STATE OF CONNECTICUT
OFFICE OF HEALTH STRATEGY

IN RE: ENCOMPASS HEALTH REHABILITATION HOSPITAL OF DANBURY, LLC – ESTABLISHMENT OF A NEW 40-BED INPATIENT REHABILITATION HOSPITAL	)	DOCKET NO. 20-32392-CON
	)	OCTOBER 12, 2022

APPLICANT'S BRIEF IN OPPOSITION TO THE PROPOSED FINAL DECISION AND EXCEPTIONS TO PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

In accordance with Section 4-179(a) of the Connecticut General Statutes and Section 19a-9-29(h) of the Regulations of Connecticut State Agencies, Encompass Health Rehabilitation Hospital of Danbury, LLC ("Encompass Danbury" or the "Applicant"), Applicant in the above-referenced Certificate of Need ("CON") proceeding under Docket No. 20-32392-CON, hereby submits the following Brief in Opposition to the Proposed Final Decision issued by Office of Health Strategy ("OHS") Redesignated Hearing Officer Alicia J. Novi, Esq. (the "Hearing Officer") on September 21, 2022, recommending denial of the Applicant's request for a CON to establish a 40-bed inpatient rehabilitation facility ("IRF") in Danbury. The Applicant's exceptions to the proposed Findings of Fact and legal conclusions contained in the Discussion section of the Proposed Final Decision are set forth below. The Applicant further requests an opportunity to present oral argument to Acting Executive Director Kimberly Martone before she issues a Final Decision in this matter.

I. Introduction

This proceeding concerns a CON Application filed by Encompass Danbury on August 14, 2020, for the establishment of a 40-bed IRF in Danbury. The facility is intended to address a significant "gap in care" for western Connecticut residents illustrated by the historically low

utilization of IRF services by Medicare patients (the primary users of IRF services) despite the large and growing Medicare population in the area. This "gap in care" means that patients discharged from acute care general hospitals who need and would benefit from intensive rehabilitation services are receiving care in suboptimal settings such as skilled nursing facilities ("SNFs"), are getting home health care, or are foregoing needed inpatient rehabilitation ("rehab") care altogether. Encompass Danbury's proposed state-of-the-art rehabilitative care hospital would help to address this "gap in care," enhancing the quality and accessibility of inpatient rehab services for all area residents, including vulnerable patient populations, and providing services in a more cost-effective manner than the only existing provider of these services in western Connecticut.

Encompass Health is the nation's largest provider of inpatient rehabilitation hospital services, with more than 150 hospitals across the United States and Puerto Rico. The company is seeking to bring a new and much-needed hospital to Connecticut and to the Danbury area in particular, where beds of this type are extremely limited and an independent rehabilitation hospital of this scope and nature does not exist. The $39 million hospital, which will permanently employ more than 100 clinical and support staff, will be constructed with Encompass Health dollars and without any request for economic incentives or assistance from the state. The proposed hospital will provide speech, occupational, and physical rehabilitation services to the victims of strokes, heart attacks, spinal cord injuries, traumatic brain injuries, and other debilitating conditions.

In its Proposed Final Decision, OHS acknowledged that the Applicant's proposal is in the best interest of patient care. The Hearing Officer made findings regarding the manner in which the proposed hospital will improve the quality of healthcare, as well as the accessibility of IRF

services for all patients including Medicaid recipients and indigent persons. She also found that the proposal was both financially feasible and cost-effective. The Hearing Officer further concluded that the proposed Encompass hospital will improve the diversity of IRF providers in the Danbury area, where the only existing provider is Danbury Hospital, giving patients meaningful choice of providers as the CON laws require.

At the same time, and notwithstanding the tremendous benefits of the proposal as acknowledged by OHS, the Hearing Officer inexplicably concluded that there was no "need" for the new hospital and that it would result in an unnecessary duplication of services. For these reasons alone, she is recommending denial of the CON. These conclusions were driven largely by the Hearing Officer's refusal to consider the sound, well-reasoned and well-documented bed-need methodology presented by the Applicant. This methodology was based on national benchmarks applied to Connecticut populations and utilization statistics, similar to methodologies presented by other applicants and accepted by the agency in approving their CON requests. Clear public need for the proposed inpatient rehabilitation hospital is indisputable, based upon publicly available, verifiable data presented by the Applicant in hundreds of pages of CON submissions and hours of public hearing testimony. Since Encompass Health filed its CON Application, another national provider has also requested permission from OHS to construct a similarly sized inpatient rehabilitation hospital in Waterbury. If there is no need for these beds, a reasonable question is why two different national hospital companies that specialize in inpatient rehabilitation services would seek to expand into the region?

The Hearing Officer also gave far too much weight to the testimony of Danbury Hospital, the only existing provider of IRF services in the Danbury area – a more-costly provider that, by its own admission, intends to open additional inpatient rehabilitation beds at its own facility to

meet a need that it insists does not exist. Danbury Hospital's motivation for intervening and opposing this CON request should be scrutinized carefully by OHS given the opposing positions the hospital took at the hearing – on the one hand, that there is no need for additional inpatient rehabilitation beds in the area, and on the other hand that it is planning to expand its own unit in the near future to meet patient demand. As the Applicant has stated throughout this process, there is sufficient need for inpatient rehabilitation services to support **both** the proposed Encompass hospital and Danbury Hospital's existing service and these providers would complement each other. Having another provider in the service area would also incentivize improvements in quality, cost control, and collaboration to ensure that the needs of patients are being met.

