



2024 CT Statewide Facility and Services Plan

Review of Current **Draft Plan** Components and Certificate of
Need (CON) Standards and Guidance

May Health Care Cabinet Meeting
May 28, 2024

Introductions



- **Corey Rhyan**, Research Director, Health Economics and Policy
- **Altarum**, a health-focused nonprofit organization that works to improve the health of individuals who have fewer financial resources and populations disenfranchised by the health care system.

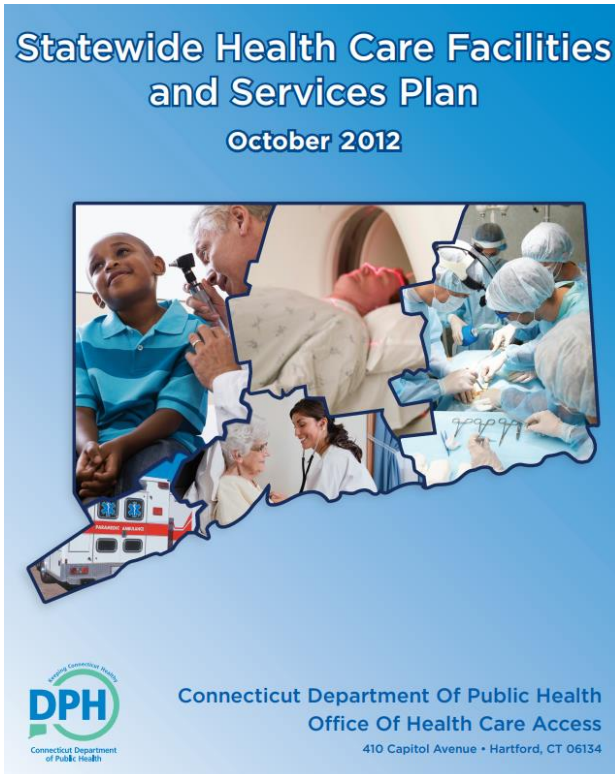
Agenda

- **Overview of current plan chapters**
- **Discussion of expanded FSP analyses and approaches**
- **Deep dive review of plan equity and utilization results**
- **Detailed review of CON Standards/Guidance Sections for:**
 - ☐ Acute Care Bed Need
 - ☐ Outpatient Surgery Facilities
 - ☐ Cardiac Care Services
 - ☐ Imaging Equipment and New Technology

Previous 2012 FSP Plan

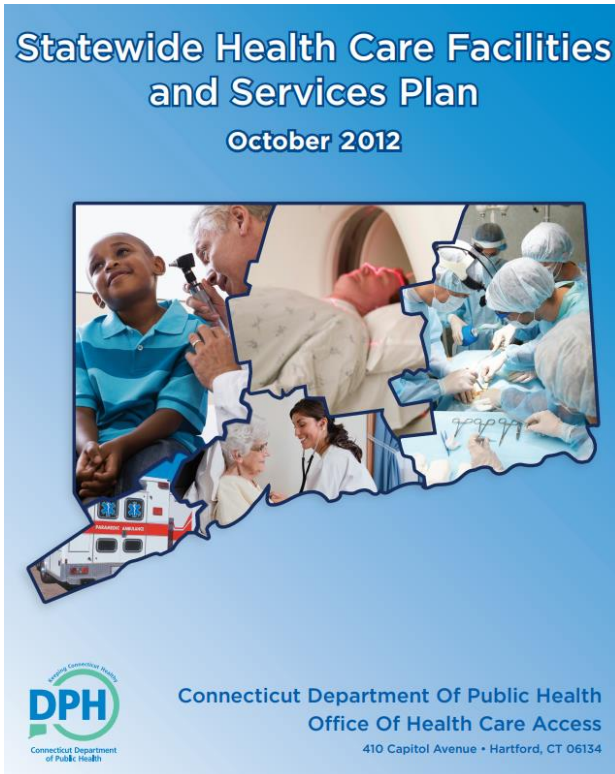
Overview of the CT Facilities and Services Plan (FSP):

- The plan is a blueprint for health care delivery in Connecticut
- It serves as a resource for policymakers and those involved in the CON process
- It provides information, policies and projections of need to guide planning for specific health care facilities and services.



Previous 2012 FSP Plan

Goals of the FSP:



- Preventing excess capacity, duplication of services, and underutilization of medical facilities
- Identifying gaps in services and unmet need
- Providing clearer guidelines for adding services
- Fostering fair competition and a level playing field for entry into the healthcare market
- Providing better access to services through transparency and data on geographic distribution

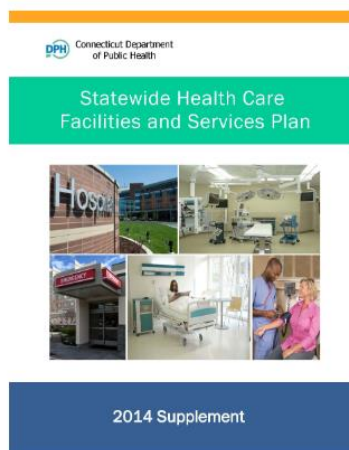
Previous Updates Since 2012

Updated Facility and Services Inventories

- 2014-2022, biannually

Supplemental Facility and Services Plans:

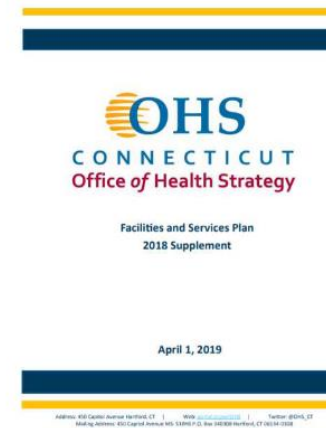
- Updated utilization statistics, revised statewide trends, additional data analyses
- Use of new data sources, including Outpatient Surgery Survey, All-Payer Claims Database (APCD) data, and imaging utilization statistics
- Targeted analyses of key topics (opioid-related ED utilization, preventable hospitalizations)



2014



2016



2018

CON Guidelines

CT Statute Sec. 19a-639: Certificate of need 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, 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.

2024 Facility and Services Plan Chapters

- **Chapter 1:** Introduction and CON Overview
- **Chapter 2:** Overarching Trends (affordability, workforce, innovation, oversight)
- **Chapter 3:** Acute Care (Inpatient beds, Emergency departments, Cardiac services, Cancer Care)
- **Chapter 4:** Outpatient Surgery Facilities
- **Chapter 5:** Imaging and New Technology
- **Chapter 6:** Long-term Services and Supports and Post-Acute Care
- **Chapter 7:** Unmet Needs and Vulnerable Populations
- **Chapter 8:** Primary Care and Maternity Care
- **Chapter 9:** Behavioral Health
- **Chapter 10:** Impacts of Health Care Consolidation
- **Chapters 11/12:** Recommendations, Next Steps, Data Limitations

2024 FSP CON Standards and Guidelines

The following chapters include specific language on CON Standards and Guidelines that were reviewed/updated:

- **Chapter 3:** Acute Care (Inpatient beds, Emergency departments, Cardiac services)
- **Chapter 4:** Outpatient Surgery Facilities
- **Chapter 5:** Imaging and New Technology
- **Chapter 9:** Behavioral Health

2024 FSP CON Standards and Guidelines

General Components of the FSP CON Standards and Guidelines:

1. Definitions of care and geographies
2. Numerical guidelines of need
3. Measures of utilization of care
4. Other guidelines (e.g. quality, ownership, financial, safety)
5. Additional considerations

2012 FSP CON Standards and Guidelines

CON Standards and Guidelines in the 2012 FSP Plan:

Service Category	Chapter or Section Included in 2012 FSP	Utilization Data in 2012 FSP (or Supplements)	Quantitative Need/Capacity Threshold Defined in 2012 FSP	Qualitative Factors Defined in 2012 FSP
1a. Acute Care Bed Need	Yes	Yes	Yes, target occupancy threshold (0.80, 0.50)	Yes
1b. Acute Care – Emergency Department Beds	Yes	Yes, greater detail in supplements	No, quality guidelines only	Yes
1c. Acute Care – Cardiac Services	Yes	Yes	No, guidelines on size limits only	Yes
2. Outpatient Surgery	Yes	Yes, only in supplements	No, optimal utilization is 75%, but otherwise not defined	Yes
3. Imaging and New Technology	Yes	Yes, 2016 only	Yes, 85% of Current Capacity	Yes
4. Behavioral Health	Yes	Yes	No	No

