Certificate of Need Task Force

Final Report

January 17, 2023

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Task Force Charge

PA 22-118 (§ 124) established a 16-member task force to study and make recommendations on certificates of need (CONs). The law requires the task force to study and make recommendations on the following 10 matters:

1. instituting a price increase cap tied to the cost growth benchmark for consolidations;
2. guaranteed local community representation on hospital boards;
3. changes to the Office of Health Strategy's (OHS's) long-term, statewide health plan to include an analysis of services and facilities and their impact on equity and underserved populations;
4. setting standards to measure quality due to a consolidation;
5. enacting higher penalties for noncompliance and increasing the staff needed for enforcement;
6. the attorney general's authority to stop activities as the result of a CON application or complaint;
7. the ability of workforce and community representatives to intervene or appeal decisions;
8. authorizing OHS to require an ongoing investment to address community needs;
9. capturing lost property taxes from hospitals that have converted to nonprofit entities; and
10. the timeliness of decisions or approvals relating to the CON process and relief available through that process.

The task force must report its findings and recommendations to the Insurance and Real Estate Committee by January 15, 2023. The task force terminates when it submits the report or on January 15, 2023, whichever is later.

Statement on Nonpartisanship

This report was produced by nonpartisan analysts from the Office of Legislative Research (OLR), on behalf of, and exclusively with information provided by, Task Force members. The contents of this report solely reflect the findings of the Task Force, and not those of OLR.

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Introduction

Broadly, existing law requires health care facilities to apply for and receive a certificate of need (CON) from the Office of Health Strategy's (OHS) Health Systems Planning Unit when proposing to: (1) establish a new facility or provide new services, (2) change ownership, (3) purchase or acquire certain equipment, or (4) terminate certain services (CGS § 19a-638 et seq.).

PA 22-118 (§ 124) establishes the CON Task Force to study and make recommendations on 10 discrete aspects of the CON process:

1. instituting a price increase cap tied to the cost growth benchmark for consolidations;
2. guaranteed local community representation on hospital boards;
3. changes to OHS's long-term, statewide health plan to include an analysis of services and facilities and their impact on equity and underserved populations;
4. setting standards to measure quality due to a consolidation;
5. enacting higher penalties for noncompliance and increasing the staff needed for enforcement;
6. the attorney general's authority to stop activities as the result of a CON application or complaint;
7. the ability of workforce and community representatives to intervene or appeal decisions;
8. authorizing OHS to require an ongoing investment to address community needs;
9. capturing lost property taxes from hospitals that have converted to nonprofit entities; and
10. the timeliness of decisions or approvals relating to the CON process and relief available through that process.

To accomplish its mission, the Task Force designated five working groups to examine the issues more closely. Three of those working groups delivered findings and recommendations to the Task Force.

The full Task Force and the individual working groups gathered information, heard testimony by experts and interested parties, and deliberated possible recommendations. A complete list of meetings, presentations, plus related documents submitted to the Task Force is available on the Task Force's website.

Executive Summary

The Task Force established five working groups, designated Working Group A through E, to focus on specific criteria impacting the CON process. Three of the five working groups (A, C, and D) submitted summary material, including findings and, in some cases, recommendations. Working groups B and E did not submit summary material to the Task Force.

Working Group A was created to investigate items 1 and 4 of the full Task Force charge: instituting a price increase cap tied to cost growth benchmarks and setting standards to measure quality resulting from consolidations. Working Group A was comprised of Jean Ahn, Patrick Charmel, Dr. Thomas Farquhar, and Dan Keenan. The Working Group found the broad application of price caps problematic and declined to recommend any specific action relating to them. The Working Group supports expanding the CON process to allow OHS to consider quality of services, provided the review is grounded in best practices.

Working Group B was assigned item 9, "capturing lost property taxes from hospitals that have converted to nonprofit entities." It did not submit recommendations to the Task Force.

Working Group C was formed to examine items 5 through 7 of the Task Force's charge, and comprised John Brady, Brenda Buchbinder, Nancy Heaton, Dan Keenan, and Rosemary McGovern. Specifically, for Item 5 ("enacting higher penalties for noncompliance and increasing the staff needed for enforcement"), the Working Group suggests expanded fines (and OHS authority to enforce them), as well as clarity regarding fine amounts and lengths. It also recommends the legislature explore a policy model similar to Massachusetts' "essential services" model. For Item 6, ("the attorney general's authority to stop activities as the result of a CON application or complaint"), the group provided the Task Force with specific statutory language that it recommends the legislature adopt in order to provide the attorney general with broader authority. For Item 7 ("the ability of workforce and community representatives to intervene or appeal decisions"), the Working Group believes the current process is working well.

