OHS CONNECTICUT Office of Health Strategy

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Via Certified Mail, Email & CON Portal

February 5, 2024

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RE: Certificate of Need Application / Docket Number: 22-32511-CON
Vassar Health Connecticut, Inc. d/b/a Sharon Hospital
Termination of Inpatient Labor and Delivery Services
Final Decision

Dear Counsel:

In accordance with Connecticut General Statutes § 4-180, enclosed please find a copy of the Final Decision rendered in the above-referenced matter.

Sincerely,

Deidre S. Gifford, MD, MPH
Executive Director

cc: Limited Intervenors (c/o Paul Knag, Esq. & Julia Boisvert, Esq.)
W. Boyd Jackson, Esq.
Antony A. Casagrande, Esq.
Daniel J. Csuka, Esq.
Rosemary McGovern, Esq.
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Encl.

Final Decision

Applicant: **Vassar Health Connecticut, Inc. d/b/a Sharon Hospital**
50 Hospital Hill Road
Sharon, CT 06069

Docket Number: **22-32511-CON**

Project Title: **Termination of inpatient or outpatient services (inpatient labor and delivery services) by a hospital (Sharon Hospital)**

The undersigned, Executive Director Deidre S. Gifford, MD, MPH, for the Office of Health Strategy ("OHS"), hereby issues her final decision in Certificate of Need ("CON") Docket No. 22-32511-CON, in which Vassar Health Connecticut, Inc. d/b/a Sharon Hospital ("SH" or the "Applicant") seeks authorization to terminate inpatient labor and delivery services (the "Application"). This final decision is issued pursuant to Connecticut General Statutes ("C.G.S.") § 4-180.

I. Procedural History

The Applicant published notice of its intent to file a CON application in *The Register Citizen* (Torrington) on October 13, 14 and 15, 2021. On January 12, 2022, the Health Systems Planning unit ("HSP") of OHS received the CON application from the Applicant for the above-referenced project and deemed the application complete on May 11, 2022. Thereafter, OHS received a number of timely and sufficient requests for hearing,[1] thereby requiring that OHS hold a hearing in this matter.

On September 9, 2022, OHS issued a Notice of Hearing, which notified SH and the public of the date, time, and place of the hearing – October 18, 2022.[2] Also on September 9, 2022, Acting Executive Director Kimberly Martone designated Attorney Daniel J. Csuka, Esq. as the hearing officer.[3] On October 14, 2022, the October 18, 2022 hearing was continued.[4] On November 10, 2022, the hearing was re-noticed for a new date.[5] On November 18, 2022, the two (2) petitioners for status – Save Sharon Hospital, Inc. and Howard Mortman, M.D. – received designation as Limited Intervenors ("LI") in the proceeding.[6] Thereafter, the hearing regarding this matter was held on December 6, 2022. OHS convened the public hearing pursuant to C.G.S. § 19a-639a(e). The proceedings were conducted pursuant to the provisions of the Uniform Administrative

[1] Exhibits E – P
[2] Exhibits R, S and DD
[3] Exhibit T
[4] Exhibit GG
[5] Exhibit KK
[6] Exhibit MM

Procedure Act ("UAPA"; Chapter 54 of the General Statutes). Hearing Officer Csuka closed the hearing record on May 5, 2023.[7]

After receiving an extension on June 30, 2023,[8] on August 28, 2023, Hearing Officer Csuka issued a Proposed Final Decision (the "PFD").[9] On August 31, 2023, the Applicant filed a request for extension of time to October 18, 2023 to submit a brief and exceptions to the PFD, and also requested oral argument.[10] On September 8, 2023, OHS granted the Applicant's request for extension of time.[11] On September 29, 2023, OHS issued a Notice of Hearing before Executive Director Gifford, which scheduled a hearing on oral argument for November 8, 2023.[12] Thereafter, the Applicant timely filed a Brief in Opposition and Written Exceptions to the PFD on October 18, 2023.[13] The hearing proceeded as scheduled and OHS provided the Applicant with an opportunity to fully address any legal claims and exceptions to the PFD. Upon the close of the hearing, Executive Director Gifford took the matter under advisement.

In the PFD, Hearing Officer Csuka determined that the Applicant had failed to meet its burden of proof in satisfying the statutory requirements of C.G.S. § 19a-639. Specifically, he found that the Applicant had failed to satisfy the following criteria: (2) consistency with the Plan; (5) improvement of quality, access, and cost effectiveness of the Proposal; (6) no change in the provision of health care services to the relevant patient populations and payer mix; (10) good cause for reducing access to services by Medicaid recipients or indigent persons, and (11) no negative impact on the diversity of health care providers and patient choice. Based upon this, Hearing Officer Csuka recommended that the Application be denied.

In the Applicant's Brief and at oral argument, SH made a number of substantive arguments for why the PFD should not be adopted by OHS and why the Application should instead be granted. In very short, these arguments can be summarized as follows: (A) the PFD incorrectly concludes that closure of the L&D unit is not consistent with the Statewide Health Care Facilities and Services Plan; (B) the PFD incorrectly concludes that clear public need is not a relevant factor for terminations of services, and the evidence demonstrates a lack of need for the continued operation of the L&D unit; (C) the PFD incorrectly concludes that Nuvance Health's financial subsidization of SH is not relevant to the Application; (D) the PFD incorrectly concludes that the proposed termination will have an impact on quality of care, and that such impact will be negative; (E) the PFD applied an incorrect legal standard concerning accessibility in the context of a request to terminate a service, and incorrectly decides that the termination will have a negative impact on access; (F) the PFD incorrectly concludes that the continued operation of the L&D unit is cost effective; (G) the PFD misinterprets C.G.S. § 19a-639(a)(6) and then uses this to incorrectly conclude that closing SH's L&D unit will detrimentally impact access to the services for the relevant patient population and payer mix; (H) the PFD incorrectly concludes that closuring SH's L&D unit will disproportionately affect disadvantaged patients; (I) the PFD incorrectly concludes that temporary staffing of the unit is sustainable rather than concluding that

[7] Exhibit NNN
[8] Exhibit PPP
[9] Exhibit QQQ
[10] Exhibit RRR
[11] Exhibit SSS
[12] Exhibit TTT
[13] Exhibit UUU

it constitutes good cause for restricting access; (J) the PFD incorrectly concludes that the indefinite financial subsidization of the L&D unit operating losses is beneficial rather than concluding that it constitutes good cause for restricting access; and (K) the PFD incorrectly concludes that terminating the L&D unit adversely impacts health care provider diversity.

As permitted by the UAPA, and after review and consideration of the full record and applicable laws, the undersigned hereby adopts the PFD issued by Hearing Officer Csuka as the Final Decision in this matter, with the following revisions and amendments:

1. Finding of Fact ("FF") 20 was revised to more accurately reflect the data and timeline supplied in the cited record evidence.
2. FF 38 was revised to clarify that the payer mix was based on "amounts charged" rather than "charges."
3. FF 39 was revised to clarify that L&D payer mix was derived from discharge numbers rather than amounts charged.
4. FF 43 was revised to clarify that there were exactly 202 days, rather than approximately 202 days, where no obstetrical delivery occurred, and also to eliminate the unnecessary record citations.
5. FF 46 was revised to clarify that it is only referring to the number of individuals from SH's PSA who gave birth in Connecticut hospitals, rather than Connecticut and New York hospitals.
6. FF 59 was revised to correct the typographical error (i.e., "a L&D patient" vs. "an L&D patient").
7. FF 77 was revised to correct a typographical error (i.e., "the ability for perform" vs. "the ability to perform").
8. FF 98 and Discussion Section E were both revised to clarify that Medicaid reimbursement, rather than coverage alone, is the same regardless of the Connecticut hospital at which the patient chooses to deliver.
9. Discussion Sections D and J were revised by deleting "made approximately $75M" in order to more accurately reflect the record evidence and Nuvance Health's financial condition.
10. Discussion Section J was revised to more objectively describe the financial condition of Nuvance Health as it relates to SH.
11. The analysis set forth in Section F of the Discussion is deleted and revised to indicate that C.G.S. § 19a-639(a)(6) is not applicable.
12. The analysis set forth in Section I of the Discussion is deleted and revised to indicate that C.G.S. § 19a-639(a)(9) is not applicable.
13. The remainder of the Discussion, Conclusion and Order sections have been revised to reflect the inapplicability of C.G.S. §§ 19a-639(a)(6) and (a)(9).
14. Footnote 48 (previously 42 in the PFD)[14] was revised to change the internal page reference from 31 to 33.
15. Footnote 54 (previously 48 in the PFD) was revised to change the internal page references from 36 and 36 to 36 and 37, respectively.

[14] The addition of six (6) footnotes preceding the Findings of Fact section has resulted in the renumbering of the Proposed Final Decision footnotes.

The undersigned attests to having reviewed the record in its entirety.

II. Provisions of Law

As stated in the PFD, CON applications are decided on a case-by-case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board*, 309 Conn. 727 (2013).

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Findings of Fact

Introduction and Background[15]

1. SH is licensed by the Connecticut Department of Public Health ("DPH") to operate as a seventy-eight (78) bed and sixteen (16) bassinet acute care general hospital with a campus located at 50 Hospital Hill Road, Sharon, Connecticut ("CT" or the "State") 06069. Ex. A – Application, pp. 13, 91-92[16]

2. SH is part of Nuvance Health ("Nuvance"), an integrated health care system that offers inpatient and outpatient hospital care, ambulatory care, and post-acute care across its multidisciplinary network of hospitals. SH provides these services, which include L&D, to the residents of the western parts of Litchfield County in Connecticut, as well as the northeastern area of Dutchess County in New York. Ex. A – Application, p. 13

3. SH is a rural hospital that is located in a rural county. Ex. CC – SH Prefile, pp. 459, 473, 475

4. SH's L&D services are resource-intensive, requiring a fully staffed birthing unit, 24/7 surgical and anesthesia support, as well as OB-GYN on-call coverage. SH's core staffing model for the Services is: two (2) nurses; one (1) obstetrician; one (1) pediatrician; a full Operating Room ("OR") team with anesthesiologist; and miscellaneous others including a unit coordinator and management professionals. Ex. CC – SH Prefile, p. 429 (Lucal); Ex. TT2 – Hearing Transcript, pp. 147-148 (McCulloch)

5. SH maintains a Level 1 newborn nursery and does not have a neonatal intensive care unit ("NICU"), which inhibits its ability to offer birthing services in certain higher-risk circumstances, including advanced maternal age births. Ex. A – Application, p. 14; Ex. C – Response to CL#1, p. 229

6. SH seeks regulatory approval from OHS to terminate the Services (the "Proposal") as part of a hospital-wide strategic plan designed to expand access to services it has determined are needed in the community, including primary care and behavioral health care, while ensuring the long-term financial health of the hospital (the "Transformation Plan"). Ex. A – Application, pp. 12-13, 24, 26

7. SH did not consider terminating any other services that it currently provides to achieve the same goal.[17] Ex. A – Application, pp. 35-36; Ex. TT2 – Hearing Transcript, p. 75 (Murphy)

8. If permitted to close its L&D unit, SH intends to allocate its resources towards expansion of other services, such as behavioral health and primary care. SH is also in the process of

[15] Use of header descriptions in this document are for organizational purposes only and are not intended as restrictions on the use of information in relation to the CON statutory criteria.
[16] Unless otherwise indicated, page numbers in citations refer to bates numbers.
[17] Although Docket No. 22-32504-CON concerns SH's termination of inpatient services, specifically the consolidation of its critical care services by termination of its Intensive Care Unit ("ICU") and establishment of a Progressive Care Unit ("PCU"), SH was not treating this proposal as a termination of services until it received a letter of determination from OHS on March 3, 2022, which was after SH had filed the instant Application.

planning the expansion of non-birthing women's health services tailored to the needs of the community. Offerings are anticipated to include gynecologic wellness and screening, minimally invasive gynecologic procedures, urogynecology, bone density screening, screening and diagnostic mammography, women's heart services, laboratory testing, fitness/nutrition, referral for genetic counseling, and disease-specific navigation.[18] Ex. A – Application, pp. 14-15, 35; Ex. TT1 – Hearing Transcript, pp. 24 (Murphy), 32 (McCulloch)

9. In December 2020, SH worked with the Foundation for Community Health in Sharon to jointly commission Stroudwater Associates to analyze how the community is receiving care and identify opportunities to leverage SH's strengths. Ex. A – Application, p. 23

10. On August 25, 2021, SH's Board of Directors approved the Transformation Plan. Ex. A – Application, p. 21; Ex. CC – SH Prefile, p. 383 (Murphy)

