

IMPORTANT

All Office of Health Strategy (OHS) Certificate Of Need (CON)-related documents (Determinations, Applications, Completeness Letter Responses and Modifications) **must be filed electronically** through OHS's single point of access, its CON Web Portal.

First time Portal users must register prior to submitting any documents. To register, click here: [Certificate of Need Web Portal](#)

To access the portal, click on the link above or and click <https://portal.ct.gov/OHS> on the "Certificate of Need Program" link and then click on the "https://dphconwebportal.ct.gov" link.

OHS may, at its discretion, utilize data from Hospital Reporting System (HRS) and the Connecticut All Payer Claims Database (APCD) to supplement the administrative record and the hearing record associated with an application. OHS may also reference and cite HRS and APCD data in its agreed settlements and final decisions.

For any questions, please email HSP@ct.gov or call (860) 418-7001.

CON Application - Main Form
Required for all CON applications

Contents:

- OHS Waiver
- Checklist
- List of Supplemental Forms
- Proposal Information
- Affidavit
- Executive Summary
- Project Description
- Public Need and Access to Health Care
- Financial Information
- Utilization

OHS Waiver

Please be advised that the Office of Health Strategy (OHS) is in the process of revising its regulations (19a-639a-3(b)) to enable it to accept new CON filings **via OHS's website**.

While proceeding through this legal process, **OHS waives the requirement for applicant(s) to file paper copies pursuant to Sec. 149 of Public Act No, 21-2 (June Special Session)**. All new CON applications filed electronically with OHS should be submitted via OHS's website ([Certificate of Need Web Portal](#)) and include the following:

1. A scanned copy of each submission in its entirety*, including all attachments, properly executed and notarized where necessary, in Adobe (.pdf) format.
2. An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

***All application components (e.g., Main Form, Supplemental Form, Financial Worksheet and Exhibits) should be compiled and paginated.**

Note: Should anyone not have the ability to file electronically, the present paper submission process may still be used.

If you have any questions regarding a CON filing with OHS, please contact us by email at HSP@ct.gov or call us directly at (860) 418-7001.

Checklist

Instructions: Review each item below and check box when completed. [**Checklist *must* be submitted as the first page of the CON application.**]

- A completed CON Main Form, including an affidavit for each applicant, signed and notarized by the appropriate individuals. CON forms can be found at [OHS Forms](#).
- A completed Supplemental Form specific to the proposal type (see next page to determine which Supplemental Form to include in the application).
- ***NEW Pursuant to Public Act 22-118, Sec. 225, the attached fee schedule shall apply to all CON applications filed on or after July 18, 2022. Until OHS's payment processing system is adjusted, Applicants should file with a \$500 fee and will be sent an invoice for the remaining amount as determined by the agency.

A filing fee using Master Card or Visa submitted electronically via OHS's website (Certificate of Need Web Portal) in the amount of **\$500.00**.

- Attached is evidence demonstrating that public notice has been published for 3 consecutive days in a newspaper that covers the location of the proposal. Use the following link to help determine the appropriate publication: [Connecticut newspapers](#). **The application must be submitted no sooner than 20 days, but no later than 90 days from the last day of the newspaper notice.**

The following information **must** be included in the public notice:

- A statement that the applicant is applying for a certificate of need pursuant to section § 19a-638 of the Connecticut General Statutes;
- A description of the scope and nature of the project;
- The street address where the project is to be located; and
- The total capital expenditure for the project.

(Please email (HSP@ct.gov) a courtesy copy of the newspaper order confirmation to OHS at the time of publication.)

- A completed Financial Worksheet specific to the application type.
- All confidential or personally identifiable information (e.g., Social Security number) has been redacted.
- All material should be submitted via OHS's website ([OHS Web Portal](#)) and include:
 1. A scanned Adobe-PDF copy of each submission in its entirety*, including all attachments in Adobe (.pdf) format.
 2. An electronic copy of the applicant's responses in MS Word (the application) and MS Excel (the Financial Worksheet).

***All application components (e.g., Main Form, Supplemental Form, Financial Worksheet and Exhibits) should be compiled and paginated.**

Note: OHS hereby waives requirement to file any paper copies.

