House of Representatives

General Assembly

File No. 327

February Session, 2024

House Bill No. 5316

House of Representatives, April 8, 2024

The Committee on Public Health reported through REP. MCCARTHY VAHEY of the 133rd Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT CONCERNING THE OFFICE OF HEALTH STRATEGY'S RECOMMENDATIONS REGARDING THE CERTIFICATE OF NEED PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (9) of section 19a-630 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(9) "Large group practice" means eight or more full-time equivalent physicians, legally organized in (A) a partnership, (B) a professional corporation, (C) a limited liability company formed to render professional services, (D) a medical foundation, (E) a not-for-profit corporation, (F) a faculty practice plan, (G) a group owned or controlled by a public company or an entity, as defined in section 33-602, (H) an entity, as defined in section 33-602, in which both the payer and provider share the financial risk of managed care or the provider entity serves as both a payer and provider, including, but not limited to, (i) a payer that offers health care, (ii) a provider that offers health care

insurance, and (iii) joint ventures between payers and providers, or **[**other**]** (I) a similar entity **[**(A)**]** (i) in which each physician who is a member of the group, including any physician working under a professional service agreement, provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; **[**(B)**]** (ii) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or **[**(C)**]** (iii) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians.

Sec. 2. Subdivision (10) of subsection (a) of section 19a-486i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(10) "Group practice" means two or more physicians, legally organized in (A) a partnership, (B) a professional corporation, (C) a limited liability company formed to render professional services, (D) a medical foundation, (E) a not-for-profit corporation, (F) a faculty practice plan, (G) a group owned or controlled by a public company or an entity, as defined in section 33-602, (H) an entity, as defined in section 33-602, in which both the payer and provider share the financial risk of managed care or the provider entity serves as both a payer and provider, including, but not limited to, (i) a payer that offers health care, (ii) a provider that offers health care insurance, and (iii) joint ventures between payers and providers, or **[**other**]** (I) a similar entity **[**(A)**]** (i) in which each physician who is a member of the group, including any

physician working under a professional service agreement, provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; **[**(B)**]** (ii) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or **[**(C)**]** (iii) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians; and

Sec. 3. Subsection (h) of section 19a-486i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(h) Not later than January 15, **[**2018**]** 2025, and annually thereafter, each group practice comprised of **[**thirty**]** eight or more physicians, including any physician working under a professional service agreement, that is not the subject of a report filed under subsection (g) of this section shall file with the Attorney General and the executive director of the Office of Health Strategy a written report concerning the group practice. Such report shall include, for each such group practice: (1) The names and specialties of each physician practicing medicine with the group practice; (2) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (3) a description of the services provided at each such location; and (4) the primary service area served by each such location.

Sec. 4. Section 19a-638 of the 2024 supplement to the general statutes

is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) A certificate of need issued by the unit shall be required for:

(1) The establishment of a new health care facility;

(2) A transfer of ownership of a health care facility;

(3) A transfer of ownership of a large group practice to any **[**entity other than a (A) physician, or (B) group of two or more physicians, legally organized in a partnership, professional corporation or limited liability company formed to render professional services and not employed by or an affiliate of any hospital, medical foundation, insurance company or other similar entity**]** person;

(4) The establishment of a freestanding emergency department;

(5) The termination of inpatient or outpatient services offered by a hospital, including, but not limited to, the termination by a short-term acute care general hospital or children's hospital of inpatient and outpatient mental health and substance abuse services;

(6) The establishment of an outpatient surgical facility, as defined in section 19a-493b, or as established by a short-term acute care general hospital;

(7) The termination of surgical services by an outpatient surgical facility, as defined in section 19a-493b, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care general hospital, provided termination of outpatient surgical services due to (A) insufficient patient volume, or (B) the termination of any subspecialty surgical service, shall not require certificate of need approval;

(8) The termination of an emergency department by a short-term acute care general hospital;

(9) The establishment of cardiac services, including inpatient and

outpatient cardiac catheterization, interventional cardiology and cardiovascular surgery;