11. On September 28 and 29, 2021, SH issued public communications leading up to a community forum at which its leadership discussed the Transformation Plan with all internal teams and other key stakeholders. Afterwards, SH distributed an email to all patients of the hospital, which described the plan. SH has continued to hold other community engagement events including roundtable forums and individual meetings with community groups. Ex. A – Application, pp. 25-26

12. In September 2021, SH notified the public that it intended to close the L&D unit, providing a date of "late spring/summer 2022." Ex. Q – Public Comment, PDF pp. 1, 204

13. On October 13, 14 and 15, 2021, SH published notice of its intent to file a CON application for the Proposal. Ex. A – Application, pp. 2-4

14. SH's reasons for seeking to terminate the Services are a sustained low volume amidst an aging demographic in the service area, and significant multidisciplinary staffing challenges that have inhibited its efforts to maintain a viable L&D unit, which SH reports are having a negative financial impact and preventing it from appropriately offering and expanding the services that are most needed in the community. Ex. A – Application, pp. 12-13

15. According to SH, due to low and declining patient volume, and its rural location, it has struggled with clinical staffing of the unit (both recruitment and retention), a challenge that pre-dates but has been exacerbated by the ongoing nationwide health care worker shortage. Ex. A – Application, pp. 24-25

16. With regard to physicians, SH has consistently had four (4) pediatricians and two (2) to four (4) obstetricians available to it over the past several years. Ex. A – Application, pp. 24-25; Ex. C – Response to CL#1, pp. 250-251; Ex. TT2 – Hearing Transcript, pp. 149-150 (McCulloch)

17. Between 2017 and 2018, SH recruited two (2) OB-GYN physicians, but both subsequently left. Ex. A – Application, pp. 24-25; Ex. C – Response to CL#1, pp. 250-251

[18] SH has already begun to expand its women's health services – it has initiated a breastfeeding working task force, pelvic floor physical therapy program, and behavioral health program. Ex. TT1 – Hearing Transcript, p. 77 (Lucal)

18. After the two OB-GYN physicians left, SH and Nuvance supported a community obstetrics and gynecology practice's attempt to hire physicians, including through offering financial support, incentives and subsidization for recruitment and on-boarding. Although one (1) physician joined the practice as a result of these efforts, SH and Nuvance did not end up providing the offered financial support, incentives and subsidization.[19] Ex. A – Application, pp. 24-25; Ex. C – Response to CL#1, p. 233, 250-251; Ex. HH – LI Prefile (Schweizer), pp. 390-391; Ex. TT1 – Hearing Transcript, p. 111

19. The following table lists the SH L&D nurse job postings that were open and recruited for between 2017 – April 2022:

Job Title	FTE	Shift	Month/Year
Registered Nurse Labor & Delivery MCH	1	Day	10/17
Registered Nurse L&D Full-Time Nights $5000 Sign On Bonus	0.9	Night	11/17
Registered Nurse	0.9	Day	4/17
Registered Nurse L&D Full-Time Night	0.9	Night	2/18
Registered Nurse L&D PD Night	Per Diem	Night	2/18
Registered Nurse-Labor & Delivery Full-Time Nights-10K SIGN ON BONUS ELIGIBLE-Sharon Hospital	0.9	Night	12/18
Nurse Residency Registered Nurse Labor and Delivery Full-Time Nights-Sharon	0.9	Night	1/19
Registered Nurse OB/Maternal Child Health Residency Program-Sharon Hospital	0.9	Night	1/19
Registered Nurse OB/Maternal Child Health Residency Program-Sharon Hospital	0.9	Night	1/19
Nurse Residency Registered Nurse Labor Delivery Full-Time Night-Sharon	0.9	Night	3/19
Registered Nurse LDRP Part-Time Night	0.6	Night	4/19
Registered Nurse Maternal Child Health Per Diem	Per Diem	Night	5/19
Registered Nurse LDRP	0.9	Day	7/19
Registered Nurse Per Diem LDRP	Per Diem	Night	8/19
Registered Nurse LDRP Per Diem Nights	Per Diem	Night	9/19
Registered Nurse Maternal Child Health FT Night $15K sign on bonus	0.9	Night	11/19
Nurse Residency Registered Nurse Labor Delivery Full-Time Night-Sharon	0.9	Night	1/20
Registered Nurse Maternal Child Health FT Night $15K sign on bonus	0.9	Night	1/20

[19] It is unclear why this failed to come to fruition. With regard to this strategy, SH reports that "unfortunately such efforts were unsuccessful." Ex. A – Application, p. 25. SH further stated that "the community practice opted to maintain its current structure and remain independent," which suggests the financial benefits were to be tied to the establishment of a formal relationship, which would have allowed for such benefits. Ex. C – Response to CL#1, p. 233. However, the independent practice – or at least the physician that joined that practice – has a different understanding. Ex. HH – LI Prefile, pp. 390-391 (Schweizer); Ex. TT1 – Hearing Transcript, p. 111 (Schweizer)

Registered Nurse - Maternal Child Health Part-Time Days	0.8	Day	4/20
Registered Nurse - Maternal Child Health Full-Time Days	0.9	Day	4/20
Registered Nurse - Labor & Delivery Per Diem Days	Per Diem	Day	5/20
Registered Nurse - Maternal Child Health Full-Time Days	0.9	Day	6/20
Registered Nurse - Maternal Child Health Full-Time Nights	0.9	Night	12/20
Delivery Room Nurse	Per Diem	Night	11/21

The number of positions by year is: 2017 - 3; 2018 - 3; 2019 - 10; 2020 - 7; 2021 - 1.

Ex. C – Response to CL#1, pp. 240-241

20. Up until December 2020, SH was receiving approximately the same level of interest and applications for each of its L&D nursing job postings. It is not clear whether there were any job postings between January 2021 and October 2021 or whether there were simply no applicants for job postings in that time, but an October 2021 posting received only two (2) applications. Ex. C – Response to CL#1, pp. 338-343

21. With regard to L&D nurses, SH currently relies to some degree on per diem and travel nurses, and this results in turnover that provides instability. At the time that SH filed its CON application, the clinical staff included five (5) employed nurses, five (5) per diem nurses, and five (5) agency nurses, with a total of 33% of the L&D nurses being agency personnel. Ex. A – Application, p. 25

22. In 2019, SH launched an obstetrical registered nurse residency program in an effort to grow its L&D nurses from within the system. At the time that the CON application was filed, five (5) nurses had completed the residency, but only two (2) remained. Ex. A – Application, p. 25; Ex. C – Response to CL#1, p. 239

23. The nursing residency program is no longer operational. SH did not provide an explanation for this. Ex. A – Application, p. 25; Ex. C – Response to CL#1, p. 239

24. In order to recruit and retain nursing staff, SH has offered competitive compensation and benefits, as well as overtime and retention bonuses to existing staff. Ex. A – Application, p. 25

25. Despite staffing difficulties, SH has not suspended the Services. In fact, SH has not had to implement a contingency plan due to a lack of staff either. However, SH has at times had to rely on general surgeons to assist with births via cesarean section ("c-section"). Ex. A – Application, pp. 25, 60; Ex. CC – SH Prefile, p. 405 (McCulloch); Ex. TT2 – Hearing Transcript, p. 148 (McCulloch)

Relationship to the Statewide Health Care Facilities and Services Plan (the "Plan")[20]

26. Among high income countries, the United States consistently faces the worst rates of pregnancy- and childbirth-related deaths. Ex. KKK – LI Motion for Administrative Notice, PDF pp. 1, 5-9

27. In the United States, maternal mortality disproportionately affects birthing women of color regardless of socioeconomic status, as well as birthing women in rural areas. Ex. EE – Petition for Status, PDF pp. 62-64; Ex. HH – LI Prefile, PDF pp. 177-179

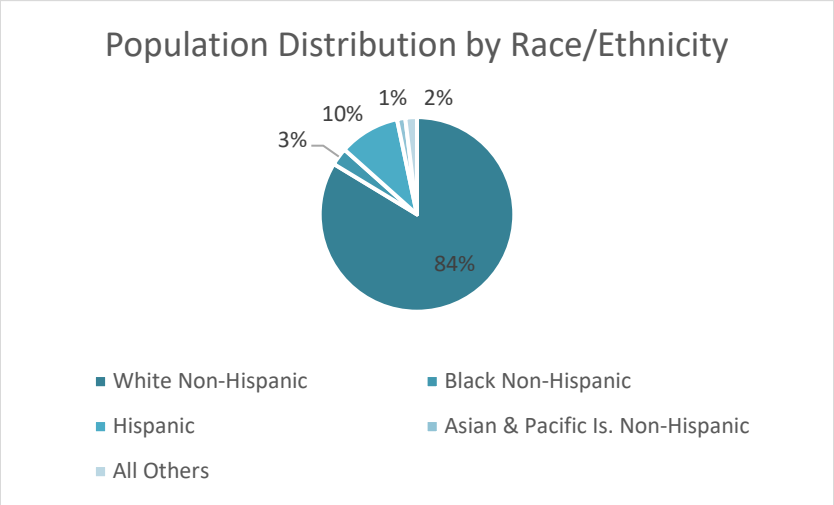
28. In the United States, there is a significant racial and ethnic disparity in maternal mortality, with Black women being more than twice (2x) as likely than White women to die from pregnancy-related causes. In Connecticut, the discrepancy is even greater, with maternal mortality impacting Black pregnant people at more than three times (3x) the rate of white pregnant people. Ex. EE – Petition for Status, PDF pp. 186-188 (CHNA); Ex. HH – LI Prefile, PDF pp. 295-297 (CHNA); Ex. KKK – LI Motion for Administrative Notice, PDF pp. 1, 5-9; *see also* Ex. Q – Public Comment, PDF pp. 809-810 (OAG)

29. In Connecticut, infant mortality impacts Black babies at two to three times (2x-3x) the rate as White babies and approximately twice (2x) the rate of Latinx babies. EE – Petition for Status, PDF pp. 186-188 (CHNA); Ex. HH – LI Prefile, PDF pp. 295-297 (CHNA); *see also* Ex. Q – Public Comment, PDF pp. 809-810 (OAG)

30. SH's primary service area ("PSA")[21] for its inpatient services consists of Connecticut towns (Canaan, Cornwall, Goshen, Kent, Salisbury, and Sharon) and additional towns in the adjacent New York market (Amenia, Dover Plains, Millbrook, Millerton, Wassaic, and Wingdale). Ex. A – Application, p. 27

31. In fiscal year ("FY")[22] 2021, SH's PSA population was 41,173, 83.7% of which consisted of white, non-Hispanic individuals, which was greater than the U.S. total of 59% of the population. All other ethnicities (Black non-Hispanic, Hispanic, Asian & Pacific Islander non-Hispanic and all others) made up 16.3% of the total population, but people of color are the fastest growing populations within SH's service area.

[20] Connecticut's first and only full Statewide Health Care Facilities and Services Plan was published in 2012. Subsequently, supplements to the Plan were published in 2014, 2016, 2018, and 2020. They can all be accessed online at https://portal.ct.gov/OHS/Services/Health-Systems-Planning/Facilities-Plan-and-Inventory.
[21] A PSA is defined as the "geographic area (by town), for the service location in the application, consisting of the lowest number of contiguous zip codes from which the applicant draws at least 75% of its patients for this service at such location."
https://portal.ct.gov//media/OHS/ohca/Publications/2012/OHCAStatewideFacilitiesandservicespdf.pdf, p. 149
[22] SH's fiscal year runs from October 1st to September 30th. Ex. A – Application, p. 43

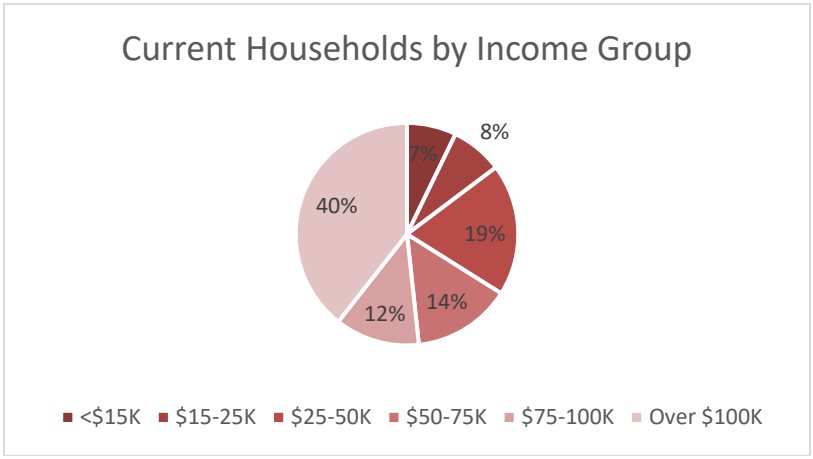


RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	**2021 Pop**	**% of Total**	**USA % of Total**
White Non-Hispanic	34,448	83.7%	59.0%
Black Non-Hispanic	1,210	2.9%	12.4%
Hispanic	4,155	10.1%	19.2%
Asian & Pacific Is. Non-Hispanic	565	1.4%	6.0%
All Others	795	1.9%	3.3%
Total	**41,173**	**100.0%**	**100.0%**

Ex. A – Application, pp. 32-33, 40; Ex. CC – SH Prefile, p. 466; Ex. EE – LI Petition for Status, PDF p. 148 (CHNA); Ex. HH – LI Prefile, PDF p. 257 (CHNA)

32. The average household income in the SH PSA is $107,608, which is higher than the U.S. and State of Connecticut averages.