Supplemental Forms

In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** listed below. Check the box of the **Supplemental Form** to be submitted with the application, below. If unsure which form to select, please call the OHS main number (860-418-7001) for assistance. All CON forms can be found on OHS's website at [CON Forms and Submission](#).

Check form included	Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
<input type="checkbox"/>	(1)	Establishment of a new health care facility (mental health and/or substance abuse) - see note below*
<input type="checkbox"/>	(2)	Transfer of ownership of a health care facility (excludes transfer of ownership/sale of hospital – see “Other” below)
<input type="checkbox"/>	(3)	Transfer of ownership of a group practice
<input type="checkbox"/>	(4)	Establishment of a freestanding emergency department
<input type="checkbox"/>	(5) (7) (8) (15)	Termination of a service: <ul style="list-style-type: none"> - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - inpatient or outpatient services offered by a hospital or other facility, or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended
<input type="checkbox"/>	(6)	Establishment of an outpatient surgical facility
<input type="checkbox"/>	(9)	Establishment of cardiac services
<input type="checkbox"/>	(10) (11)	Acquisition of equipment: <ul style="list-style-type: none"> - acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners - acquisition of nonhospital based linear accelerators
<input type="checkbox"/>	(12)	Increase in licensed bed capacity of a health care facility
<input type="checkbox"/>	(13)	Acquisition of equipment utilizing [new] technology that has not previously been used in the state
<input type="checkbox"/>	(14)	Increase of two or more operating rooms within any three-year period by an outpatient surgical facility or short-term acute care general hospital
<input type="checkbox"/>	Other	Transfer of Ownership / Sale of Hospital

*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other “health care facilities,” as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

**If termination is due to insufficient patient volume or a subspecialty is being terminated, a CON is not required.

Proposal Information

Select the appropriate proposal type from the dropdown below. If unsure which item to select, please call the OHS main number (860-418-7001) for assistance.

Proposal Type (select from dropdown)	Choose an item.
Brief Description	
Proposal Address	
Capital Expenditure	\$ Click here to enter text.
<p>Is this Application the result of a Determination indicating a CON application must be filed?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, Docket Number: Click here to enter text.</p>	

Applicant(s) Information

	Applicant One	Applicant Two (if applicable)
Applicant's Full Legal Name* & Address:		
Applicant Tax Status: (check one box)	<input type="checkbox"/> For Profit <input type="checkbox"/> Not-for-Profit	<input type="checkbox"/> For Profit <input type="checkbox"/> Not-for-Profit
Parent Corporation Full Legal Name & Address: (if applicable)		
New Company: (if applicable)		
Contact Person: (one contact person per applicant)		
Name:		
Title:		
Address:		
Email:		
Phone number:		

**For more than two applicants, attach a separate sheet providing the following information: applicant's full legal name, address, tax status and, if applicable, the parent company's name and address.*

Affidavit

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in Sections 19a-630, 19a-637, 19a-638, 19a-639 of the Connecticut General Statutes, and that all facts contained in the submitted Certificate of Need application are true and correct to the best of my knowledge.

