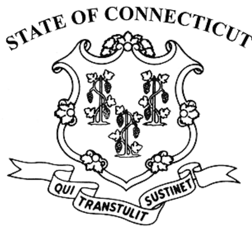

Senate

General Assembly **File No. 381**

February Session, 2024 Substitute Senate Bill No. 9

Senate, April 10, 2024

The Committee on Public Health reported through SEN. ANWAR of the 3rd Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT PROMOTING HOSPITAL FINANCIAL STABILITY.

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

1 Section 1. Subsection (a) of section 19a-494 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective July 1,*
3 *2024*):

4 (a) The Commissioner of Public Health, after a hearing held in
5 accordance with the provisions of chapter 54, may take any of the
6 following actions, singly or in combination, in any case in which the
7 commissioner finds that there has been a substantial failure to comply
8 with the requirements established under this chapter <u>or requirements</u>
9 <u>established under this title relating to institutions</u>, the Public Health
10 Code or licensing regulations:

11 (1) Revoke a license or certificate;

12 (2) Suspend a license or certificate;

13 (3) Censure a licensee or certificate holder;

14 (4) Issue a letter of reprimand to a licensee or certificate holder;

15 (5) Place a licensee or certificate holder on probationary status and
16 require **[**him**]** the licensee or certificate holder to report regularly to the
17 department on the matters which are the basis of the probation;

18 (6) Restrict the acquisition of other facilities for a period of time set
19 by the commissioner;

20 (7) Issue an order compelling compliance with applicable statutes or
21 regulations of the department; **[**or**]**

22 (8) Impose a directed plan of correction; or

23 (9) Assess a civil penalty not to exceed twenty-five thousand dollars.

24 Sec. 2. (NEW) (*Effective July 1, 2024*) (a) For the purposes of this
25 section, (1) "emergency department diversion" means the status of a
26 hospital licensed pursuant to chapter 368v of the general statutes that
27 reroutes incoming ambulances to other hospitals due to the diverting
28 hospital's emergency department saturation or lack of medical
29 capability, and (2) "emergency department saturation" means a
30 hospital's emergency department resources are fully committed and are
31 not available for additional incoming ambulance patients.

32 (b) The Commissioner of Public Health shall establish (1) emergency
33 department diversion requirements for hospitals, including, but not
34 limited to, the requirement that each hospital adopt emergency
35 department diversion policies and the required content of such policies,
36 (2) the permissible grounds for, and procedures to be followed by, a
37 hospital to declare an emergency department diversion and the
38 procedures to be followed by the hospital after declaring such diversion,
39 (3) requirements for hospitals to receive diverted patients, and (4)
40 requirements for emergency medical service organizations licensed or
41 certified under chapter 368d of the general statutes in the event that a
42 hospital declares an emergency department diversion. Prior to declaring
43 an emergency department diversion, a hospital shall provide notice to
44 the Department of Public Health in the form and manner prescribed by

45 the Commissioner of Public Health.

46 (c) The commissioner shall adopt regulations, in accordance with
47 chapter 54 of the general statutes, to implement the provisions of this
48 section. The commissioner may implement policies and procedures
49 necessary to implement the provisions of this section while in the
50 process of adopting such policies and procedures as regulations,
51 provided notice of intent to adopt regulations is published on the
52 eRegulations System not later than twenty days after the date of
53 implementation. Policies and procedures implemented pursuant to this
54 section shall be valid until final regulations are adopted in accordance
55 with the provisions of chapter 54 of the general statutes.

56 (d) The commissioner may assess a civil penalty not to exceed
57 twenty-five thousand dollars on a hospital that violates the
58 requirements established pursuant to the provisions of this section, in
59 accordance with the provisions of section 19a-494 of the general statutes,
60 as amended by this act. Failure of an emergency medical service
61 organization to comply with such requirements shall be grounds for
62 disciplinary action pursuant to subsection (c) of section 19a-180 of the
63 general statutes.

64 Sec. 3. Section 19a-630 of the general statutes is repealed and the
65 following is substituted in lieu thereof (*Effective from passage*):

66 As used in this chapter, unless the context otherwise requires:

67 (1) "Affiliate" means a person, entity or organization controlling,
68 controlled by or under common control with another person, entity or
69 organization. Affiliate does not include a medical foundation organized
70 under chapter 594b.

71 (2) "Applicant" means any person or health care facility that applies
72 for a certificate of need pursuant to section 19a-639a.