The Applicant invested considerable time and effort in providing OHS with a complete and thoroughly documented CON submission that establishes, by a preponderance of evidence, a clear public need for the proposed 40-bed IRF. It identifies the patient population to be served and a significant unmet need for IRF services by that population. The Applicant considered the capacity and utilization of Danbury Hospital and, in doing so, determined that additional beds were needed and that the facilities would complement each other, without Encompass Danbury needing or intending to shift patients from Danbury's inpatient rehabilitation service. As a result, there is no unnecessary duplication of services, but rather a proposal that meets current and future demand and benefits both patients and the healthcare system as a whole. However, the abundant evidence presented by the Applicant was all but ignored by the third OHS Hearing Officer on this matter, who issued a Proposed Final Decision replete with errors and omissions, which takes positions on matters of policy that are contrary to the manner in which the agency has decided other similar applications and is based on selective evidence in the record.

The Proposed Final Decision is also made upon unlawful procedure, which is grounds for appeal. Encompass Danbury filed its CON Application in August of 2020 and, despite prompt responses to OHS's requests for additional information and the Applicant's general availability to move the proceeding forward, a hearing on this matter was not held for over a year. Once the hearing was held in October of 2021, it took the agency another three (3) months to close the record. Then, contrary to the law requiring a decision within 60 days of the closure of the hearing record, OHS did not issue the Proposed Final Decision for another eight (8) months, nearly a year after the hearing was held. The Proposed Final Decision was issued only after repeated requests that this matter be resolved so as not to cause further prejudice to the Applicant. Thus, Encompass Danbury was denied its right to both a prompt hearing and a timely decision in this matter.

Moreover, as previously mentioned, the Hearing Officer who issued the Proposed Final Decision is the third Hearing Officer to sit on this matter. To the best of the Applicant's knowledge, the Hearing Officer is new to the agency and had never authored a CON decision before the Proposed Final Decision. She did not conduct the hearing and was not present to assess the credibility of witnesses and their testimony. She was not involved in any of the fact finding in this matter, nor did she request additional information from the Applicant to address the deficiencies that she claims support her recommendation that the CON Application be denied. As a result, the Applicant was deprived of both a fair hearing and decision on this matter.

As set forth in greater detail below, OHS's legal conclusions regarding whether this proposal meets the statutory criteria for issuance of a CON must change. The Applicant has met each of the applicable decision criteria. The Proposed Final Decision is clearly erroneous in

view of the reliable, probative, and substantial evidence in the record. The Findings of Fact and conclusions of law based on those findings are arbitrary and capricious and an unwarranted exercise of OHS's discretion. Each of the foregoing represents a basis for appeal. The Acting Executive Director's review of this matter, and her ability to right this wrong by approving the CON Application, is the only way to ensure that residents of the State of Connecticut are able to receive the rehabilitative healthcare services they deserve.

Accordingly, the Proposed Final Decision should be corrected as requested below, the Hearing Officer's recommendations should be rejected, and the Acting Executive Director should issue a Final Decision approving Encompass Danbury's CON request. Alternatively, Encompass Danbury is amenable to discussing a negotiated settlement with OHS that would address any remaining concerns with its proposal.

II. Applicable Law

A CON is required for the establishment of a health care facility, in this case a chronic disease hospital, per Section 19a-638(a)(1) of the Connecticut General Statutes. The guidelines and principles that OHS must take into consideration when reviewing a CON application filed pursuant to Section 19a-638 include:

> (1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Office of Health Strategy;
>
> (2) The relationship of the proposed project to the state-wide health care facilities and services plan;
>
> (3) Whether there is a clear public need for the health care facility or services proposed by the applicant;
>
> (4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;

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

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

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

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

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

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

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

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

See Conn. Gen. Stat. Sec. 19a-639.

The Hearing Officer correctly determined that the Applicant satisfied Sections 19a-639(a)(4), (5), and (11) of the General Statutes. However, the Hearing Officer incorrectly determined that the Applicant failed to satisfy Sections 19a-639(a)(2), (3), (6), (7), (8) and (9) when she should have concluded that these decision criteria were met based upon clear and substantial evidence in the administrative record. The erroneous and inconsistent findings by the Hearing Officer are illustrated by her conflicting findings for Sections 19a-639(3), (4) and (5), which are interrelated review criteria because if the Applicant's project will improve quality, accessibility and cost effectiveness (Section 19a-639(5)) **and** is financially feasible (Section 19a-

639(4)), which is contingent on the Applicant meeting its projected volume, there must be a clear public need for the healthcare facility or services proposed by the Applicant. No other conclusion is logical or reasonable.

This matter is governed by the Uniform Administrative Procedure Act. *See* Conn. Gen. Stat. Sec. 4-166 through 4-189. It is a contested case and, as such, the hearing and disposition of the CON Application are governed by Sections 4-177 through 4-181a of the Connecticut General Statutes. The public hearing was held in accordance with Conn. Gen. Stat. Sec. 19a-639a(e), and hearing procedure was further governed by the Department of Public Health ("DPH") Rules of Practice set forth at Sections 19a-9-1 through 19a-9-29 of the Regulations of Connecticut State Agencies.