Working Group D was assigned to research items 2, 3, and 8. It was comprised of Jean Ahn, John Brady, Patrick Charmel, Nancy Heaton, and Suzanne Lagarde. For Item 2 ("guaranteed local community representation on hospital boards"), the Working Group did not reach consensus. For Item 3 ("changes to the OHS long-term, statewide health plan to include an analysis of services and facilities and their impact on equity and underserved populations"), the group made several recommendations related to the statewide healthcare facilities and services plan. For Item 8

("authorizing OHS to require an ongoing investment to address community needs"), the Working Group recommends strengthening and expanding OHS authority related to community needs.

Working Group E was asked to study the benefits and consequences of removing the CON process entirely. It did not submit recommendations or findings to the Task Force.

Working Group Findings

Working Group A

Item 1: Instituting A Price Increase Cap Tied To The Cost Growth Benchmark For Consolidations

Working Group A expressed concern with a broad application of price caps tied to the cost growth benchmarks. Specifically, the working group states that it "is not appropriate to use cost-growth benchmark targets as a limiting factor for all transactions…" Broadly, the group supports the use of the benchmark as a tool to help manage statewide healthcare spending and improve quality and access to care.

Recommendation or Finding: The working group declined to make further recommendations.

Item 4: Setting Standards To Measure Quality Due To A Consolidation

Working Group A supports expanding the CON process to allow OHS to consider service quality. However, any consideration must be based on generally accepted, nationally recognized clinical best practices and guidelines. The group also expressed concern that OHS lacks "the capacity and bandwidth" to independently develop new standards and reassess quality of care on an ongoing basis, but did not specifically recommend increasing OHS resources. Additionally, if quality measures are used, the working group suggests that baselines should be established, and assessments and improvements should be measured in respect to the baseline. Finally, the group discussed ensuring that all providers be subject to the same quality rules.

Recommendation or Finding: The working group supports expanding the CON process to allow OHS to consider service quality, based on generally accepted, nationally recognized clinical best practices and guidelines. Quality measures should be measured against a healthcare entities baseline quality.

The working group further recommends that all providers should be subject to the same rules.

Working Group C

Item 5: Enacting Higher Penalties For Noncompliance And Increasing The Staff Needed For Enforcement

The group reached consensus that fines were a factor in determining and enforcing compliance, but the group did not reach a consensus as to how. The group raised substantive questions about how additional penalties would work, including whether fines would be suspended during subsequent CON requests. Also, the group notes that OHS does not have adequate staff to enforce additional penalties.

The working group found the Massachusetts policy model of separating the “Closure of Essential Services” from other CON requests a helpful comparison, and suggested exploring what parts of this policy might be useful in Connecticut. The Massachusetts model designates essential service closures to be reviewed by a separate department with capacity and expertise to focus on the proposed closure’s state impact. The group suggested the Connecticut legislature explore what might constitute an “essential service” and study where those services might be streamlined.

The group also considered the need for more standardized definitions, including for “essential services,” “transfer of ownership,” and several other terms.

Recommendation or Finding: The working group recommends establishing more clarity on what triggers a fine, when the fine begins, and under what conditions it ends.

The group further recommends that any assessed fine should continue to accrue after the fined entity has filed a CON application through the final decision by OHS. However, the working group recognized the uncertainty of the regulatory process and the fine’s potential impact. One member raised significant concern with this recommendation.

The group also recommends that a healthcare entity terminating its services without OHS approval bear the responsibility and costs for returning those services, if OHS determines they should have been continued. One member raised concerns about an approach that penalizes healthcare entities, rather than one that focuses on community health collaboration.

The group recommends closing a current loophole in which a healthcare entity can repeatedly “suspend” a service for 180 days (with brief periods of service in between) in order to delay or avoid a termination (which requires a CON process). One member raised concern that this might

encourage healthcare entities to file a CON to terminate services rather than collaborate with OHS to ensure community needs are met.

The group recommends the legislature explore the Massachusetts policy model related to closing "essential services."

The group recommends OHS receive additional resources to carry out its enforcement and compliance activities.

Item 6: The Attorney General's Authority To Stop Activities As The Result Of A CON Application Or Complaint

The group found that there is currently no specific role for the attorney general in the CON process, unless it involves a conversion to a for-profit institution. The group also raised specific questions, including what happens if a termination of services significantly impacts racial and ethnic health disparities.