73 (3) "Bed capacity" means the total number of inpatient beds in a
74 facility licensed by the Department of Public Health under sections 19a-
75 490 to 19a-503, inclusive.

76 (4) "Capital expenditure" means an expenditure that under generally
77 accepted accounting principles consistently applied is not properly
78 chargeable as an expense of operation or maintenance and includes
79 acquisition by purchase, transfer, lease or comparable arrangement, or
80 through donation, if the expenditure would have been considered a
81 capital expenditure had the acquisition been by purchase.

82 (5) "Certificate of need" means a certificate issued by the unit.

83 (6) "Days" means calendar days.

84 (7) "Executive director" means the executive director of the Office of
85 Health Strategy.

86 (8) "Free clinic" means a private, nonprofit community-based
87 organization that provides medical, dental, pharmaceutical or mental
88 health services at reduced cost or no cost to low-income, uninsured and
89 underinsured individuals.

90 (9) "Large group practice" means eight or more full-time equivalent
91 physicians, legally organized in a partnership, professional corporation,
92 limited liability company formed to render professional services,
93 medical foundation, not-for-profit corporation, faculty practice plan or
94 other similar entity (A) in which each physician who is a member of the
95 group provides substantially the full range of services that the physician
96 routinely provides, including, but not limited to, medical care,
97 consultation, diagnosis or treatment, through the joint use of shared
98 office space, facilities, equipment or personnel; (B) for which
99 substantially all of the services of the physicians who are members of
100 the group are provided through the group and are billed in the name of
101 the group practice and amounts so received are treated as receipts of the
102 group; or (C) in which the overhead expenses of, and the income from,
103 the group are distributed in accordance with methods previously
104 determined by members of the group. An entity that otherwise meets
105 the definition of group practice under this section shall be considered a
106 group practice although its shareholders, partners or owners of the
107 group practice include single-physician professional corporations,

108 limited liability companies formed to render professional services or
109 other entities in which beneficial owners are individual physicians.

110 (10) "Health care facility" means (A) hospitals licensed by the
111 Department of Public Health under chapter 368v; (B) specialty hospitals;
112 (C) freestanding emergency departments; (D) outpatient surgical
113 facilities, as defined in section 19a-493b and licensed under chapter
114 368v; (E) a hospital or other facility or institution operated by the state
115 that provides services that are eligible for reimbursement under Title
116 XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended;
117 (F) a central service facility; (G) mental health facilities; (H) substance
118 abuse treatment facilities; and (I) any other facility requiring certificate
119 of need review pursuant to subsection (a) of section 19a-638, as
120 amended by this act. "Health care facility" includes any parent company,
121 subsidiary, affiliate or joint venture, or any combination thereof, of any
122 such facility.

123 (11) "Nonhospital based" means located at a site other than the main
124 campus of the hospital.

125 (12) "Office" means the Office of Health Strategy.

126 (13) "Person" means any individual, partnership, corporation, limited
127 liability company, association, public company, entity, as defined in
128 section 33-602, governmental subdivision, agency or public or private
129 organization of any character, but does not include the agency
130 conducting the proceeding.

131 (14) "Physician" has the same meaning as provided in section 20-13a.

132 (15) "Termination of services" means the cessation of any services for
133 a period greater than one hundred eighty days.

134 (16) "Transfer of ownership" means (A) a transfer that impacts or
135 changes the governance or controlling body of a health care facility,
136 institution or large group practice, including, but not limited to, all
137 affiliations [,] or mergers, [or] (B) any sale or transfer of net assets of a
138 health care facility, or (C) a transfer of a controlling interest in any entity,

139 as defined in section 33-602, that possesses or controls, directly or
140 indirectly, an interest of twenty per cent or more of a health care facility,
141 institution, as defined in section 19a-490, or large group practice.

142 (17) "Unit" means the Health Systems Planning Unit.

143 Sec. 4. Section 19a-638 of the 2024 supplement to the general statutes
144 is repealed and the following is substituted in lieu thereof (*Effective*
145 *October 1, 2024*):

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

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

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

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

155 (4) The establishment of a freestanding emergency department;

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

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

163 (7) The termination of surgical services by an outpatient surgical
164 facility, as defined in section 19a-493b, or a facility that provides
165 outpatient surgical services as part of the outpatient surgery department
166 of a short-term acute care general hospital, provided termination of
167 outpatient surgical services due to (A) insufficient patient volume, or (B)

168 the termination of any subspecialty surgical service, shall not require
169 certificate of need approval;