The Applicant's right to appeal a Final Decision is this matter derives from Sections 19a-641 and 4-183 of the Connecticut General Statutes. The Proposed Final Decision contains, findings, inferences, conclusions, and decisions by OHS that are (i) in violation of statutory provisions; (ii) made upon unlawful procedure; (iii) affected by other error of law, (iv) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; and (v) arbitrary or capricious or characterized by an abuse of discretion or clearly unwarranted exercise of discretion. *See* Conn. Gen. Stat. Sec. 4-183(j). If the Hearing Officer's proposal is adopted by the Acting Executive Director as a Final Decision, the Applicant will be prejudiced by these findings, inferences, conclusions, and decisions and, as such, will have the right to file an administrative appeal. *See id.*

III. Exceptions to Findings of Fact

The Applicant takes exception to the following Findings of Fact and any legal conclusions or discussion related thereto set forth in the Discussion section of the Proposed Final Decision:

- **Section III. Provisions of Law** – OHS incorrectly cites the statutory provisions that govern this CON Application. This section should be revised to state that the proposal constitutes the establishment of a new health care facility pursuant to Conn. Gen. Stat. Sec. 19a-638(a)(1), not 19a-638(c)(1). In addition, it should state that the factors considered by OHS are set forth in Conn. Gen. Stat. 19a-639(a), not 19a-638(c).
- **FF3** – This Finding of Fact states that the Applicant is the owner and operator of 136 inpatient rehab hospitals in 35 states and Puerto Rico. This is incorrect. The Applicant, Encompass Danbury, neither owns nor operates any inpatient rehab hospitals. The Applicant's parent company, Encompass Health, through various subsidiaries, owned and operated 144 such facilities across the United States and Puerto Rico at the time of the CON hearing. *See* OHS Exhibit PP, p. 15. Now, Encompass Health owns and operates 151 such facilities in 36 states and Puerto Rico. This Finding of Fact and any Discussion related thereto should be revised accordingly.
- **FF6 –** This Finding of Fact states that Encompass Danbury does not "currently have any formal arrangements with other institutions," and cites OHS Exhibit C, p. 9 as authority. However, no such statement is made on either page 9 of the PDF of Exhibit C (Applicant's Response to Late File) or on Page 9 of the response letter itself.[1] Instead, at Bates page 490 of Exhibit C, the Applicant responded in detail to OHS's request regarding established **or**

[1] OHS Exhibit C is Bates numbered, but the Hearing Officer has not referenced a Bates numbered page.

expected agreements or relationship with other area providers that will serve as referral sources. Accordingly, this Finding of Fact should be stricken and no finding regarding Encompass Danbury's lack of current arrangements, formal or otherwise, should be used to support the denial of the CON.

- **FF7 –** This Finding of Fact states that Encompass Danbury does not "currently have any connections with medical schools or teaching facilities," and cites OHS Exhibit C, p. 9 as authority. Again, no such statement is made on either page 9 of the PDF of Exhibit C or on Page 9 of the response letter itself. As explained on Bates page 489, the Applicant has engaged in preliminary discussion with several local universities and other institutions related to clinical training opportunities. In fact, a representative of one of these institutions, Dr. Janet Gangaway, Program Director for the Physical Therapy Assistant Program at Naugatuck Valley Community College ("NVCC"), provided both a letter of support and public comment in support of Encompass Danbury's proposal at the hearing. *See* OHS Exhibit F, p. 530 & Exhibit PP, pp. 244-247. The Associate Dean for Health Sciences and Director of Nursing at NVCC, Carol Gabriele, submitted a letter of support for the proposal as well, which spoke to a teaching-learning partnership between Encompass Danbury and her school. *See* OHS Exhibit C, p. 514. Based on the foregoing, the Applicant does, in fact, have "connections" with medical schools and teaching facilities. Accordingly, this Finding of Fact should either be stricken or revised to accurately reflect evidence in the record regarding relationships between Encompass Danbury and medical schools and teaching facilities. Moreover, no findings regarding Encompass Danbury's alleged lack of "connections" with medical schools or teaching facilities should be used to support a denial of the CON.

- **FF8** – This Finding of Fact states that Encompass Danbury does not "have transfer agreements in place with other medical institutions." As explained on Bates page 492 of OHS Exhibit C, transfer agreements are not typically executed until a facility has been approved by OHS and is preparing to open. Such agreements are premature when an entity does not yet have CON approval to establish a facility and has not commenced construction.[2] *See* OHS Exhibit PP, p. 103-104. OHS has found in other dockets that transfer agreements can be established after a CON is approved, but before a facility begins providing services.[3] Accordingly, this Finding of Fact should either be stricken or revised to accurately reflect evidence in the record regarding the execution of transfer agreements between Encompass Danbury and local hospitals. Moreover, no findings regarding Encompass Danbury's alleged failure to establish transfer agreements should be used to support a denial of the CON.
- **FF9** – In this Finding of Fact, OHS notes that the Applicant used a national population-based need methodology formula to show a need for IRF beds in Connecticut. The Hearing Officer further claims that this methodology has not been "approved" for use in Connecticut. First, the Hearing Officer mischaracterizes the nature of the methodology used to suggest that it does not accurately reflect data regarding Connecticut residents and their need for IRF services. While the methodology uses national benchmarks, it is based on Connecticut population and utilization statistics. For example, the Applicant's need methodology

[2] Counsel for Danbury Hospital appeared confused about the nature of a "transfer agreement" during his cross-examination of expert witness Marty Chafin. He insinuated that a transfer agreement is necessary to ensure referrals to a facility such as the one proposed by Encompass Danbury, when in fact a transfer agreement is an agreement allowing a non-acute care general hospital provider to transfer patients in need of acute-care general hospital services (often emergency services) to an acute-care general hospital for those services. *See* OHS Exhibit PP, pp. 101-105, 145-146.