(10) The acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners, by any person, physician, provider, short-term acute care general hospital or children's hospital, except (A) as provided for in subdivision (22) of subsection (b) of this section, and (B) a certificate of need issued by the unit shall not be required where such scanner is a replacement for a scanner that was previously acquired through certificate of need approval or a certificate of need determination, including a replacement scanner that has dual modalities or functionalities if the applicant already offers similar imaging services for each of the scanner's modalities or functionalities that will be utilized;

(11) The acquisition of a proton radiotherapy machine or nonhospital based linear **[**accelerators**]** accelerator, except a certificate of need issued by the unit shall not be required where such machine or accelerator is a replacement for **[**an**]** a machine or accelerator that was previously acquired through certificate of need approval or a certificate of need determination;

(12) An increase in the licensed bed capacity of a health care facility, except as provided in subdivision (23) of subsection (b) of this section;

(13) The acquisition of equipment utilizing technology that has not previously been utilized in the state;

(14) An increase of two or more operating rooms within any three-year period, commencing on and after October 1, 2010, by an outpatient surgical facility, as defined in section 19a-493b, or by a short-term acute care general hospital; and

(15) The termination of inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII

or XIX of the federal Social Security Act, 42 USC 301, as amended.

(b) A certificate of need shall not be required for:

(1) Health care facilities owned and operated by the federal government;

(2) The establishment of offices by a licensed private practitioner, whether for individual or group practice, except when a certificate of need is required in accordance with the requirements of section 19a-493b or subdivision (3), (10) or (11) of subsection (a) of this section;

(3) A health care facility operated by a religious group that exclusively relies upon spiritual means through prayer for healing;

(4) Residential care homes, as defined in subsection (c) of section 19a-490, and nursing homes and rest homes, as defined in subsection (o) of section 19a-490;

(5) An assisted living services agency, as defined in section 19a-490;

(6) Home health agencies, as defined in section 19a-490;

(7) Hospice services, as described in section 19a-122b;

(8) Outpatient rehabilitation facilities;

(9) Outpatient chronic dialysis services;

(10) Transplant services;

(11) Free clinics, as defined in section 19a-630, as amended by this act;

(12) School-based health centers and expanded school health sites, as such terms are defined in section 19a-6r, community health centers, as defined in section 19a-490a, not-for-profit outpatient clinics licensed in accordance with the provisions of chapter 368v and federally qualified health centers;

(13) A program licensed or funded by the Department of Children

and Families, provided such program is not a psychiatric residential treatment facility;

(14) Any nonprofit facility, institution or provider that has a contract with, or is certified or licensed to provide a service for, a state agency or department for a service that would otherwise require a certificate of need. The provisions of this subdivision shall not apply to a short-term acute care general hospital or children's hospital, or 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;

(15) A health care facility operated by a nonprofit educational institution exclusively for students, faculty and staff of such institution and their dependents;

(16) An outpatient clinic or program operated exclusively by or contracted to be operated exclusively by a municipality, municipal agency, municipal board of education or a health district, as described in section 19a-241;

(17) A residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities;

(18) Replacement of existing computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners, positron emission tomography-computed tomography scanners, or nonhospital based linear accelerators, if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the unit of the date on which the equipment is replaced and the disposition of the replaced equipment, including if a replacement scanner has dual modalities or functionalities and the applicant already offers similar imaging services for each of the equipment's modalities or functionalities that will be utilized;

(19) Acquisition of cone-beam dental imaging equipment that is to be used exclusively by a dentist licensed pursuant to chapter 379;

(20) The partial or total elimination of services provided by an outpatient surgical facility, as defined in section 19a-493b, except as provided in subdivision (6) of subsection (a) of this section and section 19a-639e;

(21) The termination of services for which the Department of Public Health has requested the facility to relinquish its license;

(22) Acquisition of any equipment by any person that is to be used exclusively for scientific research that is not conducted on humans;

(23) On or before June 30, 2026, an increase in the licensed bed capacity of a mental health facility, provided (A) the mental health facility demonstrates to the unit, in a form and manner prescribed by the unit, that it accepts reimbursement for any covered benefit provided to a covered individual under: (i) An individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469; (ii) a self-insured employee welfare benefit plan established pursuant to the federal Employee Retirement Income Security Act of 1974, as amended from time to time; or (iii) HUSKY Health, as defined in section 17b-290, and (B) if the mental health facility does not accept or stops accepting reimbursement for any covered benefit provided to a covered individual under a policy, plan or program described in clause (i), (ii) or (iii) of subparagraph (A) of this subdivision, a certificate of need for such increase in the licensed bed capacity shall be required; **[**.**]**

(24) The establishment at harm reduction centers through the pilot program established pursuant to section 17a-673c; or

(25) On or before June 30, 2028, a birth center, as defined in section 19a-490, that is enrolled as a provider in the Connecticut medical assistance program, as defined in section 17b-245g.