Ex. A – Application, p. 33

33. Seven percent (7%) of residents in the SH PSA have incomes below the federal poverty level but an additional thirty-one (31%) have incomes that fall below the Asset Limited, Income Constrained, Employed (ALICE)[23] threshold necessary to meet all basic needs. Ex. EE – Petition for Status, PDF pp. 153-154 (CHNA); Ex. HH – LI Prefile, PDF pp. 262-263 (CHNA); *see also* Ex. Q – Public Comment, PDF p. 810 (OAG)

34. In Connecticut, Latinx residents are more than four times (4x) as likely to be uninsured as White residents, and Black residents are more than twice (2x) as likely. Moreover, in the SH service area, Black and Latinx residents are more than twice as likely to live in poverty as white residents. Ex. EE – Petition for Status, PDF pp. 152, 164-165 (CHNA); Ex. HH – LI Prefile, PDF pp. 261, 273-274 (CHNA)

35. In SH's PSA, lack of health insurance is a barrier to accessing healthcare. Ex. EE – Petition for Status, PDF p. 164 (CHNA); Ex. HH – LI Prefile, PDF p. 273 (CHNA)

36. Approximately 5% of the population of SH's PSA is uninsured, while Medicaid (20%), Medicare or Medicare dual eligible (24%) and private direct or exchange make up the rest of the market (51%). Ex. A – Application, p. 34

37. According to the Health Resources & Services Administration ("HRSA"), there are no medically underserved populations identified in the Connecticut portion of SH's PSA. Ex. A – Application, p. 34

38. In FY2021, SH's overall payer mix based on amounts charged was 11.8% Medicaid, 25.3% commercial, and 1.7% self-pay. Based on payments, the mix was 8.1% Medicaid, 32.8% commercial, and 0.5% self-pay. Hospital Financial Stability Report (2022), p. 66 [24]

39. In FY2021, SH's L&D payer mix based on discharges was 197 (48.4%) Medicaid, 195 (47.9%) commercial, and 15 (3.7%) self-pay, which is mostly consistent with SH's FY2020 numbers:

OHS TABLE 9
APPLICANT'S CURRENT & PROJECTED PAYER MIX [Sharon Hospital]

Payer	Most Recently Completed FY 2021		Projected FY 2023		FY 2024		FY 2025	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare	-	0.0%	-	#DIV/0!	-	0.0%	-	0.0%
Medicaid	197	48.4%	-	#DIV/0!	-	0.0%	-	0.0%
TRICARE	-	0.0%	-	#DIV/0!	-	0.0%	-	0.0%
Total Government	**197**	**48.4%**	**-**	**#DIV/0!**	**-**	**0.0%**	**-**	**0.0%**
Commercial Insurers:	195	47.9%	-	#DIV/0!	-	0.0%	-	0.0%
Uninsured								
Self-pay	15	3.7%	-	#DIV/0!	-	0.0%	-	0.0%
Workers Compensation								
Total Non-Government	**210**	**51.6%**	**-**	**#DIV/0!**	**-**	**0.0%**	**-**	**0.0%**
Total Payer Mix	**407**	**100.0%**	**-**	**#DIV/0!**	**-**	**0.0%**	**-**	**0.0%**

Volumes are reflective of deliveries only (mothers and newborns).

[23] ALICE measures the proportion of working poor and households who struggle to meet basic needs and are a paycheck or two away from acute financial strife. Ex. EE – Petition for Status, PDF pp. 153-154 (CHNA); Ex. HH – LI Prefile, PDF pp. 262-263 (CHNA); *see also* Ex. Q – Public Comment, PDF p. 810 (OAG)
[24] The HFSR is available at the following link: https://portal.ct.gov/-/media/OHS/HSP/Financial-Stability-Report_2021.pdf

OHS TABLE 9

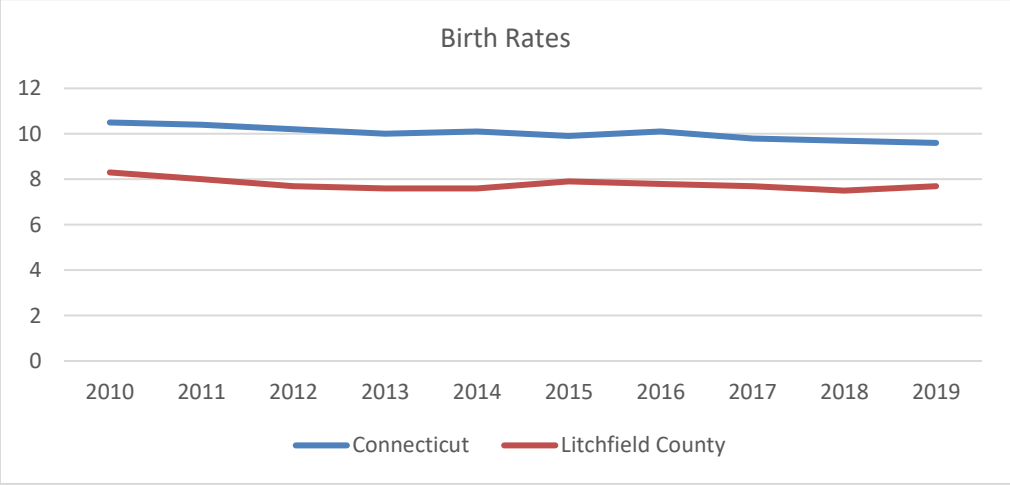
APPLICANT'S CURRENT & PROJECTED PAYER MIX [Sharon Hospital]

Payer	Most Recently Completed FY 2020		Projected FY 2023		FY 2024		FY 2025	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare	-	0.0%	-	N/A	-	N/A	-	N/A
Medicaid	188	44.0%	-	N/A	-	N/A	-	N/A
TRICARE	-	0.0%	-	N/A	-	N/A	-	N/A
Total Government	**188**	**44.0%**	**-**	N/A	**-**	N/A	**-**	N/A
Commercial Insurers:	216	50.6%	-	N/A	-	N/A	-	N/A
Uninsured								
Self-pay	23	5.4%	-	N/A	-	N/A	-	N/A
Workers Compensation								
Total Non-Government	**239**	**56.0%**	**-**	N/A	**-**	N/A	**-**	N/A
Total Payer Mix	**427**	**100.0%**	**-**	N/A	**-**	N/A	**-**	N/A

Ex. A – Application, p. 50; Ex. C – Response to CL#1, p. 221

Demonstration of Need

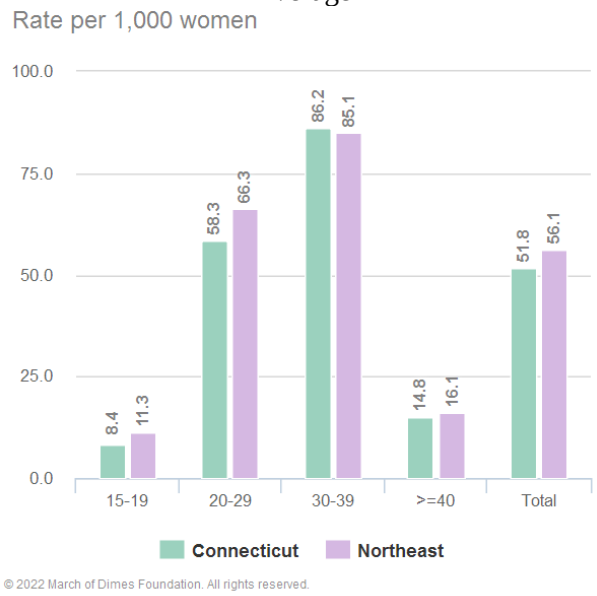
40. The State of Connecticut and Litchfield County both experienced a slow overall decline in birth rates between 2010 and 2019:



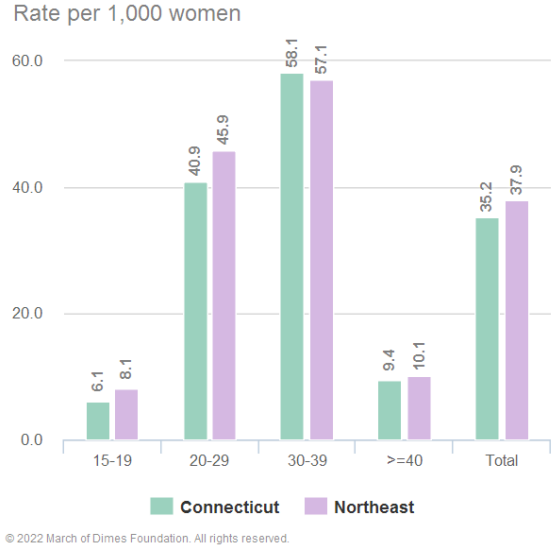
Ex. A – Application, p. 8

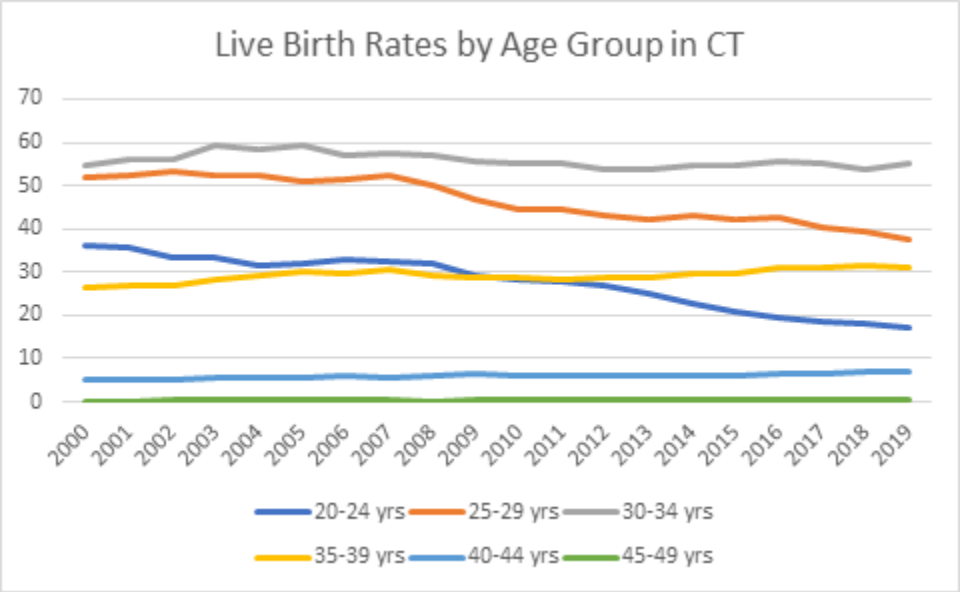
41. Rising maternal age and comorbidities are contributing to a growing proportion of high-risk pregnancies in Connecticut. The rate of births per 1,000 women aged 30-39 was 86.2 from 2017 – 2019, up from 58.1 in from 2015 – 2017, while women over 40 was 14.8, up from 9.4 in 2015 – 2017.