[3] For example, in its recent approval of a CON for establishment of the Connecticut Proton Therapy Center ("CPTC"), OHS conditioned approval of the CPTC on implementing a transfer agreement with an appropriate hospital or hospitals in the event of an emergency during proton therapy treatment **prior to the commencement of operations** (*see* Docket No. 19-32339-CON).

considered the size and aging of the Connecticut and service area populations as well as the populations' utilization of general acute care services compared to post-acute care services. *See, e.g.*, OHS Exhibit O, pp. 663 & 666. The state's and service area residents' use of general acute care hospital and post-acute care services was compared to national averages, utilization in northeastern U.S. states, and within Connecticut itself (*i.e.*, statewide utilization versus service area counties). A comparison of western Connecticut counties and statewide use rates to the national average is appropriate in this instance because historical utilization of IRF services is lower than expected based not only on objective data and Encompass' national experience, but more importantly, also on the experience of providers in Connecticut caring for patients in need of IRF services. Thus, the use of historical Connecticut IRF rates as the "benchmark" or target would only perpetuate and exacerbate the identified problem: that patients in western Connecticut in need of IRF services are not able to access that level of care.

Moreover, the Applicant's findings based on publicly available data are consistent with the experience of area physicians and community agencies, which is that while service area residents utilize general acute care hospitals at levels consistent with the national average, residents' use of IRF services is significantly and disproportionately lower than expected while service area residents' use of SNF services is significantly and disproportionately higher than expected. *See, e.g.*, OHS Exhibit O, pp. 654 & 665 and letters of support from Dr. Peter McAllister, a Clinical Assistant Professor, Yale University School of Medicine and member of the New England Institute for Neurology & Headache NEINH (OHS Exhibit F, p. 529); Dr. Earl Bueno, Chief, Department of Anesthesiology, Waterbury Hospital, Chief of Anesthesia, NAPA Central Connecticut, and Immediate Past President, Connecticut State

Society of Anesthesiologist (OHS Exhibit K, p. 4); Dr. Scott Gray of Somers Orthopaedic Surgery & Sports Medicine Group, PLLC (OHS Exhibit A, pp. 243-244); and Julie Peters, CBIS, Executive Director of the Brain Injury Alliance (OHS Exhibit A, p. 245).

Notably, the use of a national benchmark rather than historically low IRF utilization rates in western Connecticut ensures that the historical effect of the sole provider, Danbury Hospital, controlling IRF admissions does not inappropriately affect the quantitative assessment of the need for the appropriate number of IRF beds in the service area.

In addition, the Hearing Officer's claims that the methodology used by the Applicant is not "approved" in Connecticut is without precedent in CON matters. While applicants will often use Statewide Healthcare Facilities and Services Plan (the "Plan") Guidelines to assist in evaluating need for a proposal, these are not "approved" methodologies[4] and, even assuming they were, there are no such guidelines specific to freestanding IRF services.[5]

In addition, there is ample precedent for utilizing a "national" methodology, applied to Connecticut populations, to support the need for a new or expanded service. As set forth in detail in the Applicant's Late File Response, OHS has utilized this type of data to support clear public need in several CON approvals in just the last few years. *See* OHS Exhibit II. These include, notably:

- **Wildwood Behavioral Health, LLC, Docket No. 20-32402-CON** (June 18, 2021) – The applicant established a clear public need for a new healthcare facility to provide

[4] The Plan states that it is, by design, an advisory document and that standards and guidelines are not final "until adopted as regulation pursuant to Chapter 54 of the Connecticut General Statutes." *See* Plan, Sec. 1.5.

[5] The acute care general hospital bed-need methodology included in the record by OHS at Exhibit S is not itself applicable to freestanding IRFs. This bed-need methodology is targeted at overall bed need for Connecticut's acute care general hospitals, some of which happen to have Distinct Part Unit rehabilitation beds. The methodology and the data reported by OHS in the SHP does not include any specialty hospitals, which is how the proposed freestanding Encompass Danbury IRF would be licensed. Moreover, as previously noted, a bed-need methodology based on historic utilization fails to account for those individuals who are not receiving IRF-level services due to a lack of available beds.

mental health day treatment and psychiatric treatment to adults diagnosed with co-occurring substance use and mental health disorders using national data from the United States Substance Abuse and Mental Health Services Administration ("SAMHSA"); applicant further provided historic utilization for other facilities and services that it provides nearby to show the reasonableness of its volume projections; moreover, applicant provided an estimate of referrals by source to include general categories (e.g., hospitals, residential rehabilitation facilities, sober houses, clinician/professional, and self/family) rather than naming specific referring providers; applicant further argued that it would increase volume over the first three years of operation by engaging the services of an outreach consultant who will establish contacts across Connecticut providing educational and marketing services and reaching out directly to therapists, psychiatrists, hospitals, and other health care providers; OHS further acknowledged SAMHSA national survey data showing that 90% of patients in the target population are not receiving needed treatment for their substance use disorders.