2024 FSP Development Discussion

Development Steps of New 2024 CON Standards and Guidelines:

- A. Begin with the 2012 guidelines as written in the FSP
- B. Review accompanying data from OHS on the appropriateness of the 2012 guidelines in meeting state needs
- C. Conduct literature review of existing data sources used in 2012 guidelines (for updated recommendations)
- D. Conduct literature review of other data sources that could be used in 2024 development
- E. Conduct additional analysis of APCD data to validate the 2012 guidelines and to meet the needs of an equity-focused perspective
- F. Finalize validation of the guidelines or proposals for guidelines based on additional data analyses and literature review
- G. Add language and data to 2024 FSP document draft

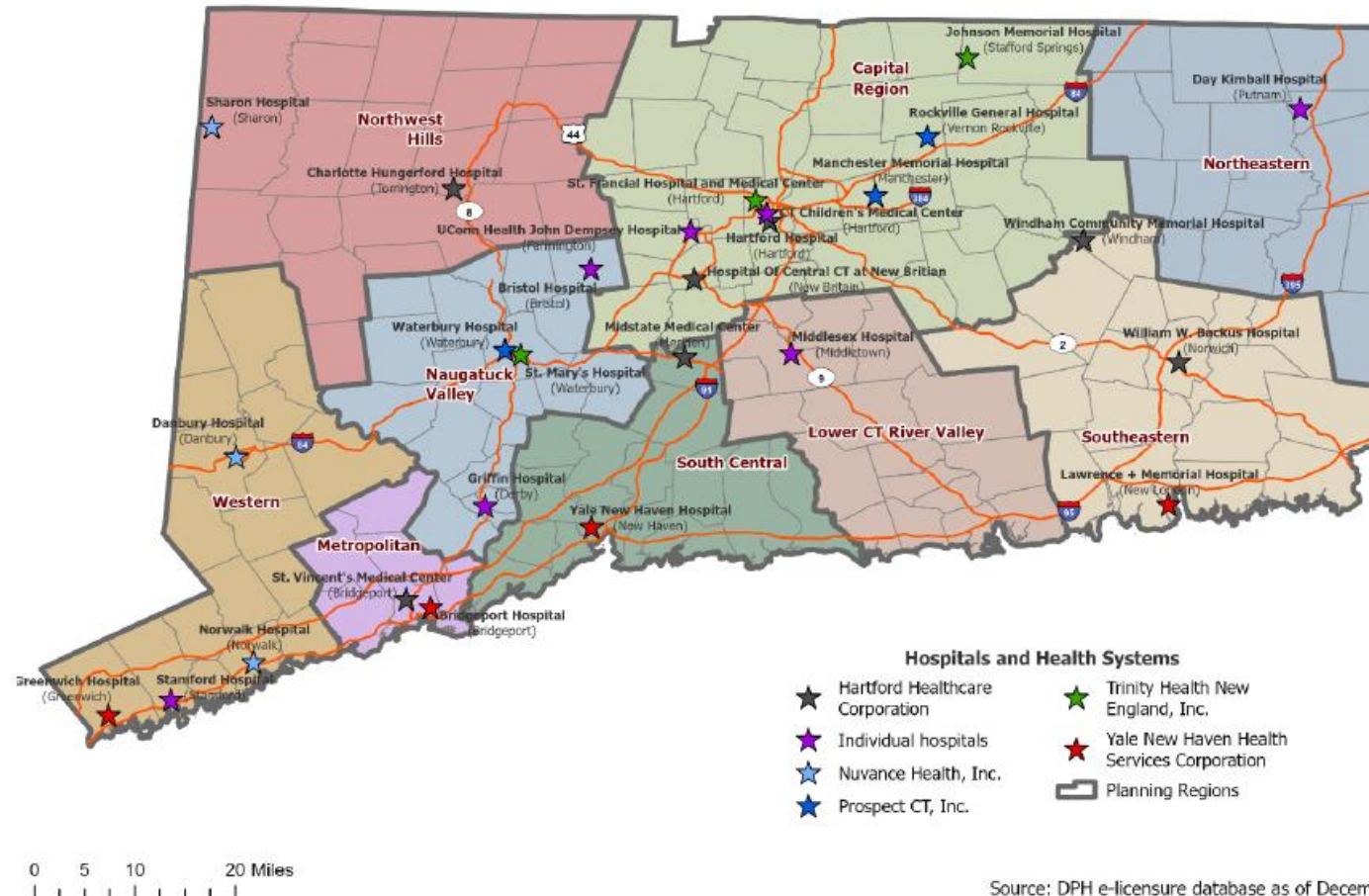
Chapter 1: CON Standards and Guidelines Approach

Section 1.8.4. Guiding Principles in Development of CON Standards, Guidelines, and Evaluating of Capacity and Need for Services

- Discussion of “ideal” measurement of need for health care services; compared to limited data that are often available to evaluate current health care capacity
- Use of utilization data can risk underestimating need / overestimating current capacity
 - ❑ Barriers to access care
- Use of utilization data can risk overestimating need / underestimating current capacity
 - ❑ Use of existing services to full capacity, defensive medicine
- Inclusion of quality-based criteria and equity-focused utilization data
- Notes of data caveats in FSP data, due to the COVID-19 pandemic

Chapter 3: Acute Care, Inpatient Bed Need

Figure 3.1 Connecticut Acute Care and Children's Hospitals by Health System



Source: DPH e-licensure database as of December, 2022

Chapter 3: Acute Care, Inpatient Bed Need

Table 3.1 List of Connecticut Hospitals, Licensed Beds, and FY 2022 Patient Days

Connecticut County	Connecticut Planning Region	Hospital	System	Licensed Beds ²	FY 2022 Patient Days ¹	Average Occupancy Rate
Hartford	Capitol	Connecticut Children's Medical Center	Independent	115	41,238	94.6%
Hartford	Capitol	Hartford	Hartford HealthCare	819	265,230	86.0%
Hartford	Capitol	The Hospital of Central Connecticut	Hartford HealthCare	414	76,713	48.2%
Hartford	Capitol	John Dempsey	Independent	224	45,205	52.1%
Hartford	Capitol	Manchester	Prospect	249	42,965	47.0%
Hartford	Capitol	St. Francis	Trinity Health	617	114,301	51.5%
Tolland	Capitol	Johnson Memorial	Trinity Health	92	8,806	26.2%
Tolland	Capitol	Rockville	Prospect	102	304	**
Middlesex	Lower Connecticut River Valley	Middlesex	Independent	275	52,650	52.5%

Chapter 3: Acute Care, Inpatient Bed Need

Table 3.2 Statewide Hospital Discharges (2016-2021), by Service Line

	Discharges						
Service Line	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	Change '16-'21
Cardiac Care (Medical)	31,302	32,271	32,972	33,539	29,625	30,807	-2%
Cardiac Care (Surgical)	13,157	13,075	13,315	13,619	11,856	12,596	-4%
Cancer Care (Medical)	7,678	8,019	7,478	7,538	6,824	6,931	-10%
Cancer Care (Surgical)	2,563	2,002	1,908	2,047	1,846	2,004	-22%
Neurological (Medical)	17,387	17,389	16,849	17,314	16,155	16,838	-3%
Neurological (Surgical)	8,934	8,703	8,865	9,205	8,635	9,429	6%
Renal/Urology (Medical)	16,660	16,105	16,099	15,136	13,308	13,493	-19%
Renal/Urology (Surgical)	3,351	3,106	3,250	3,961	3,777	3,978	19%
Women's Health	42,220	41,554	40,153	39,716	38,833	39,363	-7%

Chapter 3: Acute Care, Inpatient Bed Need

Table 3.4 FY 2021 Total Discharges per 1,000 Population, by Race/Ethnicity and Planning Region