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

172 (9) The establishment of cardiac services, including inpatient and
173 outpatient cardiac catheterization, interventional cardiology and
174 cardiovascular surgery;

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

187 (11) The acquisition of nonhospital based linear accelerators, except a
188 certificate of need issued by the unit shall not be required where such
189 accelerator is a replacement for an accelerator that was previously
190 acquired through certificate of need approval or a certificate of need
191 determination;

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

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

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

199 care general hospital; **[**and**]**

200 (15) The termination of inpatient or outpatient services offered by a
201 hospital or other facility or institution operated by the state that
202 provides services that are eligible for reimbursement under Title XVIII
203 or XIX of the federal Social Security Act, 42 USC 301, as amended;

204 (16) A transfer of ten per cent or more of the assets owned by a
205 hospital, including, but not limited to, a transfer of real estate; and

206 (17) The issuance of dividends over the course of any three-year
207 period in excess of twenty per cent of the net worth of a hospital.

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

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

211 (2) The establishment of offices by a licensed private practitioner,
212 whether for individual or group practice, except when a certificate of
213 need is required in accordance with the requirements of section 19a-
214 493b or subdivision (3), (10) or (11) of subsection (a) of this section;

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

217 (4) Residential care homes, as defined in subsection (c) of section 19a-
218 490, and nursing homes and rest homes, as defined in subsection (o) of
219 section 19a-490;

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

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

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

223 (8) Outpatient rehabilitation facilities;

224 (9) Outpatient chronic dialysis services;

225 (10) Transplant services;

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

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

232 (13) A program licensed or funded by the Department of Children
233 and Families, provided such program is not a psychiatric residential
234 treatment facility;

235 (14) Any nonprofit facility, institution or provider that has a contract
236 with, or is certified or licensed to provide a service for, a state agency or
237 department for a service that would otherwise require a certificate of
238 need. The provisions of this subdivision shall not apply to a short-term
239 acute care general hospital or children's hospital, or a hospital or other
240 facility or institution operated by the state that provides services that are
241 eligible for reimbursement under Title XVIII or XIX of the federal Social
242 Security Act, 42 USC 301, as amended;

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

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

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

254 (18) Replacement of existing computed tomography scanners,

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

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

267 (20) The partial or total elimination of services provided by an
268 outpatient surgical facility, as defined in section 19a-493b, except as
269 provided in subdivision (6) of subsection (a) of this section and section
270 19a-639e;

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

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

275 (23) On or before June 30, 2026, an increase in the licensed bed
276 capacity of a mental health facility, provided (A) the mental health
277 facility demonstrates to the unit, in a form and manner prescribed by
278 the unit, that it accepts reimbursement for any covered benefit provided
279 to a covered individual under: (i) An individual or group health
280 insurance policy providing coverage of the type specified in
281 subdivisions (1), (2), (4), (11) and (12) of section 38a-469; (ii) a self-
282 insured employee welfare benefit plan established pursuant to the
283 federal Employee Retirement Income Security Act of 1974, as amended
284 from time to time; or (iii) HUSKY Health, as defined in section 17b-290,
285 and (B) if the mental health facility does not accept or stops accepting
286 reimbursement for any covered benefit provided to a covered

287 individual under a policy, plan or program described in clause (i), (ii) or
288 (iii) of subparagraph (A) of this subdivision, a certificate of need for such
289 increase in the licensed bed capacity shall be required; **[.]**

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

292 (25) On or before June 30, 2028, a birth center, as defined in section
293 19a-490, that is enrolled as a provider in the Connecticut medical
294 assistance program, as defined in section 17b-245g.

295 (c) (1) Any person, health care facility or institution that is unsure
296 whether a certificate of need is required under this section, or (2) any
297 health care facility that proposes to relocate pursuant to section 19a-
298 639c, shall send a letter to the unit that describes the project and requests
299 that the unit make a determination as to whether a certificate of need is
300 required. In the case of a relocation of a health care facility, the letter
301 shall include information described in section 19a-639c. A person, health
302 care facility or institution making such request shall provide the unit
303 with any information the unit requests as part of its determination
304 process. The unit shall provide a determination within thirty days of
305 receipt of such request.

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

315 (e) On or before June 30, 2026, a mental health facility seeking to
316 increase licensed bed capacity without applying for a certificate of need,
317 as permitted pursuant to subdivision (23) of subsection (b) of this
318 section, shall notify the Office of Health Strategy, in a form and manner

319 prescribed by the executive director of said office, regarding (1) such
320 facility's intent to increase licensed bed capacity, (2) the address of such
321 facility, and (3) a description of all services that are being or will be
322 provided at such facility.