Birth Rates by Maternal Age
Connecticut and Northeast, 2017-2019
Average



Birth Rates by Maternal Age
Connecticut and Northeast, 2015-2017
Average





Source: CT DPH; Annual Birth rates by Mother's Age, 2000-2019

Ex. A – Application, pp. 15-16

42. SH provided two (2) sets of numbers that purportedly represent the number of births that occurred at SH by fiscal year, the second slightly lower than the first[25]:

	Option 1	Option 2
FY2016:	267	-
FY2017:	253	-
FY2018:	240	235
FY2019	197	190
FY2020:	216	214
FY2021:	210	206
FY2022:	-	173

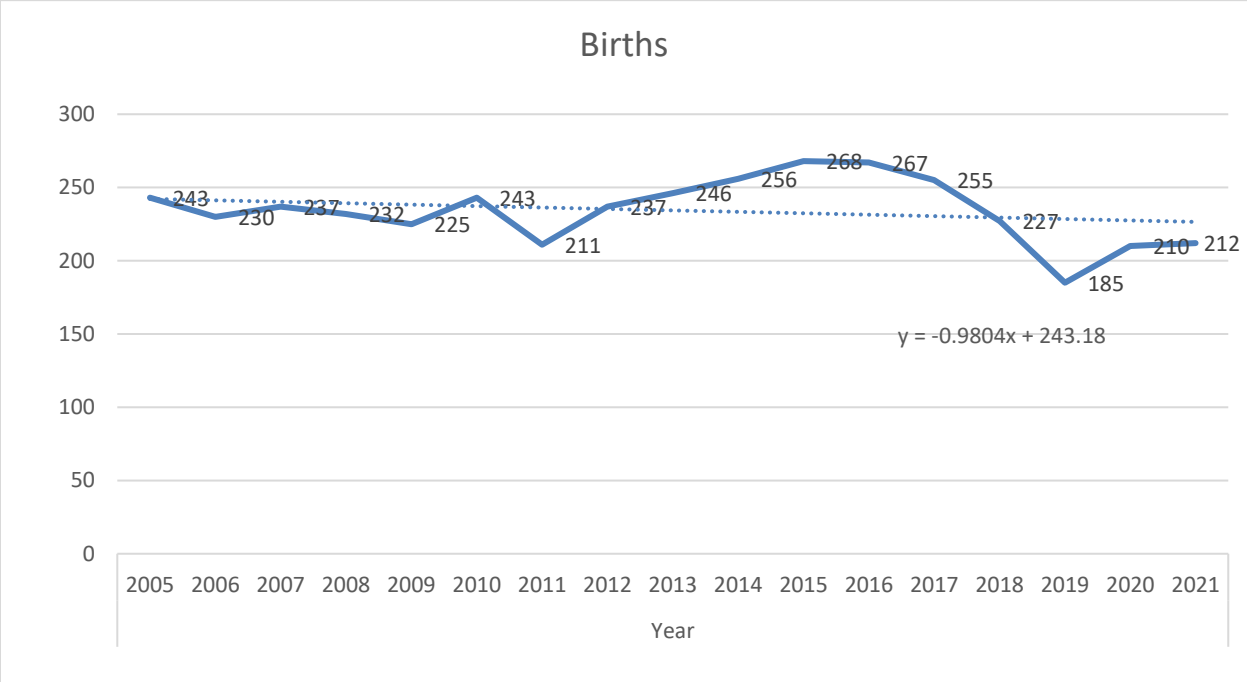
Ex. A – Application, p. 20; Ex. C – Response to CL#1, p. 225; Ex. CC – SH Prefile, pp. 402 (McCulloch), 428 (Lucal)

43. From January – December 2021, SH had deliveries on approximately 45% of the days during the year; there were 202 days (55%) where no obstetrical delivery occurred at SH. Ex. A – Application, p. 18

44. No L&D patients were diverted from SH to another facility between April 11, 2017 and April 11, 2022. Ex. C – Response to CL#1, p. 253; Ex. TT2 – Hearing Transcript, p. 127 (McCulloch)

45. The following table provides the number of occurrent births in the Town of Sharon for years 2005 – 2021, along with a dotted line showing an overall downward trend:

[25] It is unclear what accounts for the differences as no explanation has been provided.



Ex. AAA – SH Late File, p. 520 (updated by OHS to reflect the DPH's final report showing 212 rather than 210 births in 2021)

46. The following table provides data on total deliveries for residents of the SH PSA for calendar years 2018 – 2021, by the hospitals where the births occurred. The total number of individuals from SH's PSA who gave birth in Connecticut hospitals remained relatively static between 162 and 170 per year (with CY2019 being an outlier at 148):

	CY2018	CY2019	CY2020	CY2021*
Connecticut Hospitals				
Bristol	0	1	0	0
Charlotte Hungerford	39	16	25	29
Danbury	31	14	12	16
Greenwich	2	0	0	0
Hartford	2	3	0	3
Hospital of Central CT	0	0	0	1
Norwalk	0	0	0	1
Saint Francis	1	0	1	0
Saint Mary's	0	2	1	1
Sharon	78	98	114	107
UConn John Dempsey	13	8	6	4
Waterbury	0	1	1	0
Yale New Haven	4	5	2	5
CT Hospitals	**170**	**148**	**162**	**167**
% total	**78%**	**63%**	**76%**	**not available**
New York Hospitals				
Columbia Memorial Hospital	2	0	0	not available
Garnet Medical Center	1	0	0	not available
Health Alliance Kingston	1	1	0	not available
Lawrence Hospital Center	1	0	1	not available
Mount Sinai Medical Center	1	0	0	not available
Northern Dutchess Hospital	12	18	7	not available
Northern Westchester Hospital	4	8	2	not available
NY Presbyterian - Weill Cornell	0	1	1	not available
Putnam Hospital Center	3	11	7	not available
Vassar Brothers Medical Center	23	47	34	not available
White Plains Hospital	0	1	0	not available
NY Hospitals	**48**	**87**	**52**	**not available**
% total	**22%**	**37%**	**24%**	**not available**
TOTAL	**218**	**235**	**214**	**167 (CT Only)**

Ex. C – Response to CL#1, pp. 225-227

47. Out-migration of patients from SH's PSA to other hospitals has increased a small amount in two (2) of the more recent years:

Fiscal Year 2020*				
Town	**Sharon Hospital**	**Other Hospitals**	**Total**	**% Out-Migration**
Sharon	9	5	14	36%
Canaan	19	3	22	14%
Salisbury	15	5	20	25%
Kent	6	11	17	65%
Goshen	5	12	17	71%
Cornwall	5	9	14	64%
Total	**59**	**45**	**104**	**43%**
Fiscal Year 2021				
Town	**Sharon Hospital**	**Other Hospitals**	**Total**	**% Out-Migration**
Sharon	9	2	11	18%
Canaan	15	9	24	38%
Salisbury	10	4	14	29%
Kent	6	10	16	63%
Goshen	5	12	17	71%
Cornwall	4	8	12	67%
Total	**49**	**45**	**94**	**48%**

Ex. C – Response to CL#1, pp. 222-223

48. SH's PSA is expected to see minimal population growth and the population comprising females of child-bearing age is projected to stay relatively flat through 2026:

DEMOGRAPHIC CHARACTERISTICS						
	Sharon PSA	USA		2021	2026	% Change
2010 Total Population	42,691	308,745,538	Total Male Population	20,389	20,198	-0.9%
2021 Total Population	41,173	330,946,040	Total Female Population	20,784	20,486	-1.4%
2026 Total Population	40,683	340,574,349	Females, Child Bearing Age (15-44)	6,288	6,273	-0.2%
% Change 2021 - 2026	-1.2%	2.9%				
Average Household Income	$107,608	$96,765				

Ex. A – Application, pp. 20, 32

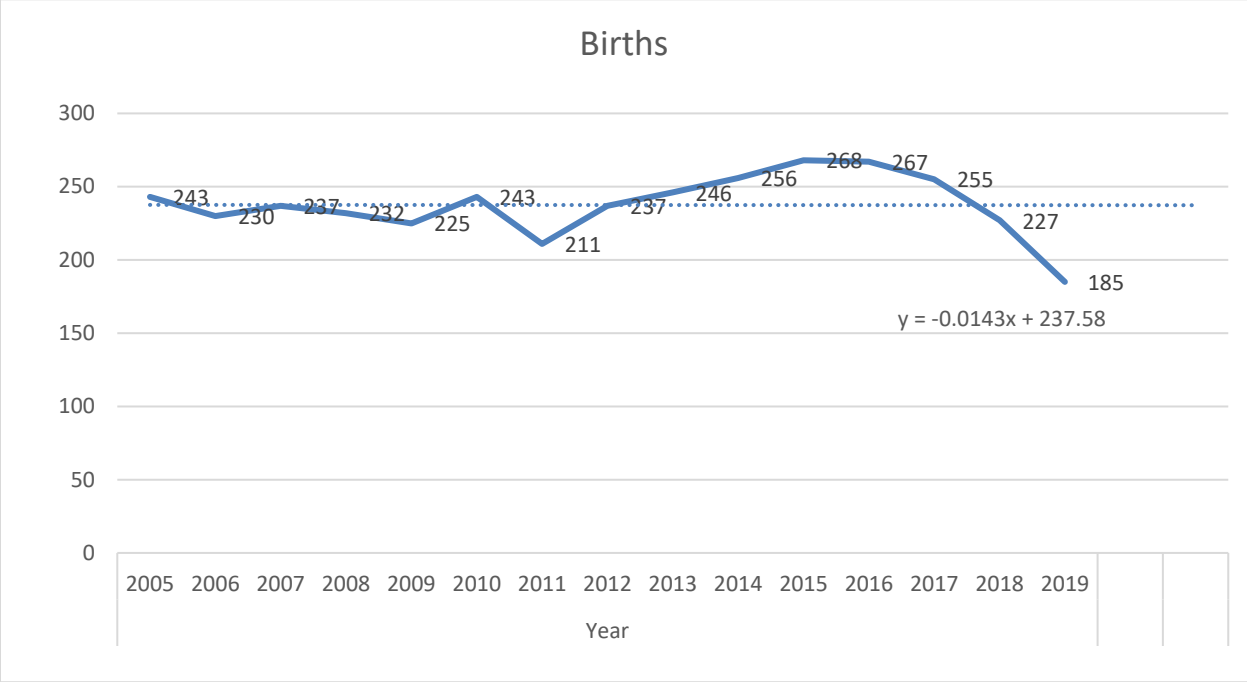
49. The target population that will be affected by the Proposal is women of childbearing years in SH's PSA. Ex. A – Application, p. 31

50. The annual total media spend[26] for the past three (3) years for promotion of SH, but not L&D specifically, is as follows: FY 2019 - $58K; FY 2020 - $155K; FY 2021 - $93K. Ex. C – Response to CL#1, pp. 231-232

51. SH's efforts to attract L&D patients ceased in early 2019. Ex. C – Response to CL#1, pp. 230-231, 294-322

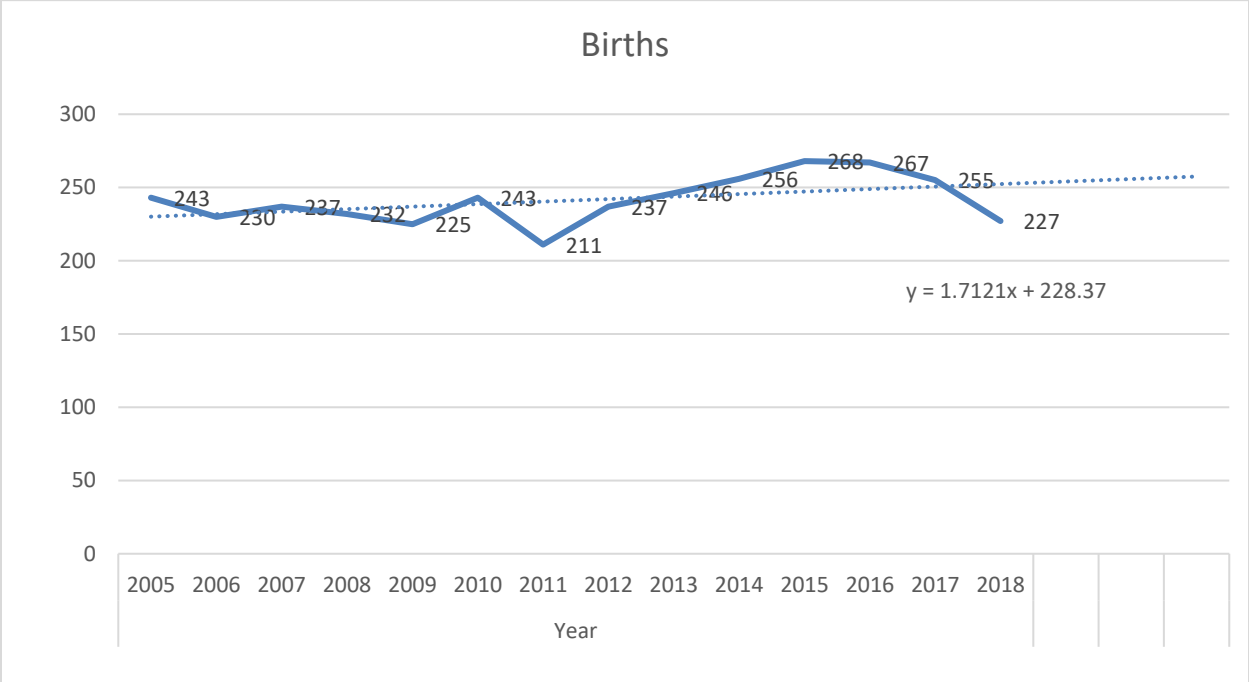
[26] "Media spend" is a term of art that represents the amount of money an entity spends on advertising.