	Discharges (per 1,000 pop)			
	Hispanic/Latine	NH Black/African American	NH White	Other
Cardiac Care (Medical)	4.8	11.4	9.9	3.9
Cardiac Care (Surgical)	1.8	2.9	4.3	2.3
Cancer Care (Medical)	1.3	2.3	2.2	1.2
Cancer Care (Surgical)	0.3	0.6	0.6	0.4
Neurological (Medical)	3.1	6.7	5.1	2.8
Neurological (Surgical)	1.5	2.8	3.1	1.6
Renal/Urology (Medical)	2.4	4.9	4.3	1.7
Renal/Urology (Surgical)	0.8	1.4	1.2	0.6
Women's Health	13.9	14.8	8.8	16.2

	Discharges (per 1,000 pop)			
	Hispanic/Latine	NH Black or African American	NH White	Other
Capitol	77.51	105.97	90.54	94.42
Greater Bridgeport	107.22	199.55	74.75	55.66
Lower CT River Valley	24.82	113.66	88.22	102.52
Naugatuck Valley	70.56	82.39	116.05	61.58
Northeast CT	7.93	34.58	87.49	38.81
Northwest Hills	24.61	26.57	97.01	64.76
South Central	74.19	149.41	101.55	49.16
Southeastern CT	76.89	117.95	92.75	42.26
Western CT	54.62	67.88	86.60	59.05

Chapter 3: Acute Care, Inpatient Bed Need

Acute Care Bed Need Methodology

- 1. Bed utilization is based on patient days and is calculated using data from three consecutive Federal Fiscal Years (FFYs). Patient days are broken down by Connecticut planning regions, hospital, service category (Medical/Surgical, Maternity, Psychiatric, Rehabilitation and Pediatric) and age group (0-14, 15-44, 45-64, 65+) – the Pediatric category uses different age groups (0-19, 20+) to better utilize population estimate age ranges.*
- 2. Patient days are divided by 365 (days) to calculate Average Daily Census (ADC) for each year of the three years.*
- 3. A Weighted ADC is calculated, giving the greatest weight to the most current year and the least weight to the oldest year. Weighted avg. daily census = $(\text{Year1} + \text{Year2} \times 2 + \text{Year3} \times 3) / 6$*
- 4. The Weighted ADC is multiplied by a population growth/attrition factor for each region (based on projected population estimates for 2025 and 2030, provided by the Connecticut State Data Center) to produce the Projected Average Daily Census.*

Chapter 3: Acute Care, Inpatient Bed Need

Acute Care Bed Need Methodology

- 5. The Projected ADC is divided by the Target Occupancy factors provided by the Acute Care/Ambulatory Surgery Subcommittee to determine the number of beds needed.*
- 6. "Beds Needed" is summed by service/age category and totaled by individual hospital.*
- 7. The sum of "Beds Needed" is deducted from a hospital's total number of licensed beds (excluding bassinets) to determine the number of excess or additional licensed beds that are required (Excess (-)/Deficit (+)).*
- 8. Individual hospital utilization and licensed bed data can be summed by the region in which hospitals are located to produce regional results. Statewide capacity is calculated using data from all 28 acute care hospitals.*

Chapter 3: Acute Care, Inpatient Bed Need

Acute Care Bed Need Methodology, Key Considerations

1. Summary data now shown for Connecticut Planning Regions (replacing county-level analyses); CON applications also use “primary service areas”
2. Use of historical data (FY 2020-2022) to project future needs
3. Use of population growth to further refine future need estimates
4. Assumptions for fungibility of beds by service line (only total licensed beds per facility is known)
5. Use of “target occupancy” rates to set capacity needs

Chapter 3: Acute Care, Inpatient Bed Need

Acute Care Bed Need Methodology, Key Considerations

6. 2012 “Additional considerations”, not currently included

OTHER FACTORS FOR CONSIDERATION

The office may also take the following criteria into consideration during its review of an application:

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

Chapter 3: Acute Care, Inpatient Bed Need

County	Services	FY 2020 patient days	FY 2021 patient days	FY 2022 patient days	FY 2020 ADC	FY 2021 ADC	FY 2022 ADC	Weighted ADC	Metropolitan Pop chg 2020 to 2030	Projected ADC	Target Occupancy	Beds Needed 2030	Licensed Beds	Excess (-) or Deficit (+)
Metropolitan Region	Medical/Surgical													
	0-14	1,153	1,892	1,058	3.2	5.2	2.9	3.7	1.01	3.7	0.80	5		
	15 - 44	19,741	21,643	20,993	54.1	59.3	57.5	57.5	1.03	59.1	0.80	74		
	45 - 64	53,737	60,272	58,847	147.2	165.1	161.2	160.2	0.94	150.2	0.80	188		
	65+	112,465	124,467	131,172	308.1	341.0	359.4	344.7	1.09	374.7	0.80	468		
	Subtotal	187,096	208,274	212,070	512.6	570.6	581.0	566.1		587.7		735		
	Maternity													
	0-14	2	7	12	0.0	0.0	0.0	0.0	1.01	0.0	0.50	0		
	15 - 44	16,295	16,929	19,024	44.6	46.4	52.1	49.0	1.03	50.3	0.50	101		
	45 - 64	123	138	152	0.3	0.4	0.4	0.4	0.94	0.4	0.50	1		
	65+	0	0	1	0.0	0.0	0.0	0.0	1.09	0.0	0.50	0		
	Subtotal	16,420	17,074	19,189	45.0	46.8	52.6	49.4		50.7		101		
	Psychiatric													
	0-14	1,597	1,825	1,993	4.4	5.0	5.5	5.1	1.01	5.2	0.80	6		
	15 - 44	19,778	22,041	20,684	54.2	60.4	56.7	57.5	1.03	59.1	0.80	74		
	45 - 64	10,292	11,686	11,836	28.2	32.0	32.4	31.6	0.94	29.6	0.80	37		
	65+	9,387	6,917	6,990	25.7	19.0	19.2	20.2	1.09	21.9	0.80	27		
	Subtotal	41,054	42,469	41,503	112.5	116.4	113.7	114.4		115.8		145		
	Rehabilitation													
	0-14	0	0	0	0.0	0.0	0.0	-	1.01	0.0	0.80	0		
	15 - 44	305	237	294	0.8	0.6	0.8	0.8	1.03	0.8	0.80	1		
	45 - 64	1,614	1,280	1,277	4.4	3.5	3.5	3.7	0.94	3.4	0.80	4		
	65+	6,003	6,440	6,677	16.4	17.6	18.3	17.8	1.09	19.3	0.80	24		
	Subtotal	7,922	7,957	8,248	21.7	21.8	22.6	22.2		23.5		29		
	Pediatric													
	0-19	900	1,094	1,086	2.5	3.0	3.0	2.9	0.98	2.9	0.80	4		
	20+	0	0	0	0.0	0.0	0.0	-	1.02	0.0	0.80	0		
	Subtotal	900	1,094	1,086	2.5	3.0	3.0	2.9		2.9		4		
	Total	253,392	276,868	282,096	694	759	773	755.0		780.5		1014	1,151	-137

Sources: CT OHS Hospital Discharge Database and CT State Data Center Population Projections; Note: Patient Days, ADC, and Acute Beds exclude newborn care and bassinets.