323 (f) Notwithstanding the provisions of this section and sections 19a-
324 639, as amended by this act, and 19a-639a, on or before December 31,
325 2025, the unit shall automatically issue a certificate of need to any large
326 group practice or health care facility, except a hospital licensed pursuant
327 to chapter 368v, for a transfer of ownership, as defined in subparagraph
328 (C) of subdivision (16) of section 19a-630, as amended by this act, upon
329 such practice or facility's submission of a certificate of need request for
330 determination to the unit.

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

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

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

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

347 (2) **[**The relationship of the**]** Whether the proposed project **[**to**]** is
348 consistent with any applicable policies and standards as set forth in the
349 state-wide health care facilities and services plan;

350 (3) Whether [there is a clear] the applicant has satisfactorily
351 demonstrated that the proposed project is consistent with a public need,
352 [for the health care facility or services proposed by the applicant]
353 including, but not limited to, a public health or community health need
354 identified in a community health needs assessment, community service
355 plan, community health improvement plan, community profile, the
356 applicant's long-term plan or other similar report characterizing the
357 health needs of the community;

358 (4) Whether the applicant has satisfactorily demonstrated [how] that
359 the proposal will not negatively impact the financial strength of the
360 health care system in the region and state; [or that the proposal is
361 financially feasible for the applicant;]

362 (5) Whether the applicant has satisfactorily demonstrated how the
363 proposal will improve the quality [, accessibility and cost effectiveness]
364 of health care delivery in the region; [, including, but not limited to,
365 provision of or any change in the access to services for Medicaid
366 recipients and indigent persons;]

367 (6) Whether the applicant has satisfactorily demonstrated how the
368 proposal will improve access to health care in the region, including the
369 provision of or any change in the access to services for Medicaid and
370 Medicare recipients and indigent persons;

371 (7) Whether the applicant has satisfactorily demonstrated how the
372 proposal will increase cost effectiveness of health care delivery in the
373 region;

374 [(6) The] (8) Whether the applicant has satisfactorily demonstrated
375 that the proposal will not negatively affect the applicant's [past and
376 proposed] provision of health care services to relevant patient
377 populations [and] or alter the applicant's payer mix, including, but not
378 limited to, [access to] a decrease in the provision of services [by] to
379 Medicaid and Medicare recipients and indigent persons;

380 [(7) Whether the applicant has satisfactorily identified the population

381 to be served by the proposed project and satisfactorily demonstrated
382 that the identified population has a need for the proposed services;

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

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

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

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

396 (12) Whether the applicant has satisfactorily demonstrated that any
397 consolidation resulting from the proposal will not adversely affect
398 health care costs or [accessibility] access to care;

399 (13) If the application is for the termination of services, whether and
400 to what extent the applicant's actions or inactions caused or contributed
401 to the conditions that resulted in the filing of the application; and

402 (14) Whether the applicant has satisfactorily demonstrated that the
403 proposal will not negatively impact the finances of the health care
404 facility so as to jeopardize or substantially impair the facility's future
405 operations.

406 (b) In deliberations as described in subsection (a) of this section, there
407 shall be a presumption in favor of approving the certificate of need
408 application for a transfer of ownership of a large group practice, as
409 described in subdivision (3) of subsection (a) of section 19a-638, as
410 amended by this act, when an offer was made in response to a request

411 for proposal or similar voluntary offer for sale.

412 (c) The unit, as it deems necessary, may revise or supplement the
413 guidelines and principles, set forth in subsection (a) of this section,
414 through regulation. The executive director may implement policies and
415 procedures necessary to implement the provisions of this section while
416 in the process of adopting such policies and procedures as regulations,
417 provided the executive director holds a public hearing at least thirty
418 days prior to implementing such policies and procedures and publishes
419 notice of intent to adopt the regulations on the Office of Health
420 Strategy's Internet web site and the eRegulations System not later than
421 twenty days after implementing such policies and procedures. Policies
422 and procedures implemented pursuant to this subsection shall be valid
423 until final regulations are adopted in accordance with the provisions of
424 chapter 54.

