan Soulsby, Budget and Fin. Mgmt. Division

Department of Public Health

Deputy Commissioner Lisa Davis

Office of Health Care Access Staff

Kimberly R. Martone, Director of Operations
Kaila J. Riggott and CON Team
Karen E. Roberts and Financial Data Team

DPH Legal Services

Kevin T. Hansted, Staff Attorney 2

Telephone Interviews

(Dec. 26, 2013 - Jan. 28, 2014)

Radiological Society of Connecticut

Alan Kaye, MD, Chairman, Legislative Committee

Connecticut Hospital Association

James Iacobellis, Senior Vice President,
Government and Regulatory Affairs

Connecticut State Medical Society

Ken Ferrucci, Senior Vice President of Gov't Affairs
Matthew Katz, Executive Vice President and CEO
Steven B. Levine, M.D., ENT & Allergy Assoc LLC
Michael M. Krinsky, M.D., Neurologist

Connecticut Ambulatory Association of Surgical Centers

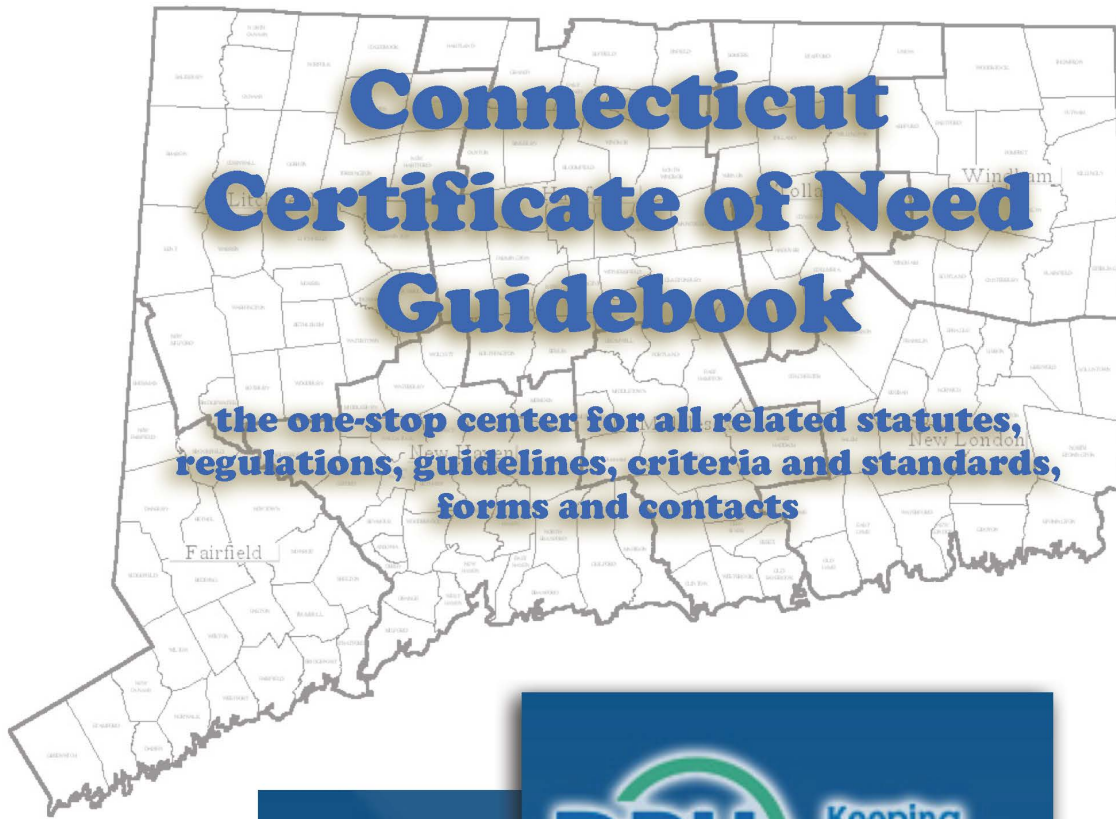
Lisa Winkler, Executive Director

Appendix H (attached as a separate document)



Connecticut Certificate of Need Guidebook

**the one-stop center for all related statutes,
regulations, guidelines, criteria and standards,
forms and contacts**





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MacQuest Consulting, LLC

1003 Boonville Road, Jefferson City, MO 65109
macquest@mac.com 573.230.5450 www.macquest.com