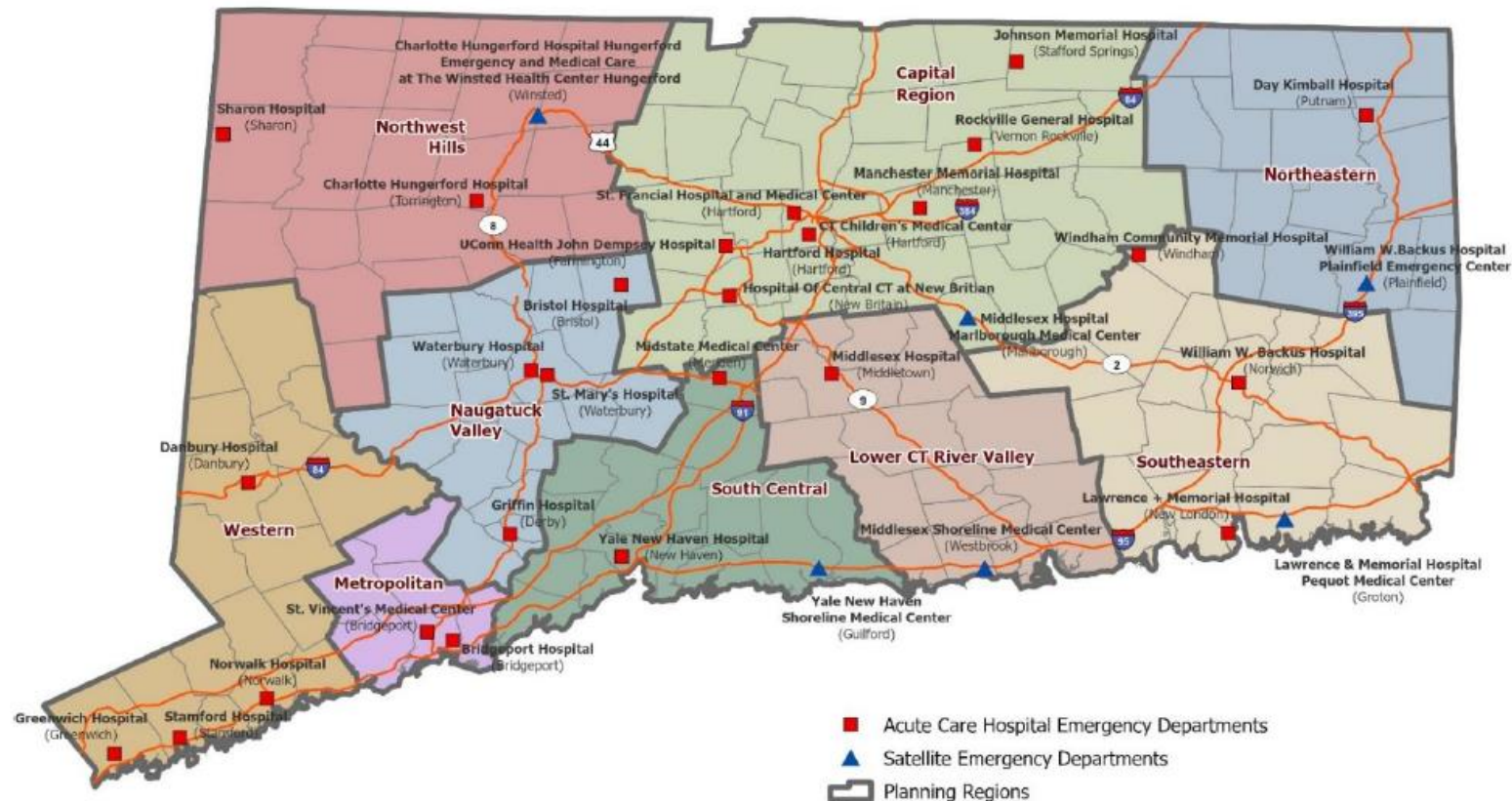
Chapter 3: Acute Care, Inpatient Bed Need

Feedback from Health Care Cabinet

1. Appropriateness of current bed need approach
2. Assumptions of fungible bed types and “target occupancies”
3. Modifications to data analyses or calculations
4. Additional considerations that should be added/subtracted from FSP

Chapter 3: Acute Care, Emergency Departments

Figure 3.2 Acute Care Hospital and Satellite Emergency Departments



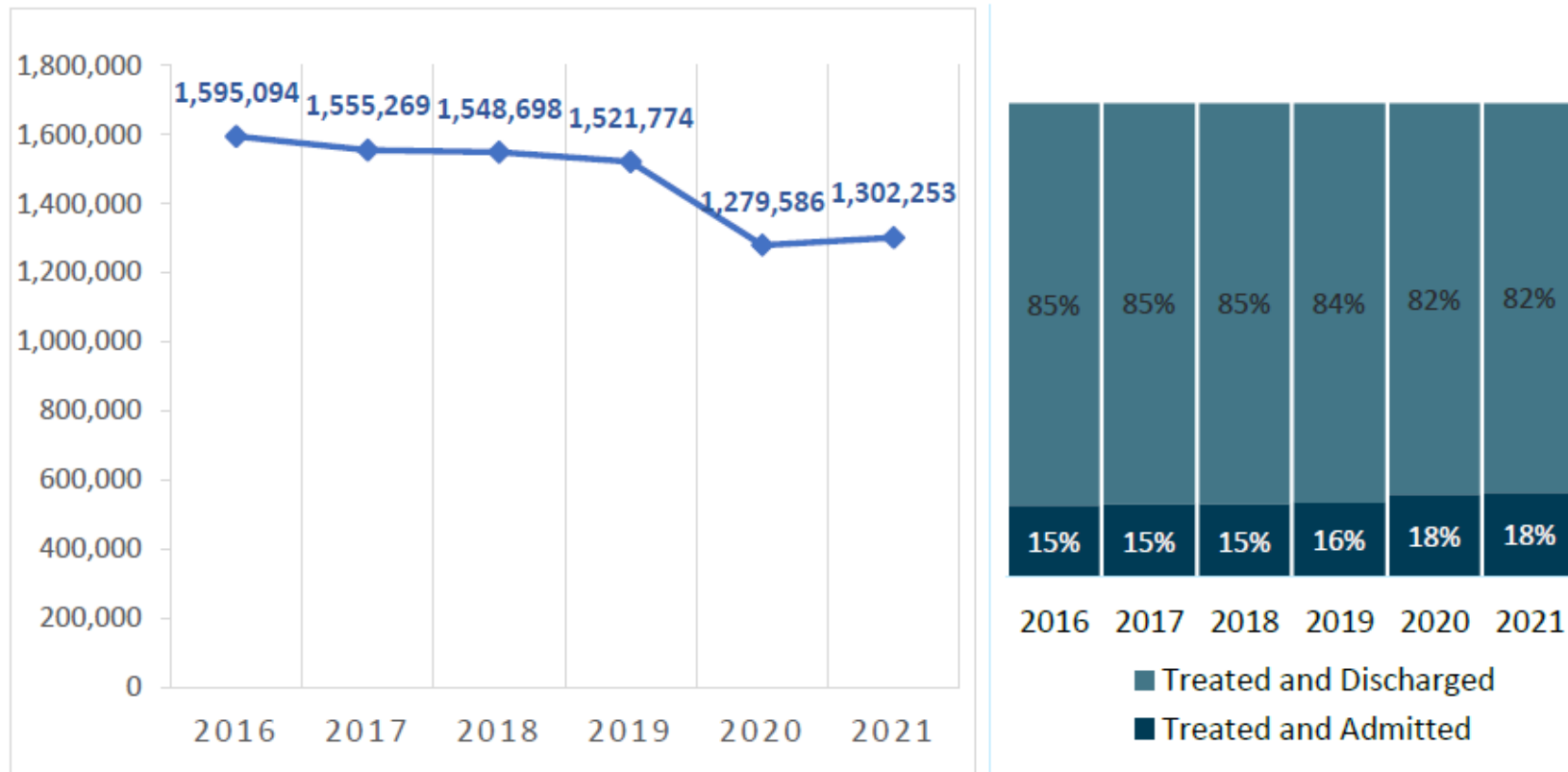
Chapter 3: Acute Care, Emergency Departments

Table 3.20 Connecticut Trauma Centers

Connecticut Designated Trauma Centers	City	Level
Bridgeport Hospital	Bridgeport	Level II (Adult)
Connecticut Children's Medical Center	Hartford	Level I (Pediatric)
Danbury Hospital	Danbury	Level II (Adult)
Hartford Hospital	Hartford	Level I (Adult)
Norwalk Hospital	Norwalk	Level II (Adult)
Saint Francis Hospital	Hartford	Level I (Adult)
Saint Mary's Hospital	Waterbury	Level II (Adult)
St. Vincent's Medical Center	Bridgeport	Level II (Adult)
Stamford Hospital	Stamford	Level II (Adult)
The Hospital of Central Connecticut	New Britain	Level III (Adult)
Waterbury Hospital	Waterbury	Level II (Adult)
William W. Backus Hospital	Norwich	Level III (Adult)
Yale-New Haven Hospital	New Haven	Level I (Adult and Pediatric)