425 (d) (1) For purposes of this subsection and subsection (e) of this
426 section:

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

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

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

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

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

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

441 course of business; and

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

448 (2) In any deliberations involving a certificate of need application
449 filed pursuant to section 19a-638, as amended by this act, that involves
450 the transfer of ownership of a hospital, the unit shall, in addition to the
451 guidelines and principles set forth in subsection (a) of this section and
452 those prescribed through regulation pursuant to subsection (c) of this
453 section, take into consideration and make written findings concerning
454 each of the following guidelines and principles:

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

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

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

470 (4) The unit may deny any certificate of need application involving a
471 transfer of ownership of a hospital subject to a cost and market impact

472 review pursuant to section 19a-639f, if the executive director finds that
473 (A) the affected community will not be assured of continued access to
474 high quality and affordable health care after accounting for any
475 consolidation in the hospital and health care market that may lessen
476 health care provider diversity, consumer choice and access to care, and
477 (B) any likely increases in the prices for health care services or total
478 health care spending in the state may negatively impact the affordability
479 of care.

480 (5) The unit may place any conditions on the approval of a certificate
481 of need application involving a transfer of ownership of a hospital
482 consistent with the provisions of this chapter. Before placing any such
483 conditions, the unit shall weigh the value of such conditions in
484 promoting the purposes of this chapter against the individual and
485 cumulative burden of such conditions on the transacting parties and the
486 new hospital. For each condition imposed, the unit shall include a
487 concise statement of the legal and factual basis for such condition and
488 the provision or provisions of this chapter that it is intended to promote.
489 Each condition shall be reasonably tailored in time and scope. The
490 transacting parties or the new hospital shall have the right to make a
491 request to the unit for an amendment to, or relief from, any condition
492 based on changed circumstances, hardship or for other good cause.

493 (6) In any deliberations involving a certificate of need application
494 filed pursuant to section 19a-638, as amended by this act, that involves
495 the transfer of ownership of a hospital and that is subject to a cost and
496 market impact review, the unit shall be permitted to consider the
497 preliminary report, response to the preliminary report, final report and
498 any written comments from the parties regarding the reports issued or
499 submitted as part of the review, provided the unit has determined that
500 the disclosure of any such reports is appropriate in light of the
501 considerations set forth in subsection (c) of section 19a-639f and each
502 party in the certificate of need proceeding was provided an opportunity
503 of not less than fourteen days after the date of issuance of the final report
504 to provide written comments on the reports issued as part of the review
505 process.

506 (e) (1) If the certificate of need application (A) involves the transfer of
507 ownership of a hospital, (B) the purchaser is a hospital, as defined in
508 section 19a-490, whether located within or outside the state, that had net
509 patient revenue for fiscal year 2013 in an amount greater than one billion
510 five hundred million dollars or a hospital system, as defined in section
511 19a-486i, whether located within or outside the state, that had net
512 patient revenue for fiscal year 2013 in an amount greater than one billion
513 five hundred million dollars, or any person that is organized or operated
514 for profit, and (C) such application is approved, the unit shall hire an
515 independent consultant to serve as a post-transfer compliance reporter
516 for a period of not less than three years after completion of the transfer
517 of ownership of the hospital. Such reporter shall, at a minimum: (i) Meet
518 with representatives of the purchaser, the new hospital and members of
519 the affected community served by the new hospital not less than
520 quarterly; and (ii) report to the unit not less than quarterly concerning
521 (I) efforts the purchaser and representatives of the new hospital have
522 taken to comply with any conditions the unit placed on the approval of
523 the certificate of need application and plans for future compliance, and
524 (II) community benefits and uncompensated care provided by the new
525 hospital. The purchaser shall give the reporter access to its records and
526 facilities for the purposes of carrying out the reporter's duties. The
527 purchaser shall hold a public hearing in the municipality in which the
528 new hospital is located not less than annually during the reporting
529 period to provide for public review and comment on the reporter's
530 reports and findings.

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

539 (3) The purchaser shall provide funds, in an amount determined by

540 the unit not to exceed two hundred thousand dollars annually, for the
541 hiring of the post-transfer compliance reporter.

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

546 Sec. 6. (NEW) (*Effective July 1, 2024*) (a) On or before October 31, 2024,
547 and quarterly thereafter, each hospital, as defined in section 12-263p of
548 the general statutes, shall submit a report to the executive director of the
549 Office of Health Strategy that identifies, for the prior calendar quarter,
550 (1) any vendor invoices that remained unpaid for more than ninety days
551 after receipt, regardless of whether the hospital disputes such invoice,
552 (2) the outstanding balances on such invoices, (3) the number of days of
553 cash on hand, (4) the operating margin, (5) the total margin, (6) unpaid
554 rent, (7) unpaid utilities, (8) fees, taxes or assessments owed to public
555 utilities, and (9) unpaid employee health insurance premiums,
556 including unpaid contributions, claims or other obligations supporting
557 employees under a self-funded insurance plan. The executive director
558 shall develop a uniform template, including definitions of terms used in
559 such template, to be used by hospitals for the purposes of complying
560 with the provisions of this subsection and post such template on the
561 Office of Health Strategy's Internet web site. Such template shall allow
562 for an explanation of any disputed charges. A hospital may request an
563 extension of not more than fifteen days to comply with the requirements
564 of this subsection in a form and manner prescribed by the executive
565 director. The executive director may grant such request for good cause,
566 as determined by the executive director.