(c) (1) Any person, health care facility or institution that is unsure

whether a certificate of need is required under this section, or (2) any health care facility that proposes to relocate pursuant to section 19a-639c, shall send a letter to the unit that describes the project and requests that the unit make a determination as to whether a certificate of need is required. In the case of a relocation of a health care facility, the letter shall include information described in section 19a-639c. A person, health care facility or institution making such request shall provide the unit with any information the unit requests as part of its determination process. The unit shall provide a determination within thirty days of receipt of such request.

(d) The executive director of the Office of Health Strategy may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the executive director holds a public hearing prior to implementing the policies and procedures and posts notice of intent to adopt regulations on the office's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

(e) On or before June 30, 2026, a mental health facility seeking to increase licensed bed capacity without applying for a certificate of need, as permitted pursuant to subdivision (23) of subsection (b) of this section, shall notify the Office of Health Strategy, in a form and manner prescribed by the executive director of said office, regarding (1) such facility's intent to increase licensed bed capacity, (2) the address of such facility, and (3) a description of all services that are being or will be provided at such facility.

(f) Notwithstanding the provisions of this section and sections 19a-639, as amended by this act, and 19a-639a, on or before December 31, 2025, the unit shall automatically issue a certificate of need to any large group practice for a transfer of ownership, as defined in subparagraph (C) of subdivision (16) of section 19a-630, to any physician or group of two or more physicians, legally organized as a partnership, professional

corporation or limited liability company formed to render professional services and not employed by or an affiliate of any hospital, medical foundation, insurance company or other similar entity, upon such large group practice's submission of a certificate of need request for determination to the unit.

[(f)**]** (g) Not later than January 1, 2025, the executive director of the Office of Health Strategy shall report to the Governor and, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning the executive director's recommendations, if any, regarding the establishment of an expedited certificate of need process for mental health facilities.

Sec. 5. Section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, as amended by this act, the unit shall take into consideration and make written findings concerning each of the following guidelines and principles:

(1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Office of Health Strategy;

(2) The relationship of the proposed project to the state-wide health care facilities and services plan;

(3) Whether there is a clear public need for the health care facility or services proposed by the applicant;

(4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;

(5) Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of

health care delivery in the region, including, but not limited to, the provision of or [any change in] the access to services for Medicaid recipients and indigent persons;

(6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;

(7) Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;

(8) The utilization of existing health care facilities and health care services in the service area of the applicant;

(9) Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;

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

(11) Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region; and

(12) Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care.

[(b) In deliberations as described in subsection (a) of this section, there shall be a presumption in favor of approving the certificate of need application for a transfer of ownership of a large group practice, as described in subdivision (3) of subsection (a) of section 19a-638, when

an offer was made in response to a request for proposal or similar voluntary offer for sale.**]**

[(c)**]** (b) The unit, as it deems necessary, may revise or supplement the guidelines and principles, set forth in subsection (a) of this section, through regulation.

[(d)**]** (c) (1) For purposes of this subsection and subsection **[**(e)**]** (d) of this section:

(A) "Affected community" means a municipality where a hospital is physically located or a municipality whose inhabitants are regularly served by a hospital;

(B) "Hospital" has the same meaning as provided in section 19a-490;

(C) "New hospital" means a hospital as it exists after the approval of an agreement pursuant to section 19a-486b, as amended by this act, or a certificate of need application for a transfer of ownership of a hospital;

(D) "Purchaser" means a person who is acquiring, or has acquired, any assets of a hospital through a transfer of ownership of a hospital;

(E) "Transacting party" means a purchaser and any person who is a party to a proposed agreement for transfer of ownership of a hospital;

(F) "Transfer" means to sell, transfer, lease, exchange, option, convey, give or otherwise dispose of or transfer control over, including, but not limited to, transfer by way of merger or joint venture not in the ordinary course of business; and

(G) "Transfer of ownership of a hospital" means a transfer that impacts or changes the governance or controlling body of a hospital, including, but not limited to, all affiliations, mergers or any sale or transfer of net assets of a hospital and for which a certificate of need application or a certificate of need determination letter is filed on or after December 1, 2015.