52. Controlling for the outlier COVID-19 years by excluding delivery data for 2020 – 2021, the volume trend of occurrent births in the Town of Sharon is flat:



Ex. AAA – SH Late File, p. 520 (graph updated by OHS)

53. Controlling for both the outlier COVID-19 years as well as the lack of marketing campaign by excluding delivery data for 2019 and also 2020 – 2021, there was an upward volume trend of occurrent births in the Town of Sharon:



Ex. AAA – SH Late File, p. 520 (graph updated by OHS)

54. In FY2020, 43% of patients in SH's PSA bypassed SH to give birth at another hospital. In FY2021, it was 48%, and in FY2022 it was back down to 43%. Ex. CC – SH Prefile, pp. 401-402 (McCulloch); Ex. TT1 – Hearing Transcript, pp. 29, 74 (McCulloch); 43 (Lucal)

55. It is unclear why patients are choosing to bypass SH to give birth at other hospitals since no study has been performed on this issue. Ex. TT1 – Hearing Transcript, pp. 61-62 (McCulloch)

56. Analysis of survey data in the SH 2022 Community Health Needs Assessment ("CHNA") indicates that significant health needs in the community served by SH include access to: primary and preventative care; behavioral health care; and maternal and child health.[27] Ex. CC – SH Prefile, p. 404 (McCulloch); Ex. EE – Petition for Status, PDF pp. 139-190; Ex. HH – LI Prefile, PDF pp. 249-299

Access

57. SH believes that there will not be a reduction in access to the Services for Medicaid recipients or indigent persons because they will still have access to L&D services at other Nuvance facilities (Danbury Hospital, Vassar Brothers Medical Center, Northern Dutchess Hospital) as well as other community hospitals. Ex. A – Application, p. 41

58. The absence of accessible public transportation to SH means that most patients arrive by car assuming they have a vehicle or access to a vehicle, which many lower income patients do

[27] Ms. McCulloch's prefile testimony omits maternal and child health even though the CHNA identifies it in the table of contents as a community health need and then dedicates an entire section to it later in the document. Ex. CC – SH Prefile, p. 404 (McCulloch) (*see* CHNA, pp. 2, 47-49)

not. Ex. CC – SH Prefile, p. 462; Ex. EE – Petition for Status, PDF pp. 160-161 (CHNA); Ex. HH – LI Prefile, PDF pp. 269-270 (CHNA)

59. SH has executed transfer agreements to accommodate the transfer of an L&D patient from its Emergency Department to Charlotte Hungerford Hospital and Fairview Hospital. Ex. A – Application, pp. 29-30, 177-195; Ex. C – Response to CL#1, pp. 246, 248-250, 345-346; Ex. TT2 – Hearing Transcript, pp. 66-68 (McCulloch)

60. For non-emergency situations, patients will be responsible for securing and paying for their own transportation. Ex. C – Response to CL#1, p. 249

61. The lack of adequate access to L&D facilities and services for women in rural areas has led to documented increases in out-of-hospital births, births in hospitals without obstetrics services, and poorer birth outcomes. Ex. EE – Petition for Status, PDF pp. 37-98; Ex. HH – LI Prefile, PDF pp. 152-213

62. Both nationally and in Connecticut, transportation issues for low-income residents disproportionately impact people of color. Ex. EE – Petition for Status, PDF pp. 37-98, 160-161 (CHNA); Ex. HH – LI Prefile, PDF pp. 152-213, 269-270 (CHNA)

63. In the United States, a majority of pregnancy-related deaths are preventable and many are the result of lack of access to care. Ex. EE – Petition for Status, PDF pp. 118-120; Ex. HH – LI Prefile, PDF pp. 214-216

64. Travel time of twenty (20) minutes or more by car is associated with an increased risk of mortality and adverse outcomes in women at term. Ex. EE – Petition for Status, PDF pp. 108-116; Ex. HH – LI Prefile, PDF pp. 353-362

65. In Litchfield County, drive times are often unpredictable or extend beyond what may be considered typical. Ex. HH – LI Prefile, PDF p. 335 (Kavle); Ex. TT1 – Hearing Transcript, p. 156 (Kavle); Ex. TT2 – Hearing Transcript, p. 38

66. SH has been in communication with Emergency Medical Services (EMS) providers to ensure they are aware they will need to redirect patients to other providers if the Services are terminated, but has not articulated a plan for ensuring that sufficient EMS providers are available when needed in relation to the Services. Ex. A – Application, pp. 15. 37, 40, 66; Ex. C – Response to CL#1, pp. 248-249; Ex. HH – LI Prefile, PDF p. 22 (Mortman); *see also* Ex. TT1 – Hearing Transcript, pp. 187-189 (Speck)

67. EMS in SH's area are mostly volunteer and lack reserve ambulances and staff. Ex. HH – LI Prefile, p. 335 (Kavle); *see also* Ex. TT1 – Hearing Transcript, pp. 187-189 (Speck)

68. Travel in Litchfield County, regardless of whether by standard vehicle or ambulance, can be dangerous – especially in winter – and travel can be blocked if there are downed trees, power lines, or an accident. Ex. EE – Petitioner for Status, PDF p. 13; Exhibit HH – LI Prefile, PDF p. 335 (Kavle); Ex. TT1 – Hearing Transcript, pp. 172-173 (Kurish)

Quality

69. SH is one (1) of only three (3) Five-Star Quality Rating hospitals for safety in Connecticut, as determined by the U.S. Centers for Medicare & Medicaid Services (CMS). Ex. CC – SH Prefile, pp. 464, 501-517; Ex. HH – LI Prefile, PDF p. 9; TT1 – Hearing Transcript, pp. 22 (Murphy), 127 (Mortman)

70. Within the Nuvance system, only two (2) hospitals have achieved the 5-star rating – SH and Northern Dutchess Hospital in NY. All other nearby hospitals that would serve birthing women in the SH PSA if SH were to terminate the Services are rated lower than 5. Ex. TT1 – Hearing Transcript, p. 48 (Murphy); Ex. Q – Public Comment, PDF p. 292

71. There have been no quality-related incidents relating to SH's L&D services since at least 2019. Ex. CC – SH Prefile, p. 469

72. In the past three to four (3-4) years, SH has had routine, urgent and emergent births. Ex. TT2 – Hearing Transcript, p. 127 (McCulloch)

73. SH is not requesting approval of the closure of the Services due to quality or safety issues. Ex. C – Response to CL#1, pp. 256-257; Ex. AAA – SH Late File, p. 522

74. In anticipation of a potential closure of the L&D unit, SH is developing plans and has initiated enhanced training in an effort to ensure that its Emergency Department providers and staff are prepared to provide birthing services in emergency situations where transport to an alternative birthing site is not feasible. Ex. A – Application, p. 14; Ex. C – Response to CL#1, pp. 254-256

75. There are no specific national guidelines regarding the provision of inpatient obstetrics and patient volume. The ACOG has not opined on volume thresholds that should be maintained by hospitals, physicians, or other providers, and studies use various thresholds ranging from 200 to 1,000 deliveries per year. Ex. A – Application, p. 28; Ex. CC – SH Prefile, p. 447 (Lucal); Ex. TT2 – Hearing Transcript, pp. 139-142, 158 (Lucal); Ex. AAA – SH Late File, pp. 521-522

76. SH's current volume hovers at a threshold that some clinicians and experts deem the minimum required by a L&D service needing to maintain safety and financial viability. Ex. CC – SH Prefile, pp. 428, 447-457 (Lucal)

77. SH has adopted the ACOG's guidelines as they relate to timelines for the performance of emergency c-section procedures. Specifically, the guidelines call for the ability to have "decision to incision" within 30 minutes; that is, the ability to perform a c-section procedure within thirty (30) minutes of the decision being made to do so. Ex. HH – LI Prefile, PDF p. 22; Ex. TT1 – Hearing Transcript, pp. 125-126 (Mortman)

78. The lack of access to maternal health services in rural communities resulting from factors including obstetric department closures "can result in a number of negative maternal health outcomes including premature birth, low-birth weight, maternal mortality, severe maternal morbidity, and increased risk of postpartum depression." Ex. EE – Petition for Status, PDF pp. 37-98

79. In the United States, 28% of rural hospitals that lack obstetric units have had births in their emergency departments. Of those 28%, 32% experienced unanticipated adverse birth outcomes, 22% experienced a delay in urgent transportation, and 80% reported a need for additional training and/or resources for emergency obstetrics. Ex. EE – Petition for Status, PDF pp. 122-132

80. The impact of the loss of accessible obstetric services and increased distance to travel to care "has been associated with increased risk of non-indicated induced Cesarean section (which can lead to more complications), postpartum hemorrhage, prolonged hospital stay, and/or postpartum depression." Ex. EE – Petition for Status, PDF pp. 15-16; Ex. HH – LI Prefile, pp. 14-15

81. In rural counties, the absence of active L&D units is associated with a significant increase in perinatal mortality. Ex. EE – Petition for Status, PDF pp. 15-16, 100-105; Ex. HH – LI Prefile, pp. 14-15

82. OB/GYN physicians undergo at least four (4) full years of daily residency to develop their competencies and skillsets. Ex. TT1 – Hearing Transcript, p. 122 (Mortman)

Financial Soundness

83. Nuvance provides financial support to SH to cover its losses, which includes payment of salaries, bills, funding of the pension plan, maintenance, recruitment of staff, certifications, and training. Ex. A – Application, p. 21; Ex. TT2 – Hearing Transcript, p. 79 (Murphy)

84. Nuvance is involved in providing operational coordination, guidance, management, and strategic planning at SH. This includes, for example, coordination of care between the Nuvance system entities; operation of a transfer center, which directs patients to SH; standardization of clinical protocols, quality measures, and safety protocols; implementation of a single electronic medical record platform; management of the SH website; recruitment and retention efforts for SH; and hosting of an OB-GYN residency program designed to provide a pipeline of candidates to address difficulties in recruiting obstetricians, including at SH. Ex. A – Application, pp. 30, 34-37, 54-55, 62, 66; Ex. C – Response to CL#1, pp. 232-244, 249, 251-254

85. The Proposal does not require any capital expenditure. Ex. A – Application, p. 44

86. SH does not anticipate any financial losses resulting from the termination; in fact, it anticipates financial gain of approximately $3 million per year. Ex. A – Application, pp. 14, 47, 69, 212-213 (Financial Worksheet A); Ex. C – Response to CL#1, pp. 260-261 (Revised Financial Worksheet A)

87. The Hospital projects that its total full-time equivalent (FTE) employee count would decrease from 268.4 to 250.3 if the Proposal is approved. Ex. A – Application, p. 213 (Financial Worksheet A)

88. SH anticipates $3 million dollars in annual savings if the Application is approved. This amount reflects $5 million dollars in projected annual expense savings, offset in part by approximately $2 million dollars in projected revenue losses associated with the cessation of deliveries at the Hospital. Ex. A – Application, p. 212 (Financial Worksheet A); Ex. C – Response to CL#1, pp. 260-261 (Revised Financial Worksheet A); Ex. AAA – SH Late File, pp. 519, 545

89. The $5 million dollars in projected annual expense savings includes the following amounts:
    - $2.3 million dollars for salaries (which includes employee salaries, per diem costs, and premium pay for agency/travel nurses, as estimated by SH based on staffing conditions at the time of submission of the Application);
    - $0.5 million dollars in related benefits;
    - $0.3 million dollars in supplies dedicated to the Services;
    - $2 million dollars in physician fees, broken down as follows:
        - $1.1 million dollars in savings related to some reduction of after-hours surgery and anesthesia services following cessation of the Services;
        - $0.6 million dollars for obstetrics and neonatal call coverage; and
        - $0.3 million dollars in obstetric physician services furnished by a Nuvance employed obstetrician.