Chapter 3: Acute Care, Emergency Departments

Figure 3.3 Statewide ED Visits, 2016 to 2021



Chapter 3: Acute Care, Emergency Departments

Table 3.19 ED Department Volume and Average Wait Times, 2022

Planning Region and Hospitals	ED Volume*	% Left Before Being Seen	Median Time before Leaving (minutes)	Median Time before Leaving (Psychiatric Patients) (minutes)
Capitol			213	294
Hartford Hospital	Very High	1%		
John Dempsey Hospital	High	1%		
Johnson Memorial Hospital	Low	1%		
Manchester Memorial Hospital	Medium	6%		
Rockville General Hospital	Low	2%		
St Francis Hospital & Medical Center	Very High	4%		
The Hospital of Central Connecticut	Very High	2%		
Lower CT River Valley			162	n/a
Middlesex Hospital	Very High	1%		
Metropolitan			166	174
Bridgeport Hospital	Very High	3%		
St Vincent's Medical Center	Very High	2%		
Naugatuck Valley			211	354
Bristol Hospital	Medium	1%		
Griffin Hospital	Medium	4%		
Saint Mary's Hospital	High	3%		
Waterbury Hospital	High	8%		

Chapter 3: Acute Care, Emergency Departments

3.3.3 Emergency Department Planning

The American College of Emergency Physicians (ACEP) Policy Statement (April 2021) on ED planning and resource guidelines²⁰⁸ is a useful resource for services in hospital-based or free-standing EDs that are open 24 hours a day. OHS encourages adherence to the ACEP Policy Statement. It states that:

- Access to emergency medical and nursing care should be unrestricted and available to all members of the public.
- EDs must have adequate resources to accommodate the evaluation, management, treatment, and disposition of all patients presenting at an ED in an appropriate and expedient manner.
- EDs should maintain appropriate levels of qualified staff, 24 hours a day, due to the unscheduled and episodic nature of health emergencies and acute illnesses. ED personnel, led by an emergency physician, must establish effective working relationships with emergency medical services (EMS) professionals, ancillary hospital staff, physicians, and other health care and social service resources to ensure the continuity of ED patient care.
- Effective policies and plans should be in place to ensure that administration, staffing, design of facility, equipment, medication and all other ancillary services are sufficiently addressed and cohesively work together to provide quality health care for patients experiencing serious health emergencies and for those with non-emergent health needs

Chapter 3: Acute Care, Emergency Departments

Feedback from Health Care Cabinet

1. Appropriateness of use of current ACEP Policy Statement (April 2021)
 - ☐ “OHS encourages adherence to the ACEP Policy Statement”
2. Inclusion of Emergency Department wait times analyses
3. Modifications to data analyses or calculations
4. Additional considerations that should be added/subtracted from FSP

Chapter 3: Acute Care, Cardiac Services

3.4.1 Relationship to Certificate of Need

CGS Section 19a-638(a)(9) specifies that a CON is required for the establishment of cardiac services, including inpatient and outpatient cardiac catheterization, interventional cardiology and cardiovascular surgery. Connecticut hospitals seeking authorization to establish a cardiac program are required to demonstrate that they meet clear public need as well as other criteria set forth in CGS Section 19a-639.

Table 3.21 Adult Cardiac Services in Connecticut

	Cardiac Angioplasty - Inpatient (Primary)	Cardiac Angioplasty - Outpatient (Elective)	Diagnostic Cardiac Catheterization - Inpatient and Outpatient	Open Heart Surgery
William W. Backus			X	
Bridgeport	X	X	X	X
Danbury	X	X	X	X
Dempsey	X	X	X	X
Greenwich	X	X	X	
Hartford	X	X	X	X
Hospital of Central Connecticut	X		X	
Lawrence & Memorial	X	X	X	
Middlesex			X	
Norwalk	X		X	
St. Francis	X	X	X	X
St. Mary's	X	X	X	X
St. Vincent's	X	X	X	X
Stamford	X	X	X	X
Waterbury	X	X	X	X
Yale New-Haven	X	X	X	X

Chapter 3: Acute Care, Cardiac Services

Table 3.22, Cardiac Inpatient Discharges, FY 2016 - 2021

Service Line	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	Change '16-'21
Cardiac Care (Medical)	31,302	32,271	32,972	33,539	29,625	30,807	-2%
Cardiac Care (Surgical)	13,157	13,075	13,315	13,619	11,856	12,596	-4%

Source: CT OHS Hospital Discharge Database

Table 3.24 Cardiac Inpatient Discharges, by Region and Race/Ethnicity, 2021

	Discharges Rate, per 1,000, Cardiac Care (Medical)					Discharges Rate, per 1,000, Cardiac Care (Surgical)			
	Hispanic/Latine	NH Black or African American	NH White	Other Races		Hispanic/Latine	NH Black or African American	NH White	Other Races
Capitol									
Greater Bridgeport	6.0	9.7	8.7	4.0		1.8	2.3	3.8	2.5
Lower CT River Valley	5.8	17.4	7.0	2.4		2.4	4.5	3.1	1.4
Naugatuck Valley	2.0	13.0	8.4	7.6		1.3	3.9	4.2	3.6
Northeast CT	4.8	9.2	12.1	3.4		1.7	2.0	5.2	1.6
Northwest Hills	0.9	6.4	10.0	5.9		0.4	2.8	3.5	2.1
South Central	1.4	2.6	8.8	5.1		0.6	0.2	4.1	3.2
Southeastern CT	4.7	15.0	10.3	3.6		2.0	4.0	4.7	2.1
Western CT	5.9	14.0	10.2	4.6		2.1	3.2	3.9	3.2

Chapter 3: Acute Care, Cardiac Services

Cardiac Services, Key Considerations

1. Major topics of consideration in the 2012 Plan
 - A. Percutaneous Coronary Intervention (PCI) / Coronary Angioplasty (PCA) in locations without surgical backup

In 2011, the American College of Cardiology Foundation/American Heart Association/Society for Cardiovascular Angiography and Interventions (ACCF/AHA/SCAI) Practice Guideline for Percutaneous Coronary Intervention without on-site surgical backup was modified from a class III (not recommended, no benefit) to a class IIb (benefit is either equal to or greater than the risk) recommendation. In 2023, the SCAI expert consensus statement on Percutaneous Coronary Intervention without on-site surgical (SOS) backup surfaced updated research and data, documenting greater volume of PCIs in settings without surgical backup with few complications and similar outcomes to those performed in settings with surgical backup:

Chapter 3: Acute Care, Cardiac Services

Cardiac Services, Key Considerations

1. Major topics of consideration in the 2012 Plan
 - B. Minimum volumes and “ideal” volumes for those providing these services

Replacement of 2011 American College of Cardiology Foundation/American Heart Association/Society for Cardiovascular Angiography and Interventions (ACCF/AHA/SCAI) Practice Guideline for Percutaneous Coronary Intervention with:

An updated 2021 ACC/AHA/SCAI clinical practice guidelines

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2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

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Chapter 3: Acute Care, Cardiac Services

Cardiac Services, Key Considerations

2. Primary Documents referenced in proposed 2024 language:
 - A. 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization
 - B. 2023 SCAI Expert Consensus Statement on Percutaneous Coronary Intervention Without On-Site Surgical Backup
 - C. 2017 ACC/AATS/AHA/ASE/ASNC/SCAI/SCCT/STS Appropriate Use Criteria for Coronary Revascularization in Patients with Stable Ischemic Heart Disease
 - D. 1996 Guidelines for Standards in Cardiac Surgery developed by the Advisory Council for Cardiothoracic Surgery and approved by the American College of Surgeons' Board of Regents in October 1996 – Bulletin of the American College of Surgeons