567 (b) Any hospital that violates or fails to comply with the provisions
568 of this section shall be subject to a civil penalty not to exceed ten
569 thousand dollars for each incident of noncompliance. Prior to imposing
570 any penalty pursuant to this subsection, the executive director shall
571 notify the hospital of the alleged violation and the accompanying
572 penalty and shall permit such hospital to request that the office review

573 its findings. A hospital shall request such review not later than fifteen
574 days after the date of receipt of the notice of violation. The executive
575 director shall stay the imposition of any penalty pending the outcome
576 of the review. Payments of penalties received pursuant to this
577 subsection shall be deposited in the General Fund.

578 (c) On or before November 30, 2024, and quarterly thereafter, the
579 executive director shall provide to the Secretary of the Office of Policy
580 and Management a summary of the reports received in accordance with
581 subsection (a) of this section for the prior calendar quarter.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2024*	19a-494(a)
Sec. 2	*July 1, 2024*	New section
Sec. 3	*from passage*	19a-630
Sec. 4	*October 1, 2024*	19a-638
Sec. 5	*October 1, 2024*	19a-639
Sec. 6	*July 1, 2024*	New section

Statement of Legislative Commissioners:
In Section 5(e)(2), "met" was changed to "satisfied" for clarity.

PH *Joint Favorable Subst.*

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:

Agency Affected	Fund-Effect	FY 25 $	FY 26 $
Office of Health Strategy	GF - Cost	96,000	96,000
State Comptroller - Fringe Benefits[1]	GF - Cost	39,600	39,600
Resources of the General Fund	GF - Revenue Gain	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

Section 1 of the bill authorizes the Department of Public Health (DPH), starting 7/1/24, to impose a civil penalty of up to $25,000 against a health care institution for noncompliance with statutory or regulatory requirements, which results in a potential minimal revenue gain to the resources of the General Fund (GF).

Section 2 results in a potential minimal GF revenue gain as it requires DPH to establish hospital Emergency Department (ED) diversion requirements[2] and allows, as of 7/1/24, it to assess a civil penalty not to exceed $25,000 on any hospital that violates these requirements.

Section 3 results in a potential revenue gain to the General Fund by

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.25% of payroll in FY 25.
[2]For example, when hospitals reroute incoming ambulances to other hospitals because their ED resources are fully committed, or they lack necessary medical expertise.

expanding the Office of Health Strategy’s (OHS') Health Systems Planning Unit (HSPU's) Certificate of Need (CON) requirements. The revenue gain is dependent on the number of applications received and the cost of the transfer associated with the application[3].

Section 4 modifies the CON program for health care entities beginning in FY 25, increasing annual HSPU expenditures by $135,600 annually to support an Associate Health Care Analyst's salary and associated fringe benefits. Costs related to HSPU are recovered via an assessment collected from the various state hospitals; this assessment results in a revenue gain to the General Fund that will offset the increased cost to OHS.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation, the number of applications received, and the costs of the transfers associated with the applications..

[3] The application fee is determined by the cost of the project, based on a scale described in subsection (a) of Sec. 19a-639a of the CT General Statutes.

OLR Bill Analysis
sSB 9

AN ACT PROMOTING HOSPITAL FINANCIAL STABILITY.

SUMMARY

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

The bill adds to the types of transactions that require CON approval: (1) transfers of a controlling interest in any entity with at least a 20% interest of a health care facility, institution, or large group practice (i.e., eight or more full-time equivalent physicians); (2) transfers of at least 10% of a hospital's assets; and (3) issuance of dividends over any three-year period that exceed 20% of a hospital's net worth.

Among other changes to CON transactions, the bill (1) eliminates current law's CON requirement for acquiring computed tomography (CT) scanners and (2) requires HSPU to automatically issue a CON for non-hospital ownership transfers, temporarily until December 31, 2025.