    Ex. AAA – SH Late File, pp. 519-520, 545

90. The projected savings of $3M does not factor in additional expenses relating to the expansion of primary care, behavioral health, or women's health services, the costs of which have not been provided or factored into the financial projections provided. Ex. TT1 – Hearing Transcript, p. 91 (Rosenberg)

Cost Effectiveness and Cost to Consumers

91. The Proposal will not result in a change to SH's Charity Care policies. Ex. A – Application, pp. 41, 197-210

92. SH has no plans to adjust price structures or impose new facility fees as a result of this Proposal. Ex. A – Application, p. 41

93. Historically, SH has delivered a minimal number of babies whose mothers were self-pay. Ex. A – Application, p. 50; Ex. C – Response to CL#1, p. 221

94. The following tables reflect the average commercial and self-pay costs per discharge at SH in 2020:

OHS TABLE 3

AVERAGE COST[1] OF DISCHARGE PER SELF-PAY PATIENT

	Historical			
	FY 2020	**FY 2023**	**FY 2024**	**FY 2025**
Mother	$4,097	N/A	N/A	N/A
Baby	$1,716	N/A	N/A	N/A
Combined	$5,813	N/A	N/A	N/A
Maternity Outpatient*	$36	N/A	N/A	N/A

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

* Primarily pre-delivery maternity patient labor checks on unit

OHS TABLE 4
AVERAGE COST[1] OF DISCHARGE PER COMMERCIALLY INSURED PATIENT

	Historical			
	FY 2020	**FY 2023**	**FY 2024**	**FY 2025**
Mother	$9,999	N/A	N/A	N/A
Baby	$2,935	N/A	N/A	N/A
Combined	$12,933	N/A	N/A	N/A
Maternity Outpatient*	$676	N/A	N/A	N/A

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

* Primarily pre-delivery maternity patient labor checks on unit

Ex. A – Application, p. 42

95. The following tables reflect the average commercial and self-pay costs per service per day for L&D at SH as compared to each of the other Nuvance hospitals. With only a few exceptions,[28] SH's costs are the lowest in every category.

MOTHER				
COMMERCIAL	2019	2020	2021	2022
Sharon Hospital	3,502	3,948	4,489	3,967
Danbury Hospital	4,214	4,615	4,842	5,051
Norwalk Hospital	4,974	5,241	5,533	5,643
Vassar Brothers	6,681	7,228	7,721	8,396
Northern Dutchess	5,618	5,993	6,239	6,623
Putnam Hospital	5,959	6,584	7,632	7,166

MOTHER				
SELF-PAY	2019	2020	2021	2022
Sharon Hospital	2,060	1,457	2,345	2,874
Danbury Hospital	2,781	2,914	3,302	3,659
Norwalk Hospital	2,767	3,450	3,591	N/A
Vassar Brothers	2,898	2,860	2,071	2,582
Northern Dutchess	2,383	1,926	3,200	2,563
Putnam Hospital	1,536	N/A	2,200	N/A

BABY - NURSERY				
COMMERCIAL	2019	2020	2021	2022
Sharon Hospital	1,145	1,326	1,615	1,495
Danbury Hospital	1,749	1,760	1,856	1,844
Norwalk Hospital	1,746	1,765	1,741	1,790
Vassar Brothers	4,878	5,675	6,366	4,921
Northern Dutchess	2,570	2,958	3,108	3,140
Putnam Hospital	2,744	2,935	3,314	3,239

BABY - NURSERY				
SELF-PAY	2019	2020	2021	2022
Sharon Hospital	786	729	856	913
Danbury Hospital	952	854	938	998
Norwalk Hospital	1,316	1,281	1,378	1,285
Vassar Brothers	965	997	1,031	1,119
Northern Dutchess	795	792	773	908
Putnam Hospital	740	745	897	896

MATERNITY OUTPATIENT				
COMMERCIAL	2019	2020	2021	2022
Sharon Hospital	780	633	536	704
Danbury Hospital	479	544	597	621
Norwalk Hospital	457	451	437	430
Vassar Brothers	2,346	2,395	2,637	2,579
Northern Dutchess	2,174	2,365	2,251	2,254
Putnam Hospital	2,074	2,383	3,149	3,413

MATERNITY OUTPATIENT				
SELF-PAY	2019	2020	2021	2022
Sharon Hospital	313	30	388	43
Danbury Hospital	536	569	564	545
Norwalk Hospital	308	303	305	341
Vassar Brothers	129	170	194	160
Northern Dutchess	405	217	328	797
Putnam Hospital	N/A	1,621	N/A	N/A

[28] Note that SH has not identified Nuvance's Putnam Hospital as a facility that would be willing and capable of accepting transfers.

Ex. AAA – SH Late File, p. 521

96. The commercial costs for L&D services at SH and Charlotte Hungerford Hospital are approximately the same. Ex. SS – APCD Data Cost Comparisons (2019-2021), Tab 1

97. With regard to cost of L&D services for self-pay patients, SH has indicated that it generally delivers a minimal number of self-pay patients. However, for patients who lack the financial means to pay, the costs to such patients for hospitals within Nuvance are governed by Nuvance's Financial Assistance Policy. This policy provided approximately 60% discounts at SH in FY2021. Ex. A – Application, pp. 36-37, 42

98. Medicaid coverage and reimbursement for childbirth is the same regardless of the hospital at which a patient chooses to deliver. Ex. A – Application, pp. 36-37

Existing Providers

99. In order of travel distance and time from SH, the area hospitals capable of serving patients seeking L&D services are Charlotte Hungerford Hospital, Fairview Hospital, Vassar Brothers Medical Center, Northern Dutchess Hospital, and Danbury Hospital:

Charlotte Hungerford Hospital: 24.9 miles, 37 minutes
Fairview Hospital: 25.7 miles, 38 minutes
Vassar Brothers Medical Center: 31.8 miles, 47 minutes
Northern Dutchess Hospital: 33 miles, 46 minutes
Danbury Hospital: 40.2 miles, 60 minutes

Ex. CC – SH Prefile, p. 462

100. The following table provides the services and service locations of existing providers in the area of SH, which may absorb SH's volume were the Proposal to be approved:

OHS TABLE 11
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Facility's Provider Name, Street Address and Town	Program or Service	Population Served	Days/Hours of Operation	Current Utilization*
Danbury Hospital, 24 Hospital Avenue, Danbury, CT	Labor & Delivery	Expecting women	24/7; 365 days a year	Available Beds: 29 ADC: 14.6
Northern Dutchess Hospital, Rhinebeck, NY	Labor & Delivery	Expecting women	24/7; 365 days a year	Available Beds: 11 ADC: 6.7
Vassar Brothers Medical Center, Poughkeepsie, NY	Labor & Delivery	Expecting women	24/7; 365 days a year	Available Beds: 32 ADC: 18.1
Charlotte Hungerford Hospital, Torrington, CT	Labor & Delivery	Expecting women	24/7; 365 days a year	Available Beds: 7
Fairview Hospital, Great Barrington, MA	Labor & Delivery	Expecting women	24/7; 365 days a year	Available Beds: 5

Ex. A – Application, pp. 53-54

101. The following table demonstrates the available volume capacity at three (3) of the five (5) closest hospitals to SH, along with total capacity of the non-Nuvance hospitals, for FY2020 – FY2021:

PROVIDERS ACCEPTING TRANSFERS/REFERRALS

Accepting Transfers/Referrals Provider(s)				**Terminating Service**	
Provider Name	**Provider Address**	**Total Capacity***	**Available Capacity****	*Sharon Hospital L&D Average Daily Census* **FY 2020**	*Sharon Hospital L&D Average Daily Census* **FY2021**
Fairview Hospital	29 Lewis Ave, Great Barrington, MA	5	***		
Charlotte Hungerford Hospital	50 Litchfield St, Torrington, CT	7	***		
Danbury Hospital	24 Hospital Avenue, Danbury, CT	29	14.4		
Northern Dutchess Hospital	6511 Springbrook Ave, Rhinebeck, NY	11	4.3		
Vassar Brothers Medical Center	45 Reade Place, Poughkeepsie, NY	32	13.9		
Total		84		1.4	1.2

* Source for Fairview Hospital: as reported through informal conversations between hospital leadership; source for Charlotte Hungerford Hospital: HRS Report 400 (2020); source for Danbury Hospital, Northern Dutchess Hospital, and Vassar Brothers Medical Center: internal data for fiscal year 2021.
** Available Capacity provided for fiscal year 2021. Available Capacity reflects total bed capacity minus average daily census of the labor and delivery unit.
*** Current utilization not available.

Ex. A – Application, pp. 64-65

102. The following table shows birth volumes and capacities for all Nuvance facilities since the establishment of Nuvance (FY2019 – FY2022):

Available Capacity	2019	2020	2021	2022	2023	2024	2025
Sharon Hospital							
Utilization (ADC)	1	1	1	1	1	1	1
Total Beds	8	8	8	8	8	8	8
Available Capacity	7	7	7	7	7	7	7
Danbury Hospital							
Utilization (ADC)	16	14	15	14	14	14	14
Total Beds	29	29	29	30	30	30	30
Available Capacity	13	15	14	16	16	16	16
Norwalk Hospital							
Utilization (ADC)	9	8	8	6	6	6	6
Total Beds	30	30	29	29	29	29	29
Available Capacity	21	22	21	23	23	23	23
Vassar Brothers							
Utilization (ADC)	20	19	18	18	18	18	18
Total Beds	32	32	32	32	32	32	32
Available Capacity	12	13	14	14	14	14	14
Northern Dutchess							
Utilization (ADC)	6	6	7	7	7	7	7
Total Beds	11	11	11	11	11	11	11
Available Capacity	5	5	4	4	4	4	4
Putnam Hospital							
Utilization (ADC)	3	2	2	2	0	1	1
Total Beds	10	10	10	10	10	10	10
Available Capacity	7	8	8	8	10	9	9

Births	2019	2020	2021	2022	2023	2024	2025
Sharon Hospital [1]	190	214	206	173	173	173	173
Danbury Hospital	1,991	1,894	2,051	1,979	1,979	1,979	1,979
Norwalk Hospital	1,104	1,137	1,101	908	908	908	908
Vassar Brothers	2,549	2,507	2,426	2,436	2,436	2,436	2,436
Northern Dutchess	826	919	968	990	990	990	990
Putnam Hospital [2]	407	377	364	134	67	113	150

Ex. AAA – SH Late File, p. 523

103. Nuvance facilities (Danbury Hospital, Northern Dutchess Hospital, and Vassar Brothers Medical Center) are available to accept patients. Additionally, based on discussions SH had with Charlotte Hungerford Hospital and Fairview Hospital, both have capacity to accept patients. Ex. A – Application, pp. 54, 63; Ex. TT2 – Hearing Transcript, pp. 66-68 (McCulloch)

Miscellaneous

104. The Hearing Officer took administrative notice of the following: the Plan; the OHS Facilities and Services Inventory; the OHS Acute-Care Hospital Discharge Database; the All Payer Claims Database claims data; Hospital Reporting System (HRS) Financial &

Utilization Data; the Connecticut Hospital Association (CHA) report titled "The Pandemic's Impact on the Financial Health of Connecticut Hospitals," dated March 7, 2023, and the underlying study conducted by Kaufman Hall for CHA; and the CDC's National Center for Health Statistics' report titled "Maternal Mortality Rates in the United States, 2021," published March 2023. Ex. TT1 – Hearing Transcript, pp. 9-10; Exhibit HHH – SH Motion for Administrative Notice; Ex. KKK – LI Motion for Administrative Notice; Ex. MMM – Order on Outstanding Motions

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Discussion

The Hospital has failed to establish that four (4) of the six (6) applicable statutory criteria set forth in C.G.S. § 19a-639 are met. Therefore, for the reasons described below, SH has failed to carry its burden of demonstrating that a CON should be approved for this Proposal.

A. C.G.S. § 19a-639(a)(1): Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the OHS

Subsection (a)(1) is *not applicable* because OHS has not yet established policies and standards as regulations.

B. C.G.S. § 19a-639(a)(2): The relationship of the proposed project to the state-wide health care facilities and services plan

The Applicant has *not demonstrated* that the Proposal is consistent with the Plan.

The mission of OHS is "to implement comprehensive, data driven strategies that promote equal access to high quality health care, control costs and ensure better health for the people of Connecticut." In furtherance of this mission, the legislature tasked OHS with preparing the Plan because OHS's planning and regulatory responsibilities "are intended to increase accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services."[29]

When asked in the Application to describe how the Proposal aligns with the Plan, SH stated:

> [T]he closing of its L&D service is necessary to position the Applicant for a more stable, sustainable future and focus on the community's greatest needs – expansion of primary and ambulatory services and behavioral health services – which align with public need as identified by the state. The Proposal represents a difficult but necessary project to support the delivery of high-quality care in response to rural demand in the Sharon Hospital PSA, maximize utility of available staff, and prevent any potential quality or safety issues by responsibly phasing out an underutilized service.[30]

The Applicant does not specifically address the Plan in any other part of the record.

As evidenced by the agency's mission and the Executive Summary of the Plan, quality, financial stability, accessibility and cost containment are important considerations, but they are certainly not the only ones. Also important are the Plan's goals of continuity of care (and its relationship to quality of healthcare services) and the avoidance of duplication of services. And inextricably intertwined with these goals is the Plan's emphasis on identifying persons at risk and vulnerable populations, and taking action to improve health equity across the state.[31]

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[29] *See* C.G.S. § 19a-634; Plan (2012), p. ix (Executive Summary)
[30] Ex. A – Application, pp. 30-31
[31] Plan (2012), pp. 81-88; Plan (2014 Supplement), pp. 6, 50-80; Plan (2016 Supplement), pp. 5, 64-102

While the Applicant's Proposal aligns with the Plan's goals of avoiding duplication of services (*see* Section I below), for the reasons set forth below in Sections E, F, and J of this Final Decision, the Applicant has failed to demonstrate that the Proposal aligns with the Plan's goals of improving quality, accessibility, continuity of care (and its relationship to quality of healthcare services), financial stability, and cost containment.