Chapter 3: Acute Care, Cardiac Services

Cardiac Services, CON Standards and Guidelines

Percutaneous Coronary Intervention (PCI)

In establishing new cardiac services conducting PCI procedures, applicants must show that they will follow up-to-date guidelines for providing cardiac care, based on professional society clinical practice guidelines. Specifically, at the time publication of the Plan, this includes:

(A) the 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization and the following recommendations:

- (i) a commitment to making treatment decisions regarding coronary revascularization in patients with coronary artery disease based on clinical indications, regardless of sex, race, or ethnicity,
- (ii) use of a multidisciplinary Heart Team approach and patient shared decision-making when patients are being considered for coronary revascularization and the optimal treatment strategy is unclear,
- (iii) consideration of disease complexity, technical feasibility of treatment, and a Heart Team discussion in patients with stable ischemic heart disease,

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Percutaneous Coronary Intervention (PCI)

In establishing new cardiac services conducting PCI procedures, applicants must show that they will follow up-to-date guidelines for providing cardiac care, based on professional society clinical practice guidelines. Specifically, at the time publication of the Plan, this includes:

- (v) participation in clinical data registries with the intent to review and continuously improve patient outcomes and comparison of outcomes through the use of national databases allows individual- and program-level assessment of the care provided and the opportunity to enhance care with quality improvement initiatives,
- (vi) for smaller-volume coronary revascularization programs, affiliation and collaboration with larger volume programs,
- (vii) tracking of quality and performance measures defined by attributes related to structure, processes, and risk-adjusted outcomes,
- (vii) and the numerous clinical guidelines for specific PCI indications, procedures, and approaches

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Cardiac Services, CON Standards and Guidelines

Percutaneous Coronary Intervention (PCI)

In establishing new cardiac services conducting PCI procedures, applicants must show that they will follow up-to-date guidelines for providing cardiac care, based on professional society clinical practice guidelines. Specifically, at the time publication of the Plan, this includes:

(B) the 2017 ACC/AATS/AHA/ASE/ASNC/SCAI/SCCT/STS Appropriate Use Criteria for Coronary Revascularization in Patients with Stable Ischemic Heart Disease

(C) the 2023 SCAI Expert Consensus Statement on Percutaneous Coronary Intervention Without On-Site Surgical Backup and the following guidelines and requirements for conducting PCI at non-on-site surgical backup locations including:

- (i) equipment and supplies
- (ii) transfer agreements
- (iii) quality assurances
- (iv) informed consent
- (v) operator requirements
- (vi) staffing requirements
- (vii) surgical consultation
- (viii) case selection and management

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Furthermore, in establishing new cardiac conducting PCI procedures applicants must additionally show the following:

- (A) a clear public need and potential public benefit of the establishment of new cardiac services, potentially through identifying that Connecticut residents within the proposed Primary Service Area have insufficient access to PCI services, are receiving suboptimal therapy for STEMI, or via demonstrating need and potential benefit for a particular patient population.
- (B) any entity providing primary PCI services must show it will be available 24 hours per day, seven days per week and have adequate staff to staff the cardiac catheterization laboratory and coronary care unit at all times.
- (C) any entity providing primary PCI services must commit to providing PCI services as soon as possible.
- (D) a hospital shall complete a PCI development plan that includes appropriate training for the emergency room, catheterization laboratory, coronary care unit and, if applicable, post-procedure unit.

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- (E) a hospital performing primary PCI without on-site cardiac surgery shall have a formal, written agreement with a tertiary institution that provides for unconditional transfer of the hospital's patients for any required additional care, including emergent or elective cardiac surgery or PCI.
- (F) and a hospital that performs primary PCI without on-site cardiac surgery shall maintain a formal written agreement with a licensed specialty care ambulance service that, when clinically necessary, guarantees arrival of the air or ground ambulance within 30 minutes of a request for patient transport by the hospital.

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1. Guidelines for Standards in Cardiac Surgery developed by the Advisory Council for Cardiothoracic Surgery and approved by the American College of Surgeons' Board of Regents in October 1996 – Bulletin of the American College of Surgeons, Vol. 82, No. 2, February 1997:

- a) An annual volume of at least 100 to 125 open heart procedures per hospital is necessary from a quality standpoint and there is a greater variation in adjusted mortality rates for teams doing lower volumes as compared with those doing a high volume.
- b) At least 200 procedures per year are necessary in order for a program to function efficiently.
- c) A team approach with a minimum of two qualified cardiac surgeons is recommended to provide adequate and continuous perioperative care as well as assistance in the OR.

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2. The following conditions must be met to initiate a new OHS program:
 - a) The annual caseload of other programs w/in the proposed PSA shall not drop below 350 procedures.
 - b) Epidemiological evidence of conditions for which OHS is appropriate w/in the PSA or demonstrates a significant unmet need in the PSA for these procedures.
 - c) Existing program(s) in the service area are performing at least 350 open heart surgeries annually.
 - d) Evidence demonstrating the performance of a minimum of 200 open heart surgeries annually within the first three years of the start of the new Open Heart Surgery program

Other Factors for Consideration

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

Chapter 3: Acute Care, Cardiac Services

Feedback from Health Care Cabinet

1. Appropriateness of replacement of current reference documents
2. Revised focus, away from PCI without surgical backup, based on new evidence
3. Revised focus, on the 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization
4. Revised focus, on the 2017 ACC/AATS/AHA/ASE/ASNC/SCAI/SCCT/STS Appropriate Use Criteria for Coronary Revascularization in Patients with Stable Ischemic Heart Disease
5. Additional considerations that should be added/subtracted from FSP

Chapter 4: Outpatient Surgery Facilities

Table 4.3 Surgeries Most Commonly Performed in Outpatient Settings by Type of Outpatient Setting, 2016 to 2021

Procedure Category	Category	2016	2017	2018	2019	2020	2021	Change
Colonoscopy and Biopsy	Total Surgeries	90,298	93,378	94,272	100,113	64,084	87,450	-2,848
	Non-Hospital OSF	47%	47%	48%	51%	54%	55%	8%
	HOPD	53%	53%	52%	49%	46%	45%	-8%
Upper Gastrointestinal Endoscopy, Biopsy	Total Surgeries	65,335	65,993	66,689	68,207	45,801	59,265	-6,070
	Non-Hospital OSF	44%	44%	45%	48%	50%	51%	7%
	HOPD	56%	56%	55%	52%	50%	49%	-7%
Suture of Skin and Subcutaneous Tissue	Total Surgeries	61,131	64,073	63,725	64,992	44,154	50,524	-
	Non-Hospital OSF	41%	39%	41%	45%	39%	42%	1%
	HOPD	59%	61%	59%	55%	61%	58%	-1%
Excision of Skin Lesion	Total Surgeries	52,998	51,037	51,344	51,749	27,830	34,811	-
	Non-Hospital OSF	76%	76%	77%	83%	83%	84%	8%
	HOPD	24%	24%	23%	17%	17%	16%	-8%
Lens and Cataract Procedures	Total Surgeries	44,559	43,893	45,532	47,546	22,885	30,155	-
	Non-Hospital OSF	59%	61%	65%	68%	74%	77%	18%
	HOPD	41%	39%	35%	32%	26%	23%	-18%
Debridement of Wound, Infection or Burn	Total Surgeries	36,263	40,169	41,391	42,956	23,690	26,922	-9,341
	Non-Hospital OSF	49%	46%	48%	46%	48%	45%	-4%
	HOPD	51%	54%	52%	54%	52%	55%	4%

Chapter 4: Outpatient Surgery Facilities

Table 4.4 Surgeries Most Commonly Performed in Outpatient Settings by Type of Outpatient Setting and Planning Region, 2016 to 2021