The bill also modifies the criteria HSPU must use when reviewing CON applications to, among other things, include whether the (1) applicant's actions or inactions contributed to the conditions that resulted in a request to terminate services and (2) applicant satisfactorily showed the proposal will not affect its finances in a way that would impair its future operations.

Additionally, the bill makes the following changes affecting health

care facility oversight:

1. authorizes the Department of Public Health (DPH) to impose a civil penalty of up to $25,000 against a health care institution for noncompliance with statutory or regulatory requirements, in addition to various other disciplinary actions authorized under existing law (e.g., license suspension or revocation, probation, or a letter of reprimand) (§ 1);

2. requires DPH to establish emergency department diversion requirements for hospitals when they reroute incoming ambulances to other hospitals and subjects hospitals and emergency medical services (EMS) organizations to disciplinary action for noncompliance with the requirements (§ 2);

3. requires hospitals to report quarterly to OHS, starting by October 31, 2024, on specified financial information (e.g., invoices unpaid for more than 90 days and their balances) and subjects them to a civil penalty of up to $10,000 for each incident of noncompliance (§ 6); and

4. requires OHS to report quarterly, starting by November 30, 2024, to the Office of Policy and Management secretary summaries of the reports it receives from hospitals for the prior calendar quarter (§ 6).

Lastly, the bill makes minor, technical, and conforming changes.

EFFECTIVE DATE: July 1, 2024, except that the provisions (1) modifying CON program requirements take effect October 1, 2024, and (2) changing CON definitions take effect upon passage.

§ 1 — DPH DISCIPLINARY AUTHORITY FOR HEALTH CARE INSTITUTIONS

The bill authorizes the DPH commissioner, after a hearing held in accordance with the Uniform Administrative Procedure Act, to impose a civil penalty of up to $25,000 on a health care institution (e.g., a hospital, freestanding emergency department, outpatient surgical

facility, or long-term care facility) when she finds that the institution substantially failed to comply with statutory or regulatory requirements, including licensing regulations.

Existing law already authorizes the commissioner to take various other disciplinary actions for these reasons, such as license suspension, revocation, or censure; probation; a corrective action plan; or a letter of reprimand.

§ 2 — HOSPITAL EMERGENCY DEPARTMENT DIVERSIONS

The bill requires DPH to establish emergency department diversion requirements for hospitals when they reroute incoming ambulances to other hospitals because (1) their emergency department's resources are fully committed and unavailable to incoming ambulance patients (i.e., "saturation") or (2) they lack medical capability.

Specifically, DPH must establish the following:

1. hospital emergency department diversion requirements that include, at a minimum, each hospital to adopt related policies and their required content;

2. the permissible grounds for which a hospital may declare an emergency department diversion and procedures it must follow after doing so;

3. requirements for hospitals receiving diverted patients (i.e., "receiving hospitals"); and

4. requirements for licensed or certified EMS organizations when a hospital declares an emergency department diversion.

Before declaring an emergency department diversion, the bill requires a hospital to notify DPH as the commissioner prescribes. It also subjects violators to (1) a civil penalty of up to $25,000 for hospitals and (2) various DPH disciplinary actions (e.g., license suspension, revocation, or censure) for EMS organizations.

Under the bill, the DPH commissioner must adopt regulations to implement the emergency department diversion requirements and may implement policies and procedures while doing so if she publishes her intent to adopt regulations on the eRegulations system within 20 days after implementing the policies and procedures. The policies and procedures are valid until the final regulations are adopted.

§§ 3-5 — CERTIFICATE OF NEED

Definition of "Person"

The bill adds public companies and entities (e.g., nonprofits, business trusts, and estates) to the statutory definition of "person" for purposes of the CON program. Under current law, "person" also includes any individual, partnership, corporation, limited liability company, association, government subdivision, agency, or private organization of any character.

By law, HSPU may impose civil penalties on a "person" that fails to file required data or information, as it may do for health care facilities and large group practices.

Transactions Requiring CON Approval

By law, health care institutions must generally receive approval from HSPU when establishing new facilities or services, changing ownership, acquiring certain equipment, or terminating services.

The bill adds to the types of transactions that require CON approval the following:

1. transfers of a controlling interest in any entity (e.g., corporation, nonprofit, limited liability company, or partnership) that directly or indirectly controls or possesses at least 20% interest of a health care facility, institution, or large group practice, instead of only ownership transfers that impact the facility, institution, or practice itself;

2. transfers of at least 10% of a hospital's assets, including real estate transfers; and

3. the issuing of dividends over any three-year period that exceed 20% of a hospital's net worth.