As to health equity, the negative impact on Medicaid recipients and indigent persons (addressed below in Sections E and F) alone is a sufficient basis to determine that the Proposal is not consistent with the Plan. Putting this aside, however, the data also demonstrates that the Proposal's negative impact on access to Medicaid recipients and indigent persons would exacerbate racial and ethnic healthcare inequities at the state, county, and town levels. In the United States, there is a significant racial and ethnic disparity in maternal mortality, with Black women being more than twice (2x) as likely than White women to die from pregnancy-related causes. In Connecticut, the discrepancy is even greater, with maternal mortality impacting Black pregnant women at more than three times (3x) the rate of white pregnant women. FF 28. In Connecticut, infant mortality impacts Black babies at two to three times (2x-3x) the rate as White babies and approximately twice (2x) the rate of Latinx babies. FF 29. SH's PSA population is approximately 41,173, 83.7% of which consisted of white, non-Hispanic individuals, which was greater than the U.S. total of 59% of the population; all other ethnicities (Black non-Hispanic, Hispanic, Asian & Pacific Islander non-Hispanic and all others) made up 16.3% of the total population. FF 31-34. No evidence has been proffered to suggest that SH, though having a smaller non-White population, is immune to these national and statewide trends. The people of color in SH's PSA are more likely to be part of the 7% of residents in the SH PSA who have incomes below the federal poverty level or 31% who have incomes that fall below the ALICE threshold necessary to meet all basic needs. FF 31, 33. Inequities in health insurance coverage further exacerbate inequities in birth outcomes as people of color are more likely to be uninsured and a lack of insurance is a known barrier to accessing healthcare. FF 34-35. In sum, this termination would negatively affect minority races and ethnicities at a disproportionately higher rate.

Accordingly, SH has failed to establish this criterion is met.

C. C.G.S. § 19a-639(a)(3): Whether there is a clear public need for the health care facility or services proposed by the Applicant

Subsection (a)(3) is *not applicable* because there cannot be clear public need for a termination of services.

D. C.G.S. § 19a-639(a)(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

The Applicant *has not demonstrated* how the Proposal will impact the financial strength of the health care system in the state, but *has demonstrated* that the Proposal is financially feasible.[32]

[32] Applicants are only required to establish that one or the other is met.

The Applicant has an established parent company – Nuvance. FF 2. Nuvance provides financial support to SH, which includes payment of salaries, bills, funding of the pension plan, maintenance, recruitment of staff, certifications, and training. FF 18, 83-84. Despite SH's losses in FY2021, Nuvance had an excess of revenue over expenses of $105M, had an increase in net assets of $242M ending the year with over $1.7B in net assets, and by all accounts appears financially stable.[33] Moreover, SH asserts that the Proposal does not require any capital expenditure and it does not anticipate any financial losses resulting from the termination of the Services. FF 85-86. In fact, SH anticipates a financial gain of approximately $3 million per year. FF 86-89.

Accordingly, SH has satisfactorily established that this criterion is met.

E. **C.G.S. § 19a-639(a)(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**

The Applicant *has not satisfactorily demonstrated* that the Proposal will improve quality, accessibility, and cost effectiveness of health care delivery in the region, particularly for Medicaid recipients and indigent persons.

Quality:

When asked to describe how the Proposal will improve quality of health care, SH stated that approving the termination of the Services "will have no impact on the quality of care in the region."[34] But the fact of the matter is that with the approval of this Proposal there will be an impact and it will not be a beneficial one.

Despite being in a rural location and having everything from routine to urgent to emergent births, SH has experienced no quality-related incidents since at least 2019. FF 71-72. SH is one (1) of only three (3) Five-Star Quality Rating hospitals for safety in Connecticut, as determined by CMS. FF 69. There is no reason to suspect SH's rating as it pertains to the Services will drop if it is required to maintain the Services since the volume of births at the hospital is still within range of what is considered safe to develop and maintain competencies. FF 75-76. Yet, within the Nuvance system, only two (2) hospitals have achieved the 5-star rating – SH and Northern Dutchess Hospital in NY. All other nearby hospitals that would serve birthing women in the SH PSA if SH were to terminate the Services are rated lower than 5. FF 70. So, if SH terminates the Services, L&D patients would be required to go to one of these other hospitals for delivery even though they carry inferior safety ratings. FF 99-103.

[33] *See* Nuvance's Audited Financial Statements through 2022 available in the HRS portal: https://dphhrswebportal.ct.gov/FinancialDocuments; *see also* Ex. A – Application, pp. 44-45; Ex. C – Response to CL#1, p. 224; Ex. AAA – SH Late File, pp. 520. Administrative notice was not taken of the 2022 Audited Financial Statements.

[34] Ex. A – Application, p. 36. In fact, SH is not requesting approval to terminate the Services even in part due to quality or safety issues. FF 14

SH's plan for termination of the Services is to ensure that its Emergency Department providers and staff are prepared to safely provide birthing services in the event of an unlikely emergency situation where transport to an alternative birthing site is not feasible. FF 74. But even the best training cannot compare to the four (4) full years of daily residency that OB/GYN physicians undergo to develop their competencies and skillsets, and there are a number of medical conditions and procedures that the Emergency Department may not be able to handle.[35] FF 82.

More broadly, there is no dispute that SH is a rural hospital that is located in a rural county. FF 3. All of the available research is clear that even when alternative arrangements are made and emergency department staff is as fully prepared as possible, rural L&D closure results in bad quality and safety outcomes, including premature birth, low-birth weight, maternal mortality, severe maternal morbidity, increased risk of postpartum depression. FF 78. Rural L&D closures also result in emergency department births, non-indicated induced c-section, postpartum hemorrhage, prolonged hospital stays, and an increase in perinatal mortality. FF 80-81. There is no reason to believe that SH's experience would be any different.[36]

Accessibility:

When asked to describe how the Proposal will improve access, SH stated: (1) that L&D services are available at neighboring hospitals, and each has the capacity to accept patients that may have been considering delivering at SH; and (2) that SH is in the process of planning the expansion of women's health services.[37] FF 57. When asked to describe how the Proposal will improve access for Medicaid recipients and indigent persons, SH responded by stating that impact on access to care for these individuals "is uncertain," but that SH is taking action to prevent a reduction in access and that the Proposal actually "may improve access" because termination of the Services is likely to result in providers who currently deliver at SH delivering at alternative facilities that are closer to the patients.[38]

The Plan recognizes that transportation is one of the top barriers to care in rural areas.[39] It is well-documented in the United States that a majority of pregnancy-related deaths are preventable, and many deaths are caused by lack of access to care. FF 63. Not only this, but lower income residents are the ones at greatest risk for facing transportation obstacles. FF 58, 62. Both nationally and in Connecticut, transportation issues for low-income residents disproportionately impact people of color. FF 62. Even though the average household income in the SH PSA is $107,608, which is higher than the U.S. and State of Connecticut averages, seven percent (7%)

[35] Ex. TT1 – Hearing Transcript, pp. 122-125, 139-140 (Mortman); Ex. TT2 – Hearing Transcript, pp. 161-166, 194-195 (Mortman). Other than Dr. Mortman, a series of other emergency medicine physicians, obstetricians and anesthesiologists voiced concerns about the Emergency Department's abilities to handle high risk births. Ex. Q – Public Comment, PDF pp. 260, 535-536, 545-546, 560-561, 762. Moreover, an anonymous group of SH's Emergency Department nurses voiced similar concerns. *Id.* at 603-604.
[36] Rather, there is reason to believe SH's experiences would be the exact same. A number of women commented that SH was the closest hospital to them, that they would not have made it to a further hospital, and that their personal birth complications very likely would have resulted in exactly the type of negative outcomes described in these articles. Ex. Q – Public Comment, PDF pp. 218, 531, 661, 668, 676, 765, 818, 846, 848, 865
[37] Ex. A – Application, p. 36; Ex. CC – SH Prefile, p. 461
[38] Ex. A – Application, p. 40
[39] Plan (2012), p. 88

of residents in the SH PSA have incomes below the federal poverty level and an additional thirty-one (31%) have incomes that fall below the ALICE threshold necessary to meet all basic needs. FF 32-33. These are significant figures. SH does not intend to implement a transportation program, so non-emergency patients in labor will be responsible for securing their own transportation and often do not have their own vehicles. FF 60. Moreover, there is an absence of accessible public transportation in the area. FF 58.

Travel distances and times by car from SH to the five (5) nearest hospitals (Charlotte Hungerford Hospital, Fairview Hospital, Vassar Brothers Medical Center, Northern Dutchess Hospital, and Danbury Hospital) are, respectively: 24.9 miles, 37 minutes; 25.7 miles, 38 minutes; 31.8 miles, 47 minutes; 33 miles, 46 minutes; 40.2 miles, 60 minutes. FF 99. Travel distances are the same by ambulance, but ambulance travel times for these hospitals were neither requested nor supplied. FF 58. These travel times do not take into account travel time from wherever the laboring individual happens to be to SH. Nor does it take into account other variables that can increase the time it would take to get to a hospital, such as not knowing whether she is in active labor and not being able to access personal transportation. Regardless of whether traveling via personal vehicle or ambulance, drive times in Litchfield County are often unpredictable or extended beyond what may be considered typical. FF 65. Travel can be dangerous – especially in winter – and can be blocked if there are downed trees, power lines, or an accident. FF 68. Transportation via helicopter may not always possible.[40]

While some women who deliver at SH live closer to other hospitals, including other Nuvance facilities (i.e., Danbury Hospital, Northern Dutchess Hospital, and Vassar Brothers Medical Center), Charlotte Hungerford Hospital, and Fairview Hospital, based on the data provided,[41] it cannot be definitively stated or determined how many actually do. For many L&D patients of SH, drive times from their homes to other area hospitals may be significantly longer.[42] The Applicant carries the burden of proof and demonstrating that the CON criteria are met, not the agency.

Reliance on EMS following the proposed termination will not improve accessibility of L&D services. For emergencies involving L&D patients, SH has executed transfer agreements to accommodate the transfer of a L&D patient from its Emergency Department to Charlotte Hungerford Hospital and Fairview Hospital. FF 59. But even though SH has been in communications with EMS providers to ensure they are aware they will need to redirect patients to other providers if the Services are terminated, it has not articulated a plan for ensuring that sufficient EMS providers are available when needed in relation to the Services. FF 66. EMS in

[40] Ex. Q – Public Comment, PDF pp. 260, 273, 690
[41] Ex. A – Application, p. 22; Ex. C – Response to CL#1, p. 218; Ex. CC – SH Prefile, pp. 418, 461-462; Ex. TT1 – Hearing Transcript, pp. 30-31 (McCulloch); Ex. TT2 – Hearing Transcript, pp. 111-118 (Mortman). The maps that SH has provided to show outmigration provide only a sampling of towns in SH's PSA. However, it is clear that significant portions of each of the towns that SH listed as examples are actually located closer to SH than to the other hospitals discussed. For example, the distance from the point that SH chose in Canaan is closer to Fairview Hospital than Sharon Hospital, but most of the rest of Canaan is closer to Sharon Hospital. Likewise, the distance from the point that SH chose in New Milford is closer to Danbury Hospital than Sharon Hospital, but the more northern portion of New Milford is closer to Sharon Hospital.
[42] *See, e.g.*, Exhibit Q – Public Comment, PDF pp. 218, 503, 515, 533, 638, 645, 672, 675, 769, 803, 840, 848, 865, 877, 887, 906

SH's area is mostly volunteer and lacking in reserve ambulances and staff. FF 67. For these reasons, timely access to EMS cannot be guaranteed and in fact could be no different than the patient herself calling 9-1-1.

SH adopted the ACOG Guideline for perinatal care that establishes 30 minutes as the time within which a person should start an emergency c-section procedure. FF 77. But even so, travel time of 20 minutes or more by car is associated with an increased risk of mortality and adverse outcomes in women at term. FF 64.

For all of the foregoing reasons, the Applicant has failed to demonstrate that accessibility of L&D services would be improved with this termination.