Signature Date

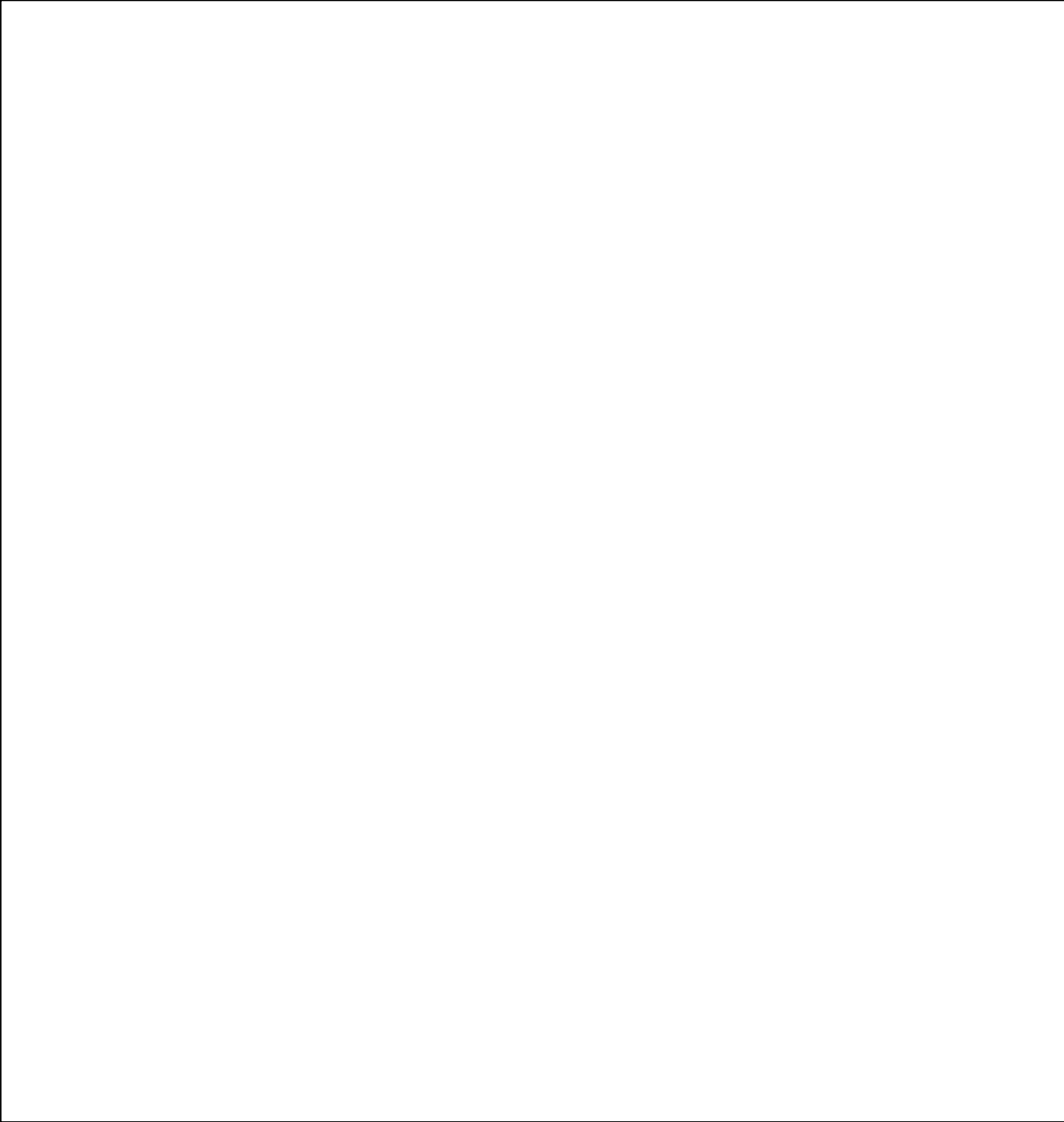
Subscribed and sworn to before me on _____

Notary Public/Commissioner of Superior Court

My commission expires: _____

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow. [Please click here to reference the 2020 CON Guidebook while completing the application.](#)



Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Strategy is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a “§” indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. Provide a detailed narrative describing the proposal. Explain how the applicant(s) determined the necessity for the proposal and discuss the benefits to the public and for each applicant, separately. Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline, anticipated start date, and why the proposal is needed in the community.
2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between applicant(s)? What have the applicant(s) accomplished so far?).
3. Provide the following information:
 - a. utilizing **OHS Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

**OHS TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS**

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination

- b. utilizing **OHS Table 2**, identify the service area towns (i.e., use **ONLY** [official town names](#)) and explain the reason for their inclusion (e.g., market share).

Please note: use of village or area names instead of an official town name (Connecticut has 169 official towns) will not be accepted and will require revision/resubmission of the table.

**OHS TABLE 2
SERVICE AREA TOWNS**

Official Town Name	Reason for Inclusion

4. List all health care facility license(s) that the applicant current holds. If the license is inactive or is “not in good standing,” please explain why and provide a recent corrective action plan. List all health care facility licenses that will be needed to implement the proposal (i.e., include licenses required by the Department of Public Health, Department of Children and Families, etc.).

[Click here to lookup a license.](#)

[Click here for DPH Facility Licensing and Investigation Section \(FLIS\) website and contact information.](#)

[Click here to view SAMHSA data.](#)

5. Submit the following information as attachments to the application:
 - a. a copy of all Connecticut Department of Public Health, Department of Children and Families license(s) currently held by the applicant(s);
 - b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;
 - c. copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the articles;
 - d. the “state, federal, national or industry-approved” protocols or Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of all relevant sections and describe how the applicant proposes to meet the protocols or guidelines; and
 - e. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

Public Need and Access to Care

§ “Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Office of Health Strategy;” Conn.Gen.Stat. § 19a-639(a)(1).