(2) In any deliberations involving a certificate of need application

filed pursuant to section 19a-638, as amended by this act, that involves the transfer of ownership of a hospital, the unit shall, in addition to the guidelines and principles set forth in subsection (a) of this section and those prescribed through regulation pursuant to subsection **[**(c)**]** (b) of this section, take into consideration and make written findings concerning each of the following guidelines and principles:

(A) Whether the applicant fairly considered alternative proposals or offers in light of the purpose of maintaining health care provider diversity and consumer choice in the health care market and access to affordable quality health care for the affected community; and

(B) Whether the plan submitted pursuant to section 19a-639a demonstrates, in a manner consistent with this chapter, how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services.

(3) The unit shall deny any certificate of need application involving a transfer of ownership of a hospital unless the executive director finds that the affected community will be assured of continued access to high quality and affordable health care after accounting for any proposed change impacting hospital staffing.

(4) The unit may deny any certificate of need application involving a transfer of ownership of a hospital subject to a cost and market impact review pursuant to section 19a-639f, as amended by this act, if the executive director finds that (A) the affected community will not be assured of continued access to high quality and affordable health care after accounting for any consolidation in the hospital and health care market that may lessen health care provider diversity, consumer choice and access to care, and (B) any likely increases in the prices for health care services or total health care spending in the state may negatively impact the affordability of care.

(5) The unit may place any conditions on the approval of a certificate

of need application involving a transfer of ownership of a hospital consistent with the provisions of this chapter. Before placing any such conditions, the unit shall weigh the value of such conditions in promoting the purposes of this chapter against the individual and cumulative burden of such conditions on the transacting parties and the new hospital. For each condition imposed, the unit shall include a concise statement of the legal and factual basis for such condition and the provision or provisions of this chapter that it is intended to promote. Each condition shall be reasonably tailored in time and scope. The transacting parties or the new hospital shall have the right to make a request to the unit for an amendment to, or relief from, any condition based on changed circumstances, hardship or for other good cause.

[(e)**]** (d) (1) If the certificate of need application (A) involves the transfer of ownership of a hospital, (B) the purchaser is a hospital, as defined in section 19a-490, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars or a hospital system, as defined in section 19a-486i, as amended by this act, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars, or any person that is organized or operated for profit, and (C) such application is approved, the unit shall hire an independent consultant to serve as a post-transfer compliance reporter for a period of three years after completion of the transfer of ownership of the hospital. Such reporter shall, at a minimum: (i) Meet with representatives of the purchaser, the new hospital and members of the affected community served by the new hospital not less than quarterly; and (ii) report to the unit not less than quarterly concerning (I) efforts the purchaser and representatives of the new hospital have taken to comply with any conditions the unit placed on the approval of the certificate of need application and plans for future compliance, and (II) community benefits and uncompensated care provided by the new hospital. The purchaser shall give the reporter access to its records and facilities for the purposes of carrying out the reporter's duties. The purchaser shall hold a public hearing in the municipality in which the new hospital is

located not less than annually during the reporting period to provide for public review and comment on the reporter's reports and findings.

(2) If the reporter finds that the purchaser has breached a condition of the approval of the certificate of need application, the unit may, in consultation with the purchaser, the reporter and any other interested parties it deems appropriate, implement a performance improvement plan designed to remedy the conditions identified by the reporter and continue the reporting period for up to one year following a determination by the unit that such conditions have been resolved.

(3) The purchaser shall provide funds, in an amount determined by the unit not to exceed two hundred thousand dollars annually, for the hiring of the post-transfer compliance reporter.