Recommendation or Finding: The group recommends the legislature remove "willfully" from the legal standard needed to be shown in order to impose a civil penalty in CGS § 19a-653. These changes were proposed by the attorney general when debating HB 5449 (2022). One member raised a concern that this will create additional confusion for healthcare providers.

The group further recommends the legislature enable OHS to issue (and the attorney general to enforce) cease and desist orders to stop a CON violation. The group has provided suggested legislative language to the Task Force.

Item 7: The Ability Of Workforce And Community Representatives To Intervene Or Appeal Decisions

The working group studied the broad authority under CGS §§ 4-117a & 4-177c of hearing officers to grant intervenor status and the level of intervenor participation (e.g., whether an intervenor has the right to cross examination the applicant). The group reached a consensus that the existing process works well.

Recommendation or Finding: The working group found that the existing process works well.

Working Group D

Item 2: Guaranteed Local Community Representation On Hospital Boards

The working group determined that there were a variety of hospital governing structures (e.g., individual or regional boards), but that it was important for members to represent the local population and be organized in a welcoming manner. The group determined that community boards do not have authority over strategic hospital decisions, and it would benefit task force members to better understand the governance structure and how hospitals use local insight or expertise to inform their strategic decisions.

The group posed several questions about whether local community or regional hospital boards can be directly responsible for a Community Needs Assessment and local implementation. Some members noted the importance of local hospital boards representing the diversity of the local population and the need to have local insight on boards to ensure the hospital better serves the community. Members also felt it was important to expand this representation to larger hospital system boards. Members debated whether boards should be required to have a minimum number of community members.

Other members thought it was important that boards have the necessary experience, skills, and expertise to manage a shifting healthcare landscape. For example, board members with expertise in strategic planning, healthcare delivery trends, and health care innovation may better serve community health needs.

The group reached consensus that individual hospital boards that are part of a larger healthcare network should have the ability to inform the larger network about strategic planning initiatives impacting the local board's community.

Finally, some members felt that individual and regional hospital boards should play a significant role in the required (every three years) Community Needs Assessment process and for monitoring the progress of its subsequent implementation plan.

Recommendation or Finding: The working group did not reach a consensus regarding the value of local representation on local hospital boards or on the larger system boards.

Item 3: Changes To OHS's Long-Term, Statewide Health Plan To Include An Analysis Of Services And Facilities And Their Impact On Equity And Underserved Populations

The working group found that OHS has contracted with an outside firm to write a new statewide healthcare facilities and services plan that includes an analysis on equity and underserved populations. The group wants to learn more about the methodology and expected deliverables, as well as how OHS intends to use or incorporate the plan into existing policy.

The working group asked several substantive discussion questions about where applicants should locate proposed facilities while balancing the need to remain financially viable, and what role the state has in ensuring services are sustainable. The group also discussed whether the plan analysis should consider: (1) minimal volume thresholds based on national benchmarks; (2) a realistic focus on long-term sustainability; and (3) an inventory of state and community resources to help address diversity, equity, and inclusion-related needs.

The group also envisions moving towards an "atlas" that maps disease prevalence and mortality data, area population, sociodemographic factors, and medical manpower (i.e., primary care and specialist physicians per population). This database should be more current than the Health Professions Shortage Area designations, and incorporate behavioral healthcare behavioral healthcare service providers and FQHC, hospital, ambulatory service facilities, diagnostic, and freestanding healthcare facility locations.

Recommendations or Finding: The group recommends that OHS Statewide Healthcare Facility Utilization Study and Statewide Healthcare Facilities Services Plan be expanded to identify disparities in health status and healthcare outcomes resulting from the distribution and availability of healthcare resources.

The group further recommends that the scope of the Statewide Healthcare Facilities and Services Plan include as much data as possible to create an "atlas" to proactively identify where additional health care facilities may be needed to address community health needs, particularly in underserved communities.

The group also recommends developing a statewide database of community-health focused grant opportunities to facilitate departments taking a broad range of approaches to address community needs, including relating to the social determinants of health.

Item 8: Authorizing OHS To Require An Ongoing Investment To Address Community Needs

The working group reached consensus that additional work needs to be done to improve community benefit programs. This includes work on transparency, guidelines, and program definitions. However, the group did not reach consensus on any specifics (such as financial amounts). The group reported that hospitals believe it would be difficult to accurately capture the value of community work or meet specific spending targets. Community advocates, in contrast, told the group that transparency and fixed spending guidelines would be beneficial. The group received information on community benefit spending from OHS and awaits additional information. The group raised questions on: (1) standardizing definitions (e.g., what counts as a community benefit), (2) how to calculate the community benefit for various projects (such as investments), and (3) whether community benefit spending targets should vary by hospital.