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Office of Health Strategy (OHS).

§ “The relationship of the proposed project to the statewide health care facilities and services plan;” Conn.Gen.Stat. § 19a-639(a)(2).

7. Describe how the proposed project aligns with the OHS Health Systems Planning’s Statewide Health Care Facilities and Services Plan, available at [HSP Publications Library](#).

§ “Whether there is a clear public need for the health care facility or services proposed by the applicant;” Conn.Gen.Stat. § 19a-639(a)(3).

8. With respect to the proposal, provide evidence and documentation that demonstrate clear public need. Include citations to referenced articles, peer-reviewed literature or other documentation that supports the application:
 - a. identify the target patient population to be served;
 - b. discuss if and how the target patient population is currently being served;
 - c. document the need for the equipment and/or service in the community;
 - d. explain why the location of the facility or service was chosen;
 - e. provide incidence, prevalence or other demographic data that demonstrates community need;
 - f. discuss how low-income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;
 - g. list any changes to the clinical services offered by the applicant(s) and explain why the change was necessary;
 - h. explain how access to care will be affected; and
 - i. discuss any alternative proposals that were considered.

§ “Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons;” Conn.Gen.Stat. § 19a-639(a)(5).

9. Describe and provide specific details on how the proposal will improve the following (i.e., include citations to referenced articles, peer-reviewed literature or other documentation that supports the application):
 - a. the quality of health care in the region (see OHS Table 12);
 - b. accessibility of health care in the region; and
 - c. the cost effectiveness of health care delivery in the region.
 - d. health equity in the region
10. What specific steps will the applicant(s) take to ensure that future health care services provided will adhere to the National Standards on culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area? (More details can be found at [National CLAS Standards](#)).
11. Describe how you are promoting health equity at your facility and/or in your programs.
12. Describe how your facility and/or programs will positively impact your community with special attention to the demographic data response in 8a (target patient population).
13. Connecticut has identified several health priorities in the state (i.e., addressing chronic conditions, access to substance use disorder treatment, childhood obesity, behavioral health treatment, lead screenings/prevention, addressing low birthweight racial gap, and emergency room use). [Please click here to be taken to the Quality Council 2022 Core Measure Set](#). Identify if the proposal addresses any of the core measures outlined as health priorities for the state. If so, describe which core measure is addressed.
14. Are you recognized as a Patient Centered Medical Home (“PCMH”)? If not, are you working toward PCMH recognition?
15. Describe how your organization has tried to positively impact primary care in Connecticut. For example, explain your participation in primary care delivery models that incentivize value via alternative payment. If this application is for a mental health or substance use facility, explain any participation in models that integrate behavioral health care into primary care. If this application relates to specialty care, explain how your proposal will integrate and coordinate with primary care.
16. Please provide a breakdown of the racial/ethnic composition for the service area and for the applicant’s patient population.

17. Provide specific details describing how this proposal will help improve the coordination of patient care.
18. Describe how this proposal will improve access to care for Medicaid recipients and indigent persons and, in addition, answer the following:
 - a. Are you a current Medicaid provider?
 - b. How will you assure that you will abide by the [Medicaid Access standards?](#)
19. Provide a copy of the applicant's charity care policy and sliding fee scale applicable to the proposal.
20. If charity care policies will be changed as a result of the proposal, list all changes and describe how the new policies will affect patients.
21. Provide a detailed explanation of how this proposal will improve cost effectiveness of health care delivery in the region. Be sure to provide any supporting evidence.

§ "Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;" Conn.Gen.Stat. § 19a-639(a)(10).

22. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

§ "Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care." Conn.Gen.Stat. § 19a-639(a)(12).

23. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees and changes to health plan reimbursement for services.

Explain how this proposal will not adversely affect health care costs for patients in the service area. Provide supporting documentation.

24. Utilizing **OHS Table 3 and 4**, include both historical and projected cost data for self-pay patients and commercially insured patients as two separate tables.

Note: If the COVID-19 pandemic affected the ability to report on FY2020 historical cost, please provide FY2019 cost data.