- **American Day CD Centers LLC, Docket No. 20-32386-CON** (May 7, 2021) – The applicant, a New Jersey-based company, established a clear public need for a new Intensive Outpatient Program and Partial Hospital Program for adults with substance abuse, psychiatric and/or co-occurring disorders using, among other sources, The Robert Wood Johnson Foundation's 2020 County Health Rankings & Roadmaps and SAMHSA national prevalence and incidence rates for substance use and mental illness applied to the population of the proposed Connecticut service area; volume projections were then based on these prevalence and incidence rates, as well as the

applicant's experience providing behavioral health services in New Jersey; referrals, which will be derived from website/advertisements and outpatient sources such as private providers, were generally categorized (e.g., acute care hospital, psychiatric hospital, other outpatient, school, legal) rather than naming specific referral sources.

- **Column Health LLC, Docket No. 19-32347-CON** (July 22, 2021) – The applicant, a Massachusetts-based company, established a clear public need for two new outpatient mental health and substance abuse clinics for adults using national SAMHSA incidence and prevalence rates, as well as The Robert Wood Johnson Foundation's 2020 County Health Rankings & Roadmaps and United States Health Resources & Services Administration ("HRSA") data; projected volumes were based in part on unmet need, with a "sharp increase" in utilization projected due to the shortage of services in the service area; referrals were generally categorized (e.g., referral partner collaboration, internet search/marketing, word of mouth, care facilities, primary care/specialty provider) rather than naming specific referral sources.
- **PATH Integrated Healthcare-CT LLC, Docket No. 19-32321-CON** (August 16, 2021) – The applicant, a provider with locations in Ohio, Vermont, and New Hampshire, established a clear public need for a mental health treatment facility using SAMHSA national prevalence and incidence data applied to the Connecticut market; applicant intends to educate the community of new services through community events, business-to-business marketing, business development activities, online marketing, and community outreach; referrals were generally categorized (e.g., clinical, self/family) and both referral sources and projected volume were supported by evidence including the company's experiences in New Hampshire and Vermont.

OHS has the flexibility to apply a population-based need methodology, based on national data, to determine clear public need for a service in Connecticut.[6] With the above-referenced decisions, OHS has shown a willingness to analyze CON applications in this manner, acknowledging need, the reasonableness of projections, general referral sources, and an applicant's ability to achieve volume through community education and outreach. It is arbitrary and capricious and an unwarranted exercise of the agency's discretion not to give Encompass Danbury's needs assessment the same consideration using the same standards.

- **FF10 –** This Finding of Fact ignores the most recent utilization data for Danbury Hospital, the sole IRF provider in western Connecticut, by referencing data that is more than three (3) years old. Based on the most recent data (FY 2021) reported by Danbury Hospital, the hospital's IRF is highly utilized, with an **average annual occupancy of 88.1%** - an annual occupancy that materially exceeds the 80% target occupancy threshold identified in the Plan. Moreover, Danbury Hospital's annual patient days have dramatically increased over the past few years, increasing 18.8% between FY 2019 and FY 2021 according to Danbury Hospital's own data and as reflected in the Hearing Officer's chart in Findings of Fact 11. *See, also* OHS Exhibit QQ p.763, Table 1 for the significant increases in IRF volume at Danbury Hospital over the last few years, despite any COVID-19 impact. Thus, based on the information provided by Danbury Hospital and evaluated by the Hearing Officer, the hospital's most recent utilization far exceeds the 74.1% cited here. At a minimum, this

[6] An important analogy between the proposed Encompass Danbury project and the approved freestanding psychiatric facility projects is the concept of "gap in care" because for both patient types (rehabilitation and psychiatric/substance abuse), historical utilization of services does not reflect need for the service, but rather, historical under-utilization of services.

Finding of Fact should either be stricken or revised to accurately reflect evidence in the record regarding the high and increasing utilization of Danbury Hospital's IRF program.

- **FF11 –** This Finding of Fact erroneously focuses on staffed beds and the percentage of days Danbury Hospital's IRF program was at 100% capacity, neither of which are appropriate measures of utilization in this instance. In fact, the table included in the Proposed Final Decision belies the conclusion drawn by the Hearing Officer, which appears to be that Danbury Hospital has available capacity. While it may be mathematically correct that "Danbury Hospital operates at compacity an average of 9.5% of the time", that is a meaningless measure because it ignores the most recent year's average annual utilization of 88.1% and the material increase in all measurements (*e.g.*, discharges, days, average daily census, and even days at 14) since FY 2019 generally and over the prior year, particularly. *See* FF11. Furthermore, as explained by Encompass Danbury in OHS Exhibit QQ, p. 763, general acute care hospitals such as Danbury Hospital typically count their daily census at midnight (*i.e.*, the midnight census), thus the number of days that its unit is full (which though not the most relevant metric in this instance) is likely understated. At a minimum, this Finding of Fact should either be stricken or revised to accurately reflect evidence in the record regarding the high and increasing utilization of Danbury Hospital's IRF program.
- **FF12 –** This Finding of Fact states that there was no wait list for services at Danbury Hospital's IRF unit in November of 2021 and cites page 267 of OHS Exhibit P as authority. This is not what Dr. Aaronson testified to on page 267 of Exhibit P; rather, she appears to acknowledge that if Danbury Hospital's IRF unit was operating at capacity, they would have to wait until a patient was discharged to admit a new patient. Moreover, even if Dr. Aaronson was testifying to an absence of a wait list for IRF services in November of 2021,