Cost Effectiveness:

When asked to describe how the Proposal will improve the cost effectiveness of health care delivery, SH stated that phasing out the Services will enable a reallocation of resources towards primary care, behavioral health and women's health services, but that the "impact from a cost perspective on potentially vulnerable populations . . . will be minimal."[43] In addition, SH was unable to determine if costs would be higher or lower for the uninsured since self-pay policies may be different at hospitals outside of Nuvance.[44] But if this Proposal is approved, there will be an impact on cost-effectiveness both for the general population as well as indigent persons, and it will not be a beneficial one. Specifically, the costs of delivering a baby at SH are lower than at any other hospital in the area that could absorb SH's volume.

Looking first at data regarding commercial payers, with the exception of the "Maternity Outpatient" category, SH has the lowest costs per service per day. FF 95-96. But even in this category, the difference between SH and the two lowest Nuvance hospitals is marginal at approximately $301 - $323, but the difference between SH and the three highest is substantial at approximately $1,294 - $1,566. FF 95. SH has not explained who will pay for any additional costs incurred by the patient for receipt of services out-of-state or out-of-network if such services happen to not be covered by insurance.[45]

Self-pay rates paint a similar picture even though SH generally delivers a minimal number of self-pay patients. FF 93-95, 97. Excluding Putnam Hospital, which SH has not identified as a facility that would be willing and capable of accepting its transfers, the only category in which SH is not the lowest cost is again "Maternity Outpatient." *Id.* SH sits roughly midway between the lowest (Vassar Brothers Medical Center, $129) and the highest (Danbury Hospital, $536). *Id.* Costs to self-pay patients who lack the financial means to pay are governed by Nuvance's Financial Assistance Policy, which provided approximately 60% discounts at SH in FY2021. FF 97. Medicaid coverage and reimbursement for childbirth is the same regardless of the hospital at which a patient chooses to deliver. FF 98.

[43] Ex. A – Application, pp. 36-37; Ex. CC – SH Prefile, pp. 469-470
[44] *Id.*
[45] Ex. TT2 – Hearing Transcript, p. 136 (Lucal)

In terms of other cost-effectiveness considerations, SH does not intend to implement a transportation program, so non-emergency patients will be responsible for securing and paying for their own transportation regardless of whether traveling from SH to the other hospitals or from their home to the other hospitals. FF 60. They will also be responsible for the costs of travel home. The absence of accessible public transportation in the area (FF 58) means patients would likely have to spend more (taxi vs. bus, for example). These costs are not insignificant, especially to the Medicaid and indigent populations, as well as to those individuals who have incomes that fall below the ALICE threshold necessary to meet all basic needs. FF 33.

Due to the significant differences in costs of delivery, a lack of explanation as to who will be responsible for non-covered costs, as well as the higher costs associated with transportation, the Applicant has failed to demonstrate that the Proposal will improve cost-effectiveness.

As the Applicant has failed to establish each of the three prongs, it has failed to establish that this criterion is met by the Proposal.

F. C.G.S. § 19a-639(a)(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

Subsection (a)(6) is *not applicable* because there cannot be a proposed provision of services and payer mix with the termination of services.

G. C.G.S. § 19a-639(a)(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

Subsection (a)(7) is *not applicable* because there is no population that can be served by the termination of services, and even if there was, there cannot be need for a termination of services.

H. C.G.S. § 19a-639(a)(8): The utilization of existing health care facilities and health care services in the service area of the Applicant

The Applicant *has demonstrated* that utilization of existing health care facilities and health care services in the Applicant's service area supports this Application.

In order of travel distance and time from SH, the area hospitals capable of serving patients seeking L&D services are Charlotte Hungerford Hospital, Fairview Hospital, Vassar Brothers Medical Center, Northern Dutchess Hospital, and Danbury Hospital. FF 99. SH has recently seen an overall decline in births from 2019 (FF 42, 45), but the total number of individuals from SH's PSA who gave birth remained relatively unchanged (FF 46) and SH's PSA is expected to see minimal population growth and the population comprising females of childbearing age is projected to stay relatively flat through 2026 (FF 48). Even if the volume of individuals who would deliver at SH were to bounce back to where it was in 2016, available information and data from the other hospitals demonstrates that they likely have availability to absorb this volume if the Proposal is approved. FF 100-103.

Accordingly, SH has satisfactorily established that other existing health care facilities can adequately handle its L&D services volume.

I. C.G.S. § 19a-639(a)(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

Subsection (a)(9) is *not applicable* because there cannot be an unnecessary duplication of existing or approved health care services with the termination of services.

J. C.G.S. § 19a-639(a)(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

The Applicant *has not demonstrated* that there is good cause for its reducing access to services by Medicaid recipients and indigent persons.

When asked to provide an explanation of good cause for reducing access to services by Medicaid recipients or indigent persons, SH stated:

> This proposal will not reduce access to services for Medicaid recipients or indigent persons as L&D services will be accessible at Nuvance Health's Danbury Hospital, Vassar Brothers Medical Center or Northern Dutchess Hospital location, as well as other community hospitals in the region.[46]

However, as described in Sections E and F of this Final Decision, the Proposal, if approved, would not only reduce access to L&D services, but reduce these populations' access to L&D services at a disproportionately high rate.

SH asserts a number of reasons why it believes good cause exists to reduce access to services by Medicaid recipients or indigent persons. They can fairly be summarized as follows: (1) a declining birth volume and changing PSA demographic indicates that the service is no longer as crucial to the community as other more utilized services; (2) difficulty staffing the L&D unit; (3) the ongoing financial losses attributable to the L&D unit are not sustainable; (4) adequate access already exists due to proximity and capacity of nearby hospitals; and (5) the changing demographics of the PSA. None of the articulated reasons support a finding of good cause.

As to (1), it is clear that since 2010, there has been a slow overall decline in birth volume both in the State of Connecticut and Litchfield County (FF 40); that since 2005, there has been a slight overall decline in occurrent birth volume in the Town of Sharon (FF 45); and that SH specifically has experienced a significant decline in volume since FY2016, with the largest drop occurring between 2019 – Present (FF 42). However, what is not clear in this data is what is causing SH's

[46] Ex. A – Application, p. 41

drop in volume since the total number of individuals from SH's PSA who gave birth in recent years has remained relatively static. FF 46. SH has stated that the SH PSA has an aging demographic (FF 41)[47]; that those who are of birthing age are bypassing SH to give birth at other hospitals with NICUs, neonatologists, and other specialty services, which provide for safer deliveries[48] (FF 5); and many women live closer to other hospitals than they do SH.[49] The LIs have argued that it is due to a combination of other reversible factors and that the volume trend is also reversible. These factors include premature announcements of L&D closure in July 2018[50] and September 2021[51] (FF 11) and a lack of advertisement and marketing of L&D since 2019 (FF 50-51). SH has not performed a study to determine the cause (FF 55), nor have the LIs provided sufficient evidence in support of their position. Accordingly, since the Applicant has not presented sufficient evidence on this issue, it cannot be said that a declining volume and an aging demographic constitute good cause.

As to (2), SH has stated that it has had difficulty staffing the L&D unit (FF 15). Notwithstanding, SH has not experienced so much difficulty that it has had to suspend the Services. In fact, it has not even had to implement what it described as a "contingency plan" due to a lack of staff. FF 25. SH's core staffing model for the Services is: two (2) nurses; one (1) obstetrician; one (1) pediatrician; a full OR team with anesthesiologist; and miscellaneous others including a unit coordinator and management professionals. FF 4. With regard to physicians, SH has consistently had four (4) pediatricians available and two (2) to four (4) obstetricians available over the past several years. FF 16-18. SH has been able to maintain a full nursing staff by relying to some degree on per diem and travel nurses.[52] FF 21. Although staffing may be challenging, the Applicant has failed to present evidence that staffing challenges constitute good cause.

With regard to (3), SH's ongoing financial losses attributable to the L&D unit do not constitute good cause for limiting access to the Services. The Applicant has an established parent company – Nuvance. FF 2. Nuvance does not have patient revenue or enter into payor agreements, and does not itself provide any health care services.[53] Nuvance is very much involved in providing hands-on operational coordination, guidance, management, and strategic planning at SH. FF 84. Nuvance also provides financial support to SH to cover its losses, which includes payment of salaries, bills, funding of the pension plan, maintenance, recruitment of staff, certifications, and training. FF 18, 83-84. Despite SH's losses in FY2021, Nuvance had an excess of revenue over expenses of $105M, had an increase in net assets of $242M ending the year with over $1.7B in net assets, and by all accounts appears financially stable.[54] The Applicant has failed to demonstrate how the proposal would significantly improve the overall financial performance of

[47] *See also* Ex. A – Application, pp. 20-21.
[48] Ex. TT1 – Hearing Transcript, p. 29 (McCulloch)
[49] *See* discussion and footnotes at center of p. 33 of this Final Decision (beginning "While some women…").
[50] Ex. Q – Public Comment, PDF pp. 1, 174
[51] SH "regrets" the prematurity of these announcements and that the announcements did not fully convey that closure was contingent upon receiving approval from OHS. Ex. C – Response to CL#1, p. 245
[52] At the time that SH filed its CON application, the clinical staff included five (5) employed nurses, five (5) per diem nurses, and five (5) agency nurses, with a total of 33% of the L&D nurses being agency personnel. FF 21
[53] Ex. C – Response to CL#1, p. 224
[54] *See* Nuvance's Audited Financial Statements through 2022 available in the HRS portal: https://dphhrswebportal.ct.gov/FinancialDocuments; *see also* Ex. A – Application, pp. 44-45; Ex. C – Response to CL#1, p. 224; Ex. AAA – SH Late File, pp. 520. Administrative notice was not taken of the 2022 Audited Financial Statements.

the hospital, whose overall operating losses exceed $20M per year, given the array of other factors involved and the relatively small gains that SH projects from the approval of the Proposal (FF 86-89).

With respect to (4), while clear that nearby hospitals have sufficient capacity to absorb SH's L&D volume, for the reasons stated above in Section E, termination of the Services would still have a negative impact on access to L&D services in SH's PSA because many patients would find it difficult to access those services at the other hospitals. Therefore, the Applicant has failed to present sufficient evidence demonstrating that the existence of nearby hospitals constitutes good cause.

Lastly, with regard to (5), SH proposes terminating one needed health service (L&D) and expanding other needed health services that more closely align with changes it anticipates in the PSA's demographics. SH's 2022 CHNA indicated that significant health needs in the community served by SH include access to: primary and preventative care, behavioral health care, and maternal and child health. FF 56. But L&D is also a needed service since the total number of individuals from SH's PSA who gave birth remained relatively static over the past few years and there is only expected to be a marginal decline in women of birthing age (FF 46, 48). While SH investing in and expanding these other services would assist Medicaid recipients' and indigent persons' access to those important services, it is not sufficient to constitute good cause for reducing access to other crucial services needed by Medicaid recipients or indigent persons.

Accordingly, the Applicant *has not demonstrated* that this criterion is met.

K. C.G.S. § 19a-639(a)(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

The Applicant *has not satisfactorily demonstrated* that the Proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region. If the application is denied, patients would have the option of choosing to deliver at any one (1) of six (6) different hospitals: Sharon Hospital, Charlotte Hungerford Hospital, Fairview Hospital, Vassar Brothers Medical Center, Northern Dutchess Hospital, or Danbury Hospital. FF 99-105. If the Proposal is approved, there would be one (1) less health care provider in the area providing L&D services. This necessarily means less diversity of health care providers and less patient choice in the geographic region. In fact, SH has even acknowledged that the Proposal will result in a negative impact to the diversity of health care providers and patient choice for L&D services.[55] Accordingly, this criterion is not met.

L. C.G.S. § 19a-639(a)(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

[55] Ex. CC – SH Prefile, pp. 470-471. SH argued that the planned expansion of other services increases diversity and patient choice in other ways, but that is outside the scope of this application.

Subsection (a)(12) is *not applicable* because there is no consolidation that would result from the Proposal.

Conclusion & Order

The Applicant has failed to meet its burden of proof in satisfying the statutory requirements of C.G.S. § 19a-639. Specifically, the Applicant failed to satisfy four (4) of the six (6) applicable criteria set forth in C.G.S. § 19a-639(a), to wit: (2) consistency with the Plan; (5) improvement of quality, access, and cost effectiveness of the Proposal; (10) good cause for reducing access to services by Medicaid recipients or indigent persons, and (11) no negative impact on the diversity of health care providers and patient choice. The Applicant has demonstrated that the Proposal meets Subsections (4) and (8). Subsections (1), (3), (6), (7), (9) and (12) are not applicable.

Based upon the foregoing Findings of Fact, Conclusions of Law and Discussion, the Certificate of Need application of Sharon Hospital to terminate L&D services is hereby ordered **DENIED**.

Respectfully Submitted,

2/5/24
Date

Deidre S. Gifford, MD, MPH
Executive Director