**OHS TABLE 3
AVERAGE COST^[1] OF _____ PER SELF-PAY PATIENT**

Historical	Projected			
FY 2020	FY 2021	FY 2022	FY 2023	FY 2024

[1] Cost is defined as the total dollar amount paid by the insurer plus patient out-of-pocket costs (e.g., deductibles, co-pays)
*Partial Year

**OHS TABLE 4
AVERAGE COST^[1] OF _____ PER COMMERCIALY INSURED PATIENT**

Historical	Projected			
FY 2020	FY 2021	FY 2022	FY 2023	FY 2024

[1] Cost is defined as the total dollar amount paid by the insurer plus patient out-of-pocket costs (e.g., deductibles, co-pays)
*Partial Year

25. Explain whether this proposal will affect patient premiums or out of pocket costs for the commercially insured? If yes, please explain how. [Click here for information on the CMS price transparency rule.](#)
26. Explain whether this proposal will affect costs to the uninsured.
27. Will the proposal result in increased costs to any State of Connecticut program (e.g., Medicaid, State employee plan)?
28. Are you currently participating in any accountable care organization (ACO) arrangements or value-based payment arrangements? If yes, please describe in detail and describe whether and how the proposal will be incorporated into such arrangements.

Financial Information

§ “Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;” Conn. Gen. Stat. § 19a-639(a)(4).

29. Provide the applicant’s fiscal year: start date (mm/dd) and end date (mm/dd).
30. Describe how this proposal will help ensure the stability of the state’s health care system or demonstrate that the proposal is financially feasible for the applicant(s).
31. Provide a detailed explanation for all capital expenditure/costs associated with the proposal and list the dollar amount in **OHS Table 5**.

**OHS TABLE 5
TOTAL PROPOSAL CAPITAL EXPENDITURE**

Category	Cost
Equipment (specify the type)	
Land/Building	
Construction/Renovation	
Other (specify)	
Total Capital Expenditure	

32. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as: interest rate; term; letter of interest or approval from a lending institution.
33. Please provide a thorough and detailed explanation of how the project’s proposed capital expenditure was calculated. In so doing, please identify any assumptions as well as any other information that is relevant to OHS’ analysis of whether the proposed capital expenditure provided is reasonable. The agency reserves the right to request additional information and adjust the application fee – either upwards or downwards – based upon its assessment of the justification provided. If the applicant refuses to pay an application fee that is adjusted upwards, its application may automatically be deemed rejected.
34. Include as an attachment:
 - a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, statement of cash flow, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current; and
 - b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available at [OHS Forms](#), providing a summary of revenue, expense, and volume statistics, “without the CON project,” “incremental to the CON project,” and “with the CON project.” **Note: the actual results reported in the Financial Worksheet must match the audited financial statements previously submitted or referenced. In**

addition, please make sure that the fiscal years reported on the Financial Worksheet are the same fiscal years reported for the utilization and payer mix tables (OHS Tables 8 and 9).

35. Fully identify the basis for the projections and explain all calculations reported in the Financial Worksheet. In providing these detailed assumptions, please include the following:

- a. Identify general assumptions for projected amounts that are estimated to be the same, both with or without this proposed project (i.e., project-neutral increases or decreases that occur between years). Explain significant variances (+/- 25% variances) that occur between years for the project neutral changes;
- b. Identify specific assumptions for all projected amounts that are estimated to change as a result of implementation of the proposed project (i.e., project-specific increases or decreases). Address projected changes in revenue, payer mix, expense categories and FTEs. In addition, connect any service, volume (utilization) or payer mix change described elsewhere in the CON application narrative or tables with these financial assumptions; and
- c. If the applicant does not project any specific increases or decreases with the project in the Financial Worksheet, explain why.

36. Describe any projected incremental losses from operations resulting from the implementation of the CON proposal. If losses will result, provide an estimate of the timeframe needed to achieve incremental operational gains.

37. Describe how your proposal will aid in controlling the cost of healthcare (to patients and to the overall healthcare system). Please support your answer with historical cost data and comparisons (i.e., cost to patient and impact on cost to the CT healthcare system).

Note: All applications will have some sort of impact whether that includes additional fees, higher copays, fewer required visits, etc.

38. Complete the table below (i.e., provide all information appropriate for your facility or service) with data from the most recently completed three fiscal years. Please use the formulas in the table below.