Planning Region	Category	2016	2017	2018	2019	2020	2021	Change
Capitol Planning Region	Total Surgeries	124,346	130,139	132,842	135,528	89,325	112,028	-12,318
	Non-Hospital OSF	62%	64%	66%	66%	68%	71%	8%
	HOPD	38%	36%	34%	34%	32%	29%	-8%
Greater Bridgeport Planning Region	Total Surgeries	49,508	50,256	52,754	52,665	31,608	39,999	-9,509
	Non-Hospital OSF	66%	65%	67%	67%	66%	65%	-1%
	HOPD	34%	35%	33%	33%	34%	35%	1%
Lower Connecticut River Valley Planning Region	Total Surgeries	19,038	20,066	20,032	23,023	16,531	19,282	244
	Non-Hospital OSF	71%	70%	69%	74%	76%	76%	5%
	HOPD	29%	30%	31%	26%	24%	24%	-5%
Naugatuck Valley Planning Region	Total Surgeries	50,207	52,184	52,589	54,314	36,735	42,885	-7,322
	Non-Hospital OSF	58%	59%	59%	58%	57%	55%	-3%
	HOPD	42%	41%	41%	42%	43%	45%	3%
Northeastern Connecticut Planning Region	Total Surgeries	5,622	5,671	5,737	5,793	3,937	4,644	-978
	Non-Hospital OSF	57%	49%	49%	49%	50%	49%	-7%
	HOPD	43%	51%	51%	51%	50%	51%	7%

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Insurance Coverage	Category	2016	2017	2018	2019	2020	2021	Change
Commercial	Total Surgeries	172,387	179,121	167,098	164,081	139,374	182,096	9,709
	Non-Hospital OSF	65%	66%	67%	69%	70%	70%	6%
	HOPD	35%	34%	33%	31%	30%	30%	-6%
Medicare	Total Surgeries	277,804	272,712	287,483	299,714	114,517	138,881	-138,923
	Non-Hospital OSF	59%	59%	60%	63%	66%	66%	7%
	HOPD	41%	41%	40%	37%	34%	34%	-7%
Medicaid	Total Surgeries	119,059	127,921	129,075	132,869	124,286	144,222	25,163
	Non-Hospital OSF	46%	45%	46%	47%	49%	48%	2%
	HOPD	54%	55%	54%	53%	51%	52%	-2%

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Outpatient Surgery Facilities, CON Standards and Guidelines

4.6.1 Definitions

2. Nothing in this subsection shall be construed to affect any obligation to comply with the provisions of Section 19a-691, CGS, concerning anesthesia accreditation or Section 19-13-D56 of the Public Health Code concerning licensing of outpatient surgical facilities operated by corporations.
3. “Primary Service area” for an OSF is the area where approximately 75% of the facility’s patients reside. Service area may be towns, zip codes, or other U.S. Census geographical type.
4. “Maximum Capacity” is the number of surgical cases that may be performed in a year based on Monday through Friday, eight hours per day, and 250 days per year. It is the responsibility of the Applicant to provide sufficient documentation to establish the length of time the average case requires and the time required for cleanup.

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Outpatient Surgery Facilities, CON Standards and Guidelines

4.6.2 Standards and Guidelines

The following guidelines and/or standards for the establishment of an OSF will be considered by OHCA when considering a Certificate of Need request:

1. When an Applicant proposes to establish a new multi-specialty OSF, the case volume of single-specialty OSFs dedicated solely and exclusively for endoscopy may be excluded from the existing; volumes when establishing need for the multi-specialty OSF as required by Sec. 19a-639 (3), CGS.
2. Unless otherwise established by the Applicant and supported with documentation:
 - The capacity of the proposed facility will be based on eight (8) hours per day, five (5) days per week fifty (50) weeks per year for a total of 2,000 hours per year;
 - The optimal utilization for an operating room in an OSF is 80%;
 - The average time for an outpatient case will be sixty (60) minutes; and
 - Thirty (30) minutes will be allocated to cleanup between cases;
3. Unstaffed operating rooms are considered as available and shall be included in any calculations for capacity and utilization;
4. Delivery rooms for Caesarean sections and operating rooms specifically reserved for cardiac cases shall be excluded from calculations for capacity and utilization;

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5. Proposed new OSFs must have written policies concerning access to care by persons who are underinsured or uninsured;
6. The Applicant must demonstrate the financial feasibility of the OSF within the first three (3) years of operations or within a reasonable time based on factors reported and supported by the Applicant;
7. The proposed new OSF will have in place at start of operations a transfer agreement with an acute care general hospital;
8. The Applicant must have in place at the start of operations a quality Assessment and Performance Improvement Program and be certified by Medicare or a national accrediting body for which CMS grants status to accredit ambulatory surgery centers;
9. The applicant must have in place at the start of operations a contract with a patient safety organization as defined at CGS § 19a-127o.

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Outpatient Surgery Facilities, CON Standards and Guidelines

4.6.3 Other factors for consideration

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

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

Chapter 4: Outpatient Surgery Facilities

Feedback from Health Care Cabinet

1. Appropriateness of current facility capacity estimates and geographic calculations
2. Modifications to data analyses or calculations
3. Additional considerations that should be added/subtracted from FSP

Chapter 5: Imaging and New Technology

Table 5.1 CT, MRI, and PET-CT Average Scans per Machine (2022)

	Number of Machines	Average Scans per Machine	Median Scans per Machine	75th Percentile Scans per Machine	Max Scans per Machine
Hospital-Based CT Scanners	60	12,437	12,494	16,882	31,659
Hospital-Owned CT Scanners (Satellite)	34	6,456	5,042	8,943	19,893
Non-Hospital CT Scanners (Satellite)	43	2,729	2,766	3,942	7,041
Hospital-Based MRI Scanners	44	4,149	4,114	4,804	14,753
Hospital-Owned MRI Scanners (Satellite)	32	2,877	3,071	4,076	5,401
Non-Hospital MRI Scanners (Satellite)	59	2,994	3,141	4,396	5,409
Hospital-Based PET-CT Scanners	15	1,614	721	2,224	5,199
Hospital-Owned PET-CT Scanners (Satellite)	7	833	865	1,035	1,190
Non-Hospital PET-CT Scanners (Satellite)	3	708	354	1,021	1,688

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Data from **Table 5.1** are used to inform the development of updated total capacity thresholds for imaging machines operating in Connecticut. The prior 2012 Facility and Services Plan used thresholds as shown in **Table 5.2**; however, research has shown imaging efficiency (scans per minute) have generally increased over time,²⁵⁶ and an evaluation of Connecticut scanner results show many machines operate well above the expected number of scans per year thresholds. As a result, the 75th percentile value of the number of scans by imaging type and location are considered alongside data points from other state CON language in developing new thresholds for imaging, shown in the second column of **Table 5.2**.²⁵⁷

Chapter 5: Imaging and New Technology

Table 5.2 Proposed New Total Capacity Thresholds for Imaging Machines, by Type, Ownership, and Location

	Prior Capacity Threshold	Proposed New Threshold
Hospital-Based CT Scanners	12,000	16,000
Hospital-Owned CT Scanners (Satellite)	3,700	8,000
Non-Hospital CT Scanners (Satellite)	3,700	3,700
Hospital-Based MRI Scanners	4,000	5,000
Hospital-Owned MRI Scanners (Satellite)	4,000	4,000
Non-Hospital MRI Scanners (Satellite)	4,000	4,000
Hospital-Based PET-CT Scanners	700	2,000
Hospital-Owned PET-CT Scanners (Satellite)	700	1,000
Non-Hospital PET-CT Scanners (Satellite)	700	1,000

Source: Prior thresholds cited from the 2012 version of the Plan, while new thresholds proposed based on data and insights above.