Temporary Automatic CON Approvals for Non-Hospital Ownership Transfers

The bill requires HSPU to automatically issue a CON for ownership transfers for large group practices and health care facilities other than hospitals that submit a CON determination request (i.e., non-hospital ownership transfers). HSPU must do this until December 31, 2025, regardless of existing CON laws.

CON Exemptions for CT Scanners

The bill eliminates the CON requirement for acquiring CT scanners. Current law requires a CON when acquiring MRI, CT, PET, and PET/CT scanners, unless they are replacements for scanners previously approved through the CON process.

CON Review Criteria

The bill adds to the factors HSPU must consider when reviewing a CON application the following:

1. for service terminations, whether and to what extent the applicant's actions or inactions caused or contributed to the conditions that result in filing the application; and

2. whether the applicant satisfactorily demonstrated that the proposal will not negatively impact the health care facility's finances in a way that jeopardizes or substantially impairs its future operations.

Under current law, the unit must consider whether there is a clear public need for the applicant's proposal. The bill specifies that this includes a public health or community health need identified in a community health needs assessment, community service plan, community health improvement plan, community profile, the applicant's long-term plan, or other similar report.

Current law also requires the unit to consider several other criteria related to health care quality, access, cost effectiveness, and financial feasibility. The bill makes minor changes to these criteria, principally by separating these different components into distinct criteria.

By law, HSPU may revise the review criteria by regulation. The bill allows the OHS executive director to implement policies and procedures to update the criteria while in the process of adopting them in regulations. Before implementing the policies and procedures, the bill requires her to (1) hold a public hearing at least 30 days before and (2) publish her intent to adopt regulations on the OHS website and eRegulations system within 20 days after implementing them. The policies and procedures are valid until the final regulations are adopted.

Cost and Market Impact Reviews

By law, HSPU must conduct a cost and market impact review (CMIR) of CON applications that propose to transfer a hospital's ownership if the purchaser is (1) an in- or out-of-state hospital or hospital system that had net patient revenue exceeding $1.5 billion for fiscal year 2013 or (2) organized or operated for profit (CGS § 19a-639f).

The bill expressly authorizes HSPU, when reviewing these CON applications, to consider the CMIR preliminary report and the response to it, the final report, and the parties' written comments on reports that are part of the review. HSPU may do this if it determined disclosing the reports is appropriate and each party in the CON proceeding was given at least 14 days after the final CMIR report was issued to submit written comments on these reports.

Additionally, when the HSPU approves a CON for these hospital ownership transfers, current law requires the unit to hire an independent consultant to serve as a post-transfer compliance reporter for three years following the transfer's completion. The bill specifies that three years is the minimum time period the reporter must serve.

§ 6 — HOSPITAL FINANCIAL REPORTING TO OHS

The bill requires hospitals to report quarterly, starting by October 31,

2024, to the OHS executive director on the following information for the prior calendar quarter:

1. any vendor invoices unpaid for more than 90 days after their receipt, regardless of whether the hospital disputed them, and their outstanding balances;
2. the number of days of cash on hand;
3. the operating and total margins;
4. unpaid rent or utilities;
5. fees, taxes, or assessments owed to public utilities; and
6. unpaid employee health insurance premiums, including unpaid contributions, claims, or other obligations supporting employees under self-insured plans.

The bill requires the executive director to develop a uniform template for hospitals to use to submit the quarterly reports to OHS and to post the template on the OHS website. The template must (1) include definitions for the terms it uses and (2) allow for hospitals to explain disputed charges.

Under the bill, hospitals may request an extension of up to 15 days to comply with the reporting requirement, as the executive director prescribes. She may grant an extension request for good cause.

Hospitals who violate the bill's reporting requirements are subject to a civil penalty of up to $10,000 for each incident of noncompliance. Before imposing a penalty, the bill requires the executive director to notify the hospital of the alleged violation and associated penalty and allow the hospital to request OHS to review its findings. A hospital must request the review within 15 days after receiving the notice and the executive director cannot impose the penalty until the review is completed. Any penalties OHS collects must be deposited into the General Fund.

The bill also requires OHS to report quarterly, starting by November 30, 2024, to the Office of Policy and Management secretary summaries of the reports it receives from hospitals for the prior calendar quarter.

BACKGROUND

Related Bills

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.

HB 5316, favorably reported by the Public Health Committee, makes various changes to CON program requirements for large group practices.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 24 Nay 12 (03/22/2024)