**OHS TABLE 6
HISTORICAL FINANCIAL INDICATORS AND MISCELLANEOUS DATA**

	Comments	Formula	FY 20__	FY20__	FY20__
A. Operating Performance					
Operating Margin	The total of net patient revenue from reimbursement of patient services by government and non-government payers plus other operating revenue.	Gains / (Loss) from Operations / Revenue from Operations			
B. Liquidity					

Days Cash on Hand	The average number of days of cash available to pay for expenses that is maintained in cash accounts. A higher number is favorable, since it indicates a greater ability to meet outstanding obligations.	$\text{Cash} + \text{Short Term Investments} / (\text{Total Expenses less depreciation}) / 365$			
C. Leverage and Capital Structure					
Long-term Debt to Capitalization	The measure of the proportion of Long-Term Debt in a capital structure. A lower proportion or percentage is desirable because it allows for obtaining of more favorable terms (i.e., lower interest rates) when borrowing.	$\text{LTD} / (\text{LTD} + \text{Net Assets})$			
D. Additional Statistics					
Income from Operations	The difference between total operating revenue and total operating expenses that results in a financial gain or loss from operating activities.	Total Operating Revenue less Total Operating Expenses			
Available bed occupancy	A measure of the volume and utilization of inpatient hospital services.	$(\text{Patient Days} \times 100) / (\text{Available beds} \times 365)$			
Annual operating revenue growth rate	The difference between total operating revenue in the current year compared with total operating revenue in the prior year.	$(\text{Current year amount less prior year amount}) / \text{prior year amount.}$ <i>(Amount added to source file.)</i>			
Annual expense growth rate	The difference between total operating expenses in the current year compared with total operating expense in the prior year.	$(\text{Current year amount less prior year amount}) / \text{prior year amount.}$			
Community Benefit amount (total by fiscal year) – IRS 990	Services and activities provided by nonprofit hospitals that address and impact the health related needs of the community the hospital serves.	Amount provided by the hospital in their annual IRS 990 submission. (Financial Assist and other Comm Benefits - Schedule H - Part I, Line 7, Col E, line K total) & (Comm. Bldg activities - Schedule H, Part II, Col E, line 10 total)			
Charity Care expenses/recipients	The difference between the hospital's published charges and the amount of reimbursement received for services provided to patients from whom reimbursement was not expected.	No formula. Amounts for expenses and recipients are provided by the hospital.			

30 day readmission penalties & rates	Under the Centers for Medicare and Medicaid Services (CMS) Hospital Readmission Reduction Program, CMS assesses penalties on and reduces Medicare payments to hospitals with excess 30 day readmissions of Medicare patients to improve healthcare by linking payments to quality of care.	Hospital Readmission Penalty Trends (MCR Worksheet E, Part A, Line 70.94)			
E. Capacity and Utilization					
Average Daily Census	The average number of patients per day in a hospital over a given period of time.	Total patient days / 365			
Case Mix Index	The average relative Diagnostic Related Group (DRG) weight of a hospital's inpatient discharges. The CMI reflects the diversity, clinical complexity, and resource needs of all the patients in the hospital.	[Sum (DRG weight x # of discharges)] / total discharges FY 2020 Final Rule and Correction Notice Tables CMS			

Utilization

§ “The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;”
Conn. Gen. Stat. § 19a-639(a)(6).

39. Complete **OHS Table 7** and **OHS Table 8** for the past three fiscal years (“FY”), current fiscal year (“CFY”) and first three projected FYs of the proposal for each of the applicant’s existing and/or proposed services. In completing these tables, please adhere to the following:

- a) Identify each service type and add lines as necessary. Provide the number of visits or discharges as appropriate for each service type and **label** what the **volumes represent** (e.g., visits) and the **fiscal year** reflected in the table.
- b) For CFY periods 6 months or greater, report annualized volume, identify the months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the months covered.
- c) For OHS Table 8, if the first year of the proposal is only a partial year, provide the partial year utilization and indicate the months included in a footnote. In addition, provide projections for the first three complete FYs.

Note: Please make sure that the fiscal years reported on OHS Table 8 match the fiscal years reported in the Financial Worksheet and payer mix (OHS Table 9) projections.