that would not be relevant to whether a wait list exists currently or will exist in the future, particularly considering the aging of the population in the service area and the increases in discharges, days, average daily census, etc. mentioned in response to FF11 above. *See* OHS Exhibit O, p. 666. Accordingly, this Finding of Fact should be stricken and no finding regarding the absence of a wait list at Danbury Hospital for IRF services should be used to support the denial of the CON.

- **FF13 –** This Finding of Fact states that Danbury receives one (1) IRF referral per month from Norwalk Hospital and that many accepted patients from Norwalk Hospital decline the referral because it is geographically too far away. The Hearing Officer cites pages 273-274 of OHS Exhibit PP as authority. While Dr. Aaronson acknowledged that Danbury Hospital has historically received approximately one (1) IRF referral per month from Norwalk Hospital, she further states that this number "potentially will grow once we have a screener in place who will be working closely with the doctors, the case managers and that potentially will grow … [s]o again, that's a potential growth phase that we are trying to accommodate for …." *See* OHS Exhibit PP, p. 274. Without inclusion of this qualifying statement by Dr. Aaronson, the Finding of Fact is incomplete and misleading. Moreover, nowhere on pages 273-274 of Exhibit P does it state that the patients from Norwalk Hospital decline referrals because it is "geographically too far away" from Danbury Hospital. Accordingly, this Finding of Fact should either be stricken or revised to accurately reflect the evidence in the record. Moreover, no finding regarding the alleged lack of referrals from Norwalk Hospital for inpatient rehabilitation services should be used to support a denial of the CON.
- **FF14** – This Finding of Fact is incomplete and incorrect in two primary ways. First, the Hearing Officer incorrectly states that the Applicant did not quantify "the extent to which

patients will be referred from general acute care hospitals to Encompass Danbury" when, in fact, Encompass Danbury did quantify the number of patient referrals expected from each Connecticut general acute care hospital in OHS Exhibit II, p. 721, Table 2. Second, the Hearing Officer attempts to support her erroneous claim that the Applicant did not quantify the patient referrals from general acute care hospitals by referencing Encompass Danbury's discussion that, based on its experience operating IRFs across the country, there are a number of factors (*e.g.*, individual patients' needs and circumstances, physicians' patient mix, and referrals from community agencies/services for specific types of patient injuries and illnesses) that affect patient referral patterns. Ironically, while the Hearing Officer seems to reference these factors in an attempt to undermine the need for the project, it is Encompass Danbury's understanding of these very factors that ensures the hospital's and patient's success when Encompass enters a new market.

- **FF30** – This Finding of Fact, which shows that Encompass Danbury is by far the lower cost provider when compared with Danbury Hospital, is incorrectly cited. Encompass Danbury's cost of care evidence was included in Exhibit C, Tables 2 and 3, page 494. The Finding of Fact should be revised accordingly. Moreover, the fact that Danbury Hospital's FY 2021 charges are more than double (2x higher) Encompass Danbury's FY 2023 charges should be noted because of the positive impact Encompass Danbury's comparatively lower costs will have on the financial strength of the health care system in the state, the cost effectiveness of the health care delivery in the region, and the provision of services to relevant patient populations and payer mix, including indigent persons who are categorized as self-pay patients. *See* OHS Exhibit QQ, p. 764.

- **FF32** – This Finding of Fact erroneously focuses on the days that Danbury Hospital did not operate at "full capacity", which as discussed previously is a misleading and inappropriate metric in this instance by which to evaluate an existing providers' utilization. Moreover, Danbury Hospital's President stated in her testimony that Danbury Hospital has plans to expand its unit despite their protestations that there is no need for additional beds. *See* OHS Exhibit PP, pp. 185-186. The contradiction in Danbury Hospital's positions (*i.e.*, no need for additional beds yet its plans to expand beds) is demonstrated by Sharon Adams statements that the hospital has an architect and tentative schematic drawings for the IRF bed expansion in addition to the allocation of funds for the planned expansion of beds, as well as testimony by the hospital's Medical Director of Inpatient Rehabilitation Dr. Beth Aaronson that "Nuvance Health has prioritized an expansion of the inpatient rehabilitation unit **in Fiscal Year 2022**." *See* OHS Exhibit Y, p. 21 (emphasis added).

IV. Argument

The Applicant has established, by a preponderance of the evidence, that all relevant statutory criteria for the issuance of a CON have been met. *See Jones v. Connecticut Medical Examining Board*, 309 Conn. 727 (2013). A fair preponderance of the evidence is "properly defined as the better evidence, the evidence having the greater weight, the more convincing force in your mind." [Internal quotation marks omitted.] *Santos v. Comm'r of Correction*, 186 Conn. App. 107, 114, 198 A.3d 698, 705 (2018).