Recommendation or Finding: The working group recommends strengthening OHS oversight authority regarding community health needs assessments. OHS should be able to ensure that these assessments are tied to hospital implementation plans, including transparency to ensure that resources spent on implementation are connected to a hospital's community benefit report.

The group further recommends that OHS's authority be expanded to include healthcare provider organizations, excluding those that primarily serve Medicaid and underserved patient populations, beyond just hospitals.

Recommendations and Findings by Task Force Charge

1. Instituting A Price Increase Cap Tied To The Cost Growth Benchmark For Consolidations

Working Group A expressed concern with this concept, and declined to make further recommendations.

2. Guaranteed Local Community Representation On Hospital Boards

Working Group D did not reach a consensus regarding the value of local representation on local hospital boards or on the larger system boards.

3. Changes To OHS's Long-Term, Statewide Health Plan To Include An Analysis Of Services And Facilities And Their Impact On Equity And Underserved Populations

Working Group D recommends that the OHS Statewide Healthcare Facility Utilization Study and Statewide Healthcare Facilities Services Plan be expanded to identify disparities in health status and healthcare outcomes resulting from the distribution and availability of healthcare resources.

The group further recommends that the scope of the Statewide Healthcare Facilities and Services Plan include as much data as possible to create an "atlas" to proactively identify where additional health care facilities may be needed to address community health needs, particularly in underserved communities.

The group also recommends developing a statewide database of community-health focused grant opportunities to facilitate departments taking a broad range of approaches to address community needs, including relating to the social determinants of health.

4. Setting Standards To Measure Quality Due To A Consolidation

Working Group A supports expanding the CON process to allow OHS to consider service quality, based on generally accepted, nationally recognized clinical best practices and guidelines. Quality measures should be measured against a healthcare entities baseline quality.

The working group further recommends that all providers should be subject to the same rules.

5. Enacting Higher Penalties For Noncompliance And Increasing The Staff Needed For Enforcement

Working Group C recommends establishing more clarity on what triggers a fine, when the fine begins, and under what conditions it ends.

The group further recommends that any assessed fine should continue to accrue after the fined entity has filed a CON application through the final decision by OHS. However, the working group recognized the uncertainty of the regulatory process and the fine's potential impact. One member raised significant concern with this recommendation.

The group recommends that a healthcare entity terminating its services without OHS approval bear the responsibility and costs for returning those services, if OHS determines they should have been continued. One member raised concerns about an approach that penalizes healthcare entities, rather than one that focuses on community health collaboration.

The group recommends closing a current loophole in which a healthcare entity can repeatedly "suspend" a service for 180 days (with brief periods of service in between) in order to delay or avoid a termination (which requires a CON process). One member raised concern that this might encourage healthcare entities to file a CON to terminate services rather than collaborate with OHS to ensure community needs are met.

The group recommends the legislature explore the Massachusetts policy model related to closing "essential services."

The group recommends OHS receive additional resources to carry out its enforcement and compliance activities.

6. The Attorney General's Authority To Stop Activities As The Result Of A CON Application Or Complaint

Working Group C recommends the legislature remove "willfully" from the legal standard needed to be shown in order to impose a civil penalty in CGS § 19a-653. These changes were proposed by the attorney general when debating HB 5449 (2022). One member raised a concern that this will create additional confusion for healthcare providers.

The group further recommends the legislature enable OHS to issue (and the attorney general to enforce) cease and desist orders to stop a CON violation. The group has provided suggested legislative language to the Task Force.

7. The Ability Of Workforce And Community Representatives To Intervene Or Appeal Decisions

Working Group C believes the current process works well.

8. Authorizing OHS To Require An Ongoing Investment To Address Community Needs

Working group D recommends strengthening OHS oversight authority regarding community health needs assessments. OHS should be able to ensure that these assessments are tied to hospital implementation plans, including transparency to ensure that resources spent on implementation are connected to a hospital's community benefit report.

The group further recommends that OHS's authority be expanded to include healthcare provider organizations, excluding those that primarily serve Medicaid and underserved patient populations, beyond just hospitals.

9. Capturing Lost Property Taxes From Hospitals That Have Converted To Nonprofit Entities

There are no findings or recommendations related to this charge.

10. The Timeliness Of Decisions Or Approvals Relating To The Con Process And Relief Available Through That Process.

There are no findings or recommendations related to this charge.