**OHS TABLE 7
HISTORICAL UTILIZATION BY SERVICE**

Service	Actual Volume [indicate type] (Last 3 Completed FYs)			CFY Volume*
	FY ____	FY ____	FY ____	FY ____
Total				

*Months include _____

**OHS TABLE 8
PROJECTED UTILIZATION BY SERVICE**

Service	Projected Volume [indicate type]			
	Partial FY ____*	FY ____	FY ____	FY ____
Total				

*Months include _____

40. Provide a detailed explanation and justification of all assumptions used in the derivation/calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHS Tables 7 and 8.

41. Provide the current and projected patient population mix **by individual service location(s)** for the proposal using **OHS Table 9**, provide the number and percentage of patients by payer, all assumptions and label what the volume represents (e.g., discharges).

Note: payer mix should be calculated from patient volumes, not patient revenues. Also, current year should be the most recently completed fiscal year. Projected years should match OHS Table 8 and the Financial Worksheet.

**OHS TABLE 9
APPLICANT'S CURRENT & PROJECTED PAYER MIX [indicate location]**

Payer	Most Recently Completed		Projected					
	FY ____		FY ____		FY ____		FY ____	
	Volume: (indicate type)	%	Volume: (indicate type)	%	Volume: (indicate type)	%	Volume: (indicate type)	%
Medicare								
Medicaid								
TRICARE								
Total Government								
Commercial Insurers: In-Network								
Commercial Insurers: Out-of-Network								
Uninsured								
Self-pay								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;"
Conn.Gen.Stat. § 19a-639(a)(7).

42. Describe the population (as identified in question 8(a)) by gender, race/ethnicity, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence, or other demographic data) that demonstrates a need for the proposed service or proposal. **Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health and Connecticut State Data Center) in a format consistent with the standards established in compliance with C.G.S. Sec. 19a-754d.**

43. Using **OHS Table 10**, provide a breakdown of utilization by town (i.e., use **ONLY official town names**) for the **most recently completed fiscal year**. Indicate the fiscal year and the type of volume being reported: number of persons, visits, scans or other appropriate unit. Provide the source of data.

**OHS TABLE 10
UTILIZATION BY TOWN**
FY _____

Official Connecticut Town	Volume: (indicate type)

§ "The utilization of existing health care facilities and health care services in the service area of the applicant;" Conn.Gen.Stat. § 19a-639(a)(8).

44. Using **OHS Table 11**, identify all existing providers in the service area and, as available, list the services provided, population served, days/hours of operation and current utilization. Include providers in the towns served or proposed to be served by the applicant, as well as providers in towns contiguous to the service area.

**OHS TABLE 11
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS**

Facility's Provider Name, Street Address and Town	Program or Service	Population Served	Days/Hours of Operation	Current Utilization

45. Will this proposal shift volume away from existing providers in the area? If not, explain in detail why the proposal will have no impact on existing provider volumes. Please justify the utilization figured provided.
46. Describe what effect the proposal will have on existing physician referral patterns in the service area.
47. Describe how this proposal will affect the overall health care system/market concentration. Include how the proposal will impact other providers, referral patterns, regional impact, rates, and any other applicable factors.
48. Will the proposal result in additional providers added to your staff? If yes, provide the number, location, provider types, and justification to be added.

49. If applicable, describe how the proposal will help advance the applicant's ability to participate in alternative payment arrangements for healthcare delivery and reimbursement (e.g., shared savings arrangements).
50. Considering the proposed transaction as a whole, describe any potential constraints or limitations that will impact the applicant's ability to participate in the Connecticut Health Information Alliance d/b/a Connie. [Health Information Alliance \(ct.gov\)](http://HealthInformationAlliance.ct.gov)

§ "Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;" Conn.Gen.Stat. § 19a-639(a)(9).

51. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

§ "Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;" Conn.Gen.Stat. § 19a-639(a)(11).

52. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

**OHS TABLE 12
HOSPITAL QUALITY INDICATORS**

Purpose of Quality Indicators	Quality Indicator (Measure)	FY2021	FY2020	FY2019	Comment
Inpatient Quality Indicators (IQIs) provide a perspective on quality of care inside hospitals and identify areas that might need further study	IQI 90 Mortality for Selected Procedures* <i>(Esophageal or pancreatic resection, abdominal aortic aneurysm, PCI, carotid endarterectomy to reduce stroke)</i>				
	IQI 91 Mortality for Selected Conditions* <i>(Heart failure, acute stroke, gastro hemorrhage, hip fracture & pneumonia)</i>				
The Patient Safety Indicators (PSIs) provide information on potentially avoidable safety events that represent opportunities for improvement in the delivery of care. More specifically, they focus on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth. The measure also helps to identify issues that might need further study.	PSI 90 Patient Safety for Selected Indicators* <i>(Pressure ulcer, iatrogenic pneumonia, fall with hip fracture, peri-operative hemorrhage/hematoma, postop acute kidney injury, respiratory failure, embolism/DVT, sepsis, wound dehiscence, abdominal-pelvic accidental puncture or laceration)</i>				
The Pediatric Quality Indicators (PDIs) focus on potentially preventable complications and iatrogenic events for pediatric patients treated in hospitals and on preventable hospitalizations among pediatric patients, taking into account the special characteristics of the pediatric population. They can help hospitals identify problems in pediatric hospital care that may need further study and evaluate preventive care for children in outpatient settings.	PDI 90 Pediatric Quality Overall Composite* <i>(Asthma, diabetes short-term complications, gastroenteritis, UTI)</i>				
	PDI 91 Pediatric Quality Acute Composite <i>(Gastroenteritis, UTI)</i>				
	PDI 92 Pediatric Quality Chronic Composite <i>(Asthma, diabetes)</i>				

<p>The Prevention Quality Indicators (PQIs) identify issues of access to outpatient care, including appropriate follow-up care after hospital discharge. More specifically, the PQIs use data from hospital discharges to identify admissions that might have been avoided through access to high-quality outpatient care. The PQIs are population-based indicators that capture all cases of the potentially preventable complications that occur in a given population (in a community or region) either during a hospitalization or in a subsequent hospitalization. The PQIs are a key tool for community health needs assessments.</p>	<p>PQI 90 Prevention Quality Overall Composite* <i>(Diabetes - short- and long-term complications, uncontrolled, lower extremity amputation, COPD/adult asthma, hypertension, heart failure, community-acquired pneumonia, UTI, younger adult asthma)</i></p>				
	<p>PQI 91 Prevention Quality Acute Composite <i>(Community-acquired pneumonia, UTI)</i></p>				
	<p>PQI 92 Prevention Quality Chronic Composite <i>(Diabetes - short- and long-term complications, uncontrolled, lower extremity amputation, COPD/adult asthma, hypertension, heart failure, UTI, younger adult asthma)</i></p>				
	<p>PQI 93 Prevention Quality Diabetes Composite <i>(Diabetes - short- and long-term complications, uncontrolled, lower extremity amputation)</i></p>				
<p>Hospital-wide readmissions of patients to the same hospital within 30 days of discharge.</p>	<p>30-day All-cause readmissions**</p>				

Source: Applying the Agency for Healthcare Research and Quality (AHRQ) Quality indicator tool available at <https://www.qualityindicators.ahrq.gov/Modules/Default.aspx> to inpatient data <https://www.qualityindicators.ahrq.gov/Modules/Default.aspx>

*Measures the overall quality performance in the focus area

**HEDIS [https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/#:~:text=Plan%20All%2DCause%20Readmissions%20\(PCR\)&text=Assesses%20the%20rate%20of%20adult.and%20older\)%20health%20plan%20members.](https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/#:~:text=Plan%20All%2DCause%20Readmissions%20(PCR)&text=Assesses%20the%20rate%20of%20adult.and%20older)%20health%20plan%20members.)

CON Application Fee Schedule

Pursuant to Public Act 22-118, Sec. 225, the following fee schedule shall apply to all CON applications filed on or after July 18, 2022. Until OHS's payment processing system is adjusted, Applicants should file with a \$500 fee and will be sent an invoice for the remaining amount as determined by the agency.

<u>Fee</u>	<u>Cost</u>
\$1,000	<\$50,000
\$2,000	\$50,000< cost <\$100,000
\$3,000	\$100,000< cost <\$500,000
\$4,000	\$500,000< cost <\$1,000,000
\$5,000	\$1,000,000< cost <\$5,000,000
\$8,000	\$5,000,000< cost <\$10,000,000
\$10,000	\$10,000,000< cost