The better evidence provided by the Applicant in support of its proposal to establish a 40-bed IRF in Danbury shows that there is in fact a clear public need for the proposal and that, given the substantial "gap in care" in Connecticut for these critically important healthcare services, the proposed hospital can be established without unnecessarily duplicating the limited and more

costly inpatient rehabilitation services available at Danbury Hospital. OHS has already concluded that the proposal improves the quality, accessibility, and cost-effectiveness of rehabilitative care in Connecticut; that it is financially feasible; that it does not reduce services for Medicaid recipients and indigent persons[7]; and that it increases diversity of providers and improves patient choice for inpatient rehab services in the Danbury area. As discussed in greater detail below, OHS is also compelled to conclude that this proposal, which meets virtually all (if not all) of the objectives of the Plan as outlined by the Hearing Officer, is in fact consistent with the Plan. Based on the foregoing, the weight of the evidence clearly supports approval of the Applicant's proposal to establish a freestanding IRF in Danbury. To the contrary, there is **not** substantial evidence in the record to support OHS's erroneous denial of the CON request.

The agency must correct the substantial errors and omissions in its Findings of Fact and Discussion related thereto. In doing so, and even without doing so, it will become evident that the weight of the evidence in the record supports a finding that all relevant statutory decision criteria have been met. As such, approval of the CON is required.

A. The Applicant's Proposal is Consistent with the Statewide Health Care Facilities and Services Plan (Conn. Gen. Stat. 19a-639(a)(2))

As is discussed throughout this Argument section, the Applicant's proposal is consistent with the Plan's Guiding Principles, as well as the mission of OHS 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 particular, this proposal is in clear alignment with the goals set forth in the introduction to Section 1.4 of the Plan, Guiding Principles, which states as follows:

[7] See Section IV.B. below for additional discussion regarding the proposal's impact on access to services for Medicaid recipients and indigent persons.

> The goal of OHCA's planning and regulation activities are to improve the health of Connecticut's residents; increasing the accessibility, continuity and quality of health services; prevent unnecessary duplication of services; and provide financial stability and cost containment of health care services.

Moreover, while this proposal is in alignment with all the Guiding Principles set forth in the Plan, it particularly addresses the following: promotion and support of the long-term viability of the state's health care delivery system; facilitating access to preventive and medically necessary health care services; and maintaining and improving the quality of health care services offered to the state's residents. *See* OHS Exhibit A, p. 48.

Throughout the CON submissions, the Applicant has provided evidence to support the fact that the proposal aligns with the Plan's stated goals of improving quality, accessibility, continuity of care (and its relationship to quality of health services), financial stability and cost containment. OHS concedes, through its Proposed Final Decision, that the Applicant has met each of the aforementioned goals, including accessibility for indigent persons as discussed in Section IV.B. below. It follows also that this proposal meets the Plan goal of improving the health of Connecticut's residents. *See* Plan, Sec. 1.4.

OHS claims, however, that the Applicant has failed to show a need for additional IRF services in the Danbury area and that this project does not represent an unnecessary duplication of services, with the latter being a stated goal of the Plan. The Hearing Officer argues that failure to meet this single stated goal (prevent unnecessary duplication of health resources – *see* Plan, Sec. 1.4) makes the proposal inconsistent with the Plan. The Applicant disagrees. First, as set forth in Sections IV.C. and IV.D. below, the Applicant has established by a preponderance of evidence that there is a need for additional IRF services in the Danbury area and that the proposed Encompass Danbury hospital does not unnecessarily duplicate the inpatient rehabilitation services provided by Danbury Hospital. However, even if the single goal of

avoiding the unnecessary duplication of services is not met, which the Applicant denies is the case, the proposal remains consistent with a vast majority of the stated goals of the Plan.

Accordingly, OHS must find that the statutory decision criterion around the relationship of the proposal to the Plan has been met.

B. The Applicant Has Established that The Proposal Will Provide Access to Medicaid Recipients & Indigent Persons (Conn. Gen. Stat. Sec. 19a-639(a)(6))

OHS claims that the Applicant has not met Section 19a-639(a)(6) of the General Statutes, which requires that the proposal provide access to Medicaid recipients and indigent persons, because the Applicant does not have a charity care policy. This is incorrect and inconsistent with evidence in the record and the Hearing Officer's own Findings of Fact and conclusions of law.

The Encompass Health Financial Assistance Policy, which will be implemented at the proposed Encompass Danbury hospital, is included in OHS Exhibit A at pages 390-395. The Hearing Officer concludes in FF18 that "[i]ndigent persons will receive treatment in accordance with Encompass Health's Financial Assistance Policy" and in FF28 that "[i]ndigent persons will receive treatment in accordance with the Applicant's Financial Assistance Policy." She further concludes in FF15 that "Encompass Danbury has demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons."[8]

Based on the foregoing, OHS's finding that Section 19a-639(a)(6) has not been met because the "Applicant does not have a charity care policy so they cannot show that their project will provide access to indigent persons" is clearly erroneous. Discussion Section J of the

[8] This forms the basis for her finding that Section 19a-639(a)(10) of the General Statutes regarding reduced access to services by Medicaid recipients or indigent persons is not applicable. *See* Proposed Final Decision, Discussion Section J. A similar finding was made with respect to Section 19a-639(a)(5) and the accessibility of services for these individuals. *See* Proposed Final Decision, Discussion Section E.