[(f)**]** (e) Nothing in subsection **[**(d)**]** (c) or **[**(e)**]** (d) of this section shall apply to a transfer of ownership of a hospital in which either a certificate of need application is filed on or before December 1, 2015, or where a certificate of need determination letter is filed on or before December 1, 2015.

Sec. 6. Subsection (b) of section 19a-486b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(b) The executive director and the Attorney General may place any conditions on the approval of an application that relate to the purposes of sections 19a-486a to 19a-486h, inclusive. In placing any such conditions the executive director shall follow the guidelines and criteria described in subdivision (4) of subsection **[**(d)**]** (c) of section 19a-639, as amended by this act. Any such conditions may be in addition to any conditions placed by the executive director pursuant to subdivision (4) of subsection **[**(d)**]** (c) of section 19a-639, as amended by this act.

Sec. 7. Subsection (d) of section 19a-639f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(d) The cost and market impact review conducted pursuant to this section shall examine factors relating to the businesses and relative market positions of the transacting parties as defined in subsection **[**(d)**]** (c) of section 19a-639, as amended by this act, and may include, but need not be limited to: (1) The transacting parties' size and market share within its primary service area, by major service category and within its dispersed service areas; (2) the transacting parties' prices for services, including the transacting parties' relative prices compared to other health care providers for the same services in the same market; (3) the transacting parties' health status adjusted total medical expense, including the transacting parties' health status adjusted total medical expense compared to that of similar health care providers; (4) the quality of the services provided by the transacting parties, including patient experience; (5) the transacting parties' cost and cost trends in comparison to total health care expenditures state wide; (6) the availability and accessibility of services similar to those provided by each transacting party, or proposed to be provided as a result of the transfer of ownership of a hospital within each transacting party's primary service areas and dispersed service areas; (7) the impact of the proposed transfer of ownership of the hospital on competing options for the delivery of health care services within each transacting party's primary service area and dispersed service area including the impact on existing service providers; (8) the methods used by the transacting parties to attract patient volume and to recruit or acquire health care professionals or facilities; (9) the role of each transacting party in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within each transacting party's primary service area and dispersed service area; (10) the role of each transacting party in providing low margin or negative margin services within each transacting party's primary service area and dispersed service area; (11) consumer concerns, including, but not limited to, complaints or other allegations that a transacting party has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (12) any other factors that the unit determines to be in the public interest.

Sec. 8. Subsection (j) of section 19a-639f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(j) The unit shall retain an independent consultant with expertise on the economic analysis of the health care market and health care costs and prices to conduct each cost and market impact review, as described in this section. The unit shall submit bills for such services to the purchaser, as defined in subsection **[**(d)**]** (c) of section 19a-639, as amended by this act. Such purchaser shall pay such bills not later than thirty days after receipt. Such bills shall not exceed two hundred thousand dollars per application. The provisions of chapter 57, sections 4-212 to 4-219, inclusive, and section 4e-19 shall not apply to any agreement executed pursuant to this subsection.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-630(9)
Sec. 2	*October 1, 2024*	19a-486i(a)(10)
Sec. 3	*October 1, 2024*	19a-486i(h)
Sec. 4	*October 1, 2024*	19a-638
Sec. 5	*October 1, 2024*	19a-639
Sec. 6	*October 1, 2024*	19a-486b(b)
Sec. 7	*October 1, 2024*	19a-639f(d)
Sec. 8	*October 1, 2024*	19a-639f(j)

PH *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill modifies Certificate of Need (CON) program requirements for physician group practices, requires CON approval for proton radiotherapy machine purposes, and makes technical changes. There is no fiscal impact to OHS as any additional workload is expected to be handled by existing staff.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

HB 5316

AN ACT CONCERNING THE OFFICE OF HEALTH STRATEGY'S RECOMMENDATIONS REGARDING THE CERTIFICATE OF NEED PROGRAM.

SUMMARY

By law, the Office of Health Strategy's (OHS) Health Systems Planning Unit (HSPU) administers the state's Certificate of Need (CON) program for health care entities. Under this program, health care entities must generally receive CON approval when establishing new facilities or services, changing ownership, acquiring certain equipment, or terminating certain services.