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Table 5.3 MRI Scanner Counts and Utilization, by Region (Scanner Location), 2022

	MRI Scanners	Estimated Total Capacity	Region Percent Utilization	Population (2020)	Scans per 1,000 Pop.
Capitol	42	184,000	72%	994,214	132
Greater Bridgeport (Metropolitan)	8	34,000	98%	318,379	105
Lower Connecticut River Valley	6	25,000	68%	176,940	96
Naugatuck Valley	16	67,000	61%	451,413	91
Northeast Connecticut	2	9,000	44%	100,086	40
Northwest Hills	2	10,000	89%	114,482	77
South Central	24	105,000	98%	575,652	179
Southeastern Connecticut	9	40,000	107%	294,356	145
Western Connecticut	26	110,000	63%	579,083	120

Sources: OHS 2022 Inventory data and Connecticut Population Data, Connecticut State Data Center

Chapter 5: Imaging and New Technology

Table 5.4 CT Scanner Counts and Utilization, by Region (Scanner Location), 2022

	Number of CT Scanners	Estimated Total Capacity	Region Percent Utilization	Population (2020)	Scans per 1,000 Pop.
Capitol	44	459,200	70%	994,214	322
Greater Bridgeport (Metropolitan)	8	83,100	120%	318,379	313
Lower Connecticut River Valley	4	40,000	63%	176,940	142
Naugatuck Valley	19	173,600	62%	451,413	238
Northeast Connecticut	2	24,000	88%	100,086	211
Northwest Hills	3	40,000	59%	114,482	204
South Central	25	229,000	100%	575,652	399
Southeastern Connecticut	9	107,700	82%	294,356	300
Western Connecticut	23	234,500	72%	579,083	290

Sources: OHS 2022 Inventory data and Connecticut Population Data, Connecticut State Data Center

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Table 5.5 PET-CT Scanner Counts and Utilization, by Region (Scanner Location), 2022

	PET-CT Scanners	Estimated Total Capacity	Region Percent Utilization	Population	Scans per 1,000 Pop.
Capitol	6	10,000	74%	994,214	7.4
Greater Bridgeport (Metropolitan)	3	4,000	49%	318,379	6.1
Lower Connecticut River Valley	1	1,000	60%	176,940	3.4
Naugatuck Valley	4	6,000	41%	451,413	5.5
Northeast Connecticut	1	1,000	14%	100,086	1.4
Northwest Hills	1	1,000	296%	114,482	25.9
South Central	4	4,000	304%	575,652	21.1
Southeastern Connecticut	2	3,000	75%	294,356	7.6
Western Connecticut	3	2,000	115%	579,083	4.0

Sources: OHS 2022 Inventory data and Connecticut Population Data, Connecticut State Data Center

Chapter 5: Imaging and New Technology

Table 5.7 CT Population Utilization, by Primary Insurance Coverage and Region (Patient's location), 2021

CT Planning Region	Rate per 1,000		
	Medicaid	Medicare	Private
Capitol Planning Region	289	780	173
Greater Bridgeport Planning Region	237	803	172
Lower Connecticut River Valley Planning Region	310	866	205
Naugatuck Valley Planning Region	294	825	201
Northeastern Connecticut Planning Region	337	930	231
Northwest Hills Planning Region	272	719	194
South Central Connecticut Planning Region	303	847	194
Southeastern Connecticut Planning Region	345	1004	232
Western Connecticut Planning Region	229	773	169

Source: CT APCD Analyses

Chapter 5: Imaging and New Technology

Imaging, CON Standards and Guidelines

5.5.2 MRI Scanners Standards and Guidelines

1. Information Supporting Need Analysis

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

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2. Need Analysis – Statewide Benchmark

- a. “Utilization Rate per Capita” means the number of scans/1,000 population as determined by data collected and published by the Office of Health Strategy through its data collection and survey processes. If such data is not available from the Office, the applicant is responsible for including reliable statistics, with citations, to establish the utilization rate.
- b. “Utilization Rate” means procedure per year for the PSA calculated by multiplying the Utilization Rate per Capita by the population in the PSA using the most recently available census data.
- c. “Current Estimated Capacity” means 5,000 scans/year multiplied by the number of hospital-based scanners in the PSA at the time of the application and 4,000 scans/year multiplied by the number of non-hospital-based scanners in the PSA at the time of the application.

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d. “Percent Utilization of Current Capacity” means the “Utilization Rate/Current Estimated Capacity.” For current estimated capacity to remain in effect, it must be updated and such update published by OHS not less than every two years based on the Statewide Facilities and Services Plan. If the Office does not publish an update, the applicant may present reliable capacity estimates for consideration by OHS to establish the capacity.

3. Need Methodology

The Applicant shall demonstrate that the proposed scanner will be located in a Primary Service Area where the Percent Utilization of Current Capacity exceeds 85%.

If the applicant is unable to demonstrate a clear public need for the proposed scanner based upon the assumptions and need methodology in subsection (3)(a) and the requirements of subsection (3)(b) have been met, the Applicant may rely upon any other relevant factors, including those described in subsection 6, to demonstrate need among the population it intends to serve.

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4. Quality and Accessibility

The Applicant shall demonstrate that the proposal meets the following criteria:

- a. Hospital applicants shall be accredited by the Joint Commission on Accreditation of Healthcare Organizations or certified by Medicare directly or through a deeming agency.
- b. Non-hospital facilities shall obtain accreditation from the American College of Radiology within eighteen months of the date on which imaging activities are first conducted.
- c. A full-time board certified radiologist, who is a member in good standing with the American College of Radiology, shall be responsible for managing the operation of the MRI scanner and for the written interpretation of the MRI scan.
- d. Personnel shall be trained, consistent with guidance of the American College of Radiology, in the use of the MRI scanner and the safety procedures to follow in the event of an emergency.
- e. When imaging is performed a physician must be available either on-site or with immediate access to remote viewing of images as they are acquired. The physician in this case must be qualified to interpret images, make adjustments to imaging parameters or protocols, make decisions regarding magnetic field strength risks, and consult with the technologists on technical factors related to the study acquisition. This physician must be board certified to perform and interpret the examinations so produced.

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6. Other Factors for Consideration

The office may also take the following criteria into consideration during its review of an application:

- a. The capabilities of the proposed MRI scanner as compared to existing scanners.
- b. The ability of the applicant to serve an underserved population and not jeopardize the financial viability of the project.
- c. The impact on existing services, including avoiding delays in timely diagnosis or treatment.
- d. The use of the scanner for clinical research.
- e. The history of the applicant in running accredited, financially successful facilities.
- f. The applicant's current percent utilization of any of its own MRI scanners operating within the Primary Service Area of the proposed scanner.
- g. The applicant's ability to make radiation dose exposure decisions.

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6. Other Factors for Consideration

The office may also take the following criteria into consideration during its review of an application:

- a. The capabilities of the proposed MRI scanner as compared to existing scanners.
- b. The ability of the applicant to serve an underserved population and not jeopardize the financial viability of the project.
- c. The impact on existing services, including avoiding delays in timely diagnosis or treatment.
- d. The use of the scanner for clinical research.
- e. The history of the applicant in running accredited, financially successful facilities.
- f. The applicant's current percent utilization of any of its own MRI scanners operating within the Primary Service Area of the proposed scanner.
- g. The applicant's ability to make radiation dose exposure decisions.



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- Prior FSP Language:

3. Need Methodology

The Applicant shall demonstrate that the proposed scanner meets either of the following criteria:

- a. The applicant is generally expected to demonstrate that the Percent Utilization of Current Capacity in the Primary Service Area exceeds 85%.
- b. If the applicant has a CT scanner in the Primary Service Area, the applicant is expected demonstrate that its Percent Utilization of Current Capacity exceeds 85%.

If the applicant is unable to demonstrate a clear public need for the proposed scanner based upon the assumptions and need methodology in subsection 3(a) and subsection 3(b) have been met, the Applicant may rely upon any other relevant factors, including those described in subsection (7), to demonstrate need among the population it intends to serve.

- Proposed New Language:

f. The applicant's current percent utilization of any of its own MRI scanners operating within the Primary Service Area of the proposed scanner.

g. The applicant's ability to make radiation dose management decisions

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Feedback from Health Care Cabinet

1. Revisions to the estimated capacity per machine, updates and use of current utilization data 75th percentiles
2. Revisions to the estimated capacity per machine, separating machines based on location and ownership
3. Updates to new regional definitions (Planning Regions)
4. Revised consideration of “applicant’s current scanner utilization”
5. Modifications to data analyses or calculations
6. Additional considerations that should be added/subtracted from FSP

Next Steps for the 2024 FSP



1. Review and updates to FSP draft with OHS staff feedback
2. Presentation of current findings and proposed language via community conversations
3. Finalization of FSP draft
4. Development of Social, Economic, and Public Health Factors Addendum to current FSP

Other Questions?



Thank you!