This bill modifies CON program requirements for physician group practices by doing the following:

1. expanding the statutory definitions of "large group practice" and "group practice" to (a) include, among other things, those owned or controlled by public companies or entities and (b) count physician members who work under a professional service agreement (§ 1 & 2);

2. starting January 15, 2025, lowering the threshold, from group practices of 30 or more physicians, to eight or more physicians, that triggers an annual requirement under existing law to report on the group practice to OHS and the attorney general (AG) (§ 3);

3. eliminating current law's exemption from CON requirements for ownership transfers of large group practices to a physician or certain other group practices (§ 4);

4. temporarily requiring HSPU, until December 31, 2025, to automatically grant a CON for ownership transfers of large

group practices to a physician or certain other group practices (§ 4); and

5. removing a provision in current law providing a presumption in favor of approving a CON application for an ownership transfer of a large group practice when the offer to buy the practice was made in response to a request for proposal or similar voluntary offer for sale (§ 5).

The bill also requires CON approval for the acquisition of a proton radiotherapy machine, unless it is a replacement for a machine previously acquired through a CON (§ 4).

Lastly, the bill makes various technical changes (§§ 6-8).

EFFECTIVE DATE: October 1, 2024, except the provision changing the statutory definition of "large group practice" takes effect upon passage.

§§ 1 & 2 — DEFINITION OF GROUP PRACTICE AND LARGE GROUP PRACTICE

The bill expands the statutory definitions of "group practice" (two or more physicians) and "large group practice" (eight or more physicians) to include those organized in:

1. a group owned or controlled by a public company or entity (e.g., nonprofits, business trusts, and estates) or

2. an entity in which both the payer and provider share the financial risk of managed care or the provider serves as both a payer and provider (i.e., a payer offering health care, a provider offering health insurance, or joint ventures between payers and providers).

Under current law, a group practice and large group practice also include those organized in a partnership, professional corporation, limited liability company (LLC), medical foundation, nonprofit corporation, faculty practice plan, or other similar entity.

As under current law, a group practice or large group practice is one in which:

1. member physicians provide and bill substantially all of their services in the practice's name and payments are treated as group receipts;

2. the practice's overhead expenses and income are distributed by a method the practice members determine; or

3. each physician in the practice provides substantially the full range of services they normally provide through the joint use of office space, facilities, equipment, or personnel.

For the latter, the bill specifies that this includes physicians who work under a professional service agreement.

§ 3 — LARGE GROUP PRACTICE ANNUAL REPORTING REQUIREMENT

Current law requires certain group practices to file an annual report with the AG and OHS on their practices that includes the following:

1. the name and specialty of each physician practicing within the group practice;

2. the names of the business entities that provide services as part of the group practice, including the addresses for each location where services are provided;

3. a description of the services provided at each location; and

4. the primary service area served by each location.

Starting January 15, 2025, the bill applies the annual reporting requirement to group practices with eight or more physicians (including those working under a professional service agreement), instead of those with 30 or more physicians, as under current law.

§ 4 — LARGE GROUP PRACTICE OWNERSHIP TRANSFERS

The bill requires CON approval for ownership transfers of large group practices to any person (i.e., individual, partnership, corporation, LLC, association, government subdivision, agency, or public or private organization). Current law exempts ownership transfers to (1) a physician or (2) another group practice that is not an employee or affiliate of a hospital, medical foundation, insurance company, or other entity.

However, the bill temporarily requires HSPU, until December 31, 2025, to automatically issue a CON to any large group practice that submits a request to transfer its ownership to a physician or group practice as described above. The unit must do this regardless of existing CON laws or the bill's requirements.

BACKGROUND

Related Bills

sSB 9, favorably reported by the Public Health Committee, makes various changes to the CON program, such as adding to the types of transactions requiring CON approval and modifying criteria HSPU must use when reviewing CON applications.

SB 440, favorably reported by the Public Health Committee, makes various changes to the CON program, such as modifying the types of transactions that require, and are exempt from, CON approval; transferring responsibility, from HSPU to the attorney general, for conducting cost and market impact reviews of certain hospital ownership transfers; and shortening the deadlines for certain CON processes.

COMMITTEE ACTION

Public Health Committee

Joint Favorable
Yea 25 Nay 12 (03/20/2024)