Proposed Final Decision must be revised to reflect that the Applicant has a Financial Assistance Policy that it will put in place to ensure access for indigent persons. As a result, OHS must conclude that Section 19a-639(a)(6) has been met.

C. The Applicant Has Established a Clear Public Need For the Proposal & Identified the Population Affected by the Proposal & Its Need for Inpatient Rehabilitation Services (Conn. Gen. Stat. Sec. 19a-639(a)(3) & (7))

OHS appears to take issue with three aspects of the Applicant's demonstration of clear public need and identification of affected populations and their need for the proposed hospital: (1) the Applicant's comparison and use of national IRF utilization to Connecticut; (2) Encompass' documentation of the inappropriate use of skilled nursing services in lieu of needed IRF services; and (3) Encompass Danbury's lack of quantification of referrals from Connecticut general acute care hospitals. In its discussion, OHS failed to recognize the following facts in the record specific to each issue.

(1) The Applicant's comparison and use of national IRF utilization to Connecticut is appropriate when historical utilization does not reflect need for the service.

OHS, similar to Danbury Hospital, apparently believes that the need methodology for IRF services in Connecticut should be based on historical utilization, either ignoring or simply not understanding that when patients who need IRF services cannot (for whatever reason) obtain those services, historical utilization is not an appropriate measure of need. Rather, historically low utilization in that instance reflects the need for greater access to the needed service, which is why the Applicant proposes to establish a new 40-bed IRF facility in Danbury.

The Applicant began its market assessment by having discussions with community physicians and referral agency representatives who identified the need for additional IRF

services in Danbury. Some of the physicians and community agencies with whom the Applicant discussed its proposed services wrote letters of support discussing Connecticut residents' inability to receive needed IRF services. *See* FF9 discussion above. The receipt of these letters is notable given the fact that Danbury Hospital strongly dissuaded physicians from supporting the project, as attested to by Dr. Scott Gray in his supplemental letter of support. *See* OHS Exhibit II, pp. 739-740.

Given the gap in care for IRF services experienced by patients cared for by local healthcare providers, Encompass Danbury then quantified the identified need for additional IRF beds and services by appropriately using national benchmarks applied to service area population. In this way, Encompass Danbury was able to quantify the gap in care between historical utilization of IRF services and the need for IRF services attested to by the local community providers. *See* OHS Exhibit O, pp. 632-678. Encompass Danbury further quantified the gap in care between historically low utilization of IRF services and the need for services by providing OHS with the actual number of the hundreds of Connecticut Medicare residents who travel out-of-state annually to receive IRF services because they are unable to receive that care locally. *See* OHS Exhibit II, p. 728, Tables 6 and 7.

Interestingly enough, the Hearing Officer's rejection of the Applicant's use of national benchmarks appears to contradict the use of national benchmarks by OHS staff members, illustrated by the request by OHS for Encompass Danbury to provide information comparing its quality measure ratings to national benchmarks. *See* OHS Exhibit II, pp. 728-729, Table 8.

(2) Skilled Nursing Facilities and IRFs provide distinct services and the use of SNF services when IRF is needed is not in the patient's best interest.

The Hearing Officer states, "the Applicant's methodology suggests that thousands of patients in Connecticut are being inappropriately discharged every year to skilled nursing facilities and other post-acute care settings that are not medically appropriate". The Applicant respectfully requests that the record accurately reflect the arguments made by Encompass Danbury, which is that there is a distinction between the level of inpatient rehabilitation services provided by SNFs and IRFs – and that distinction is recognized not only by Encompass but by CMS and OHS as well, as evidenced by the different regulatory rules for the two types of facilities. Because of the differences in the level of services provided in each setting, patients who need and would benefit from IRF services receive **suboptimal care** when admitted to the less intensive SNF setting rather than the IRF setting that provides more intensive and more frequent rehabilitative care. *See, e.g.*, OHS Exhibit A, pp. 18-22.

The Applicant provided letters from local community members, including caregivers and referral agencies, that attested to the distinction between the levels of care provided in an IRF and a SNF, among other settings. *See* FF9 discussion above. Additionally, the Applicant provided publicly available data showing that while Connecticut residents' use of general acute care hospitals is similar to the national average, the use of IRF services is significantly lower while the use of SNF services is significantly higher. *See* OHS Exhibit O, pp. 632-678. This data, taken with the local community members' experience makes clear that not only is there a distinction between SNF and IRF services, but that Connecticut residents are using SNF in lieu of IRF services when IRF would be the best setting for the patient.

Finally, it is important to note that the Hearing Officer's interpretation of the Applicant's methodology is in fact not her own nor, more importantly, is it based on evidence presented by the Applicant. Rather, it is the unsupported opinion of Danbury Hospital's President who stated in her opposition that Encompass Danbury's methodology "implicitly suggests that thousands of patients in Connecticut are being inappropriately discharged every year to skilled nursing facilities and other post-acute care settings that are not medically appropriate." *See* OHS Exhibit Y, p. 5.

(3) Encompass Danbury quantified the patient referrals from general acute care hospitals and recognizes those referrals are affected by a number of factors.

First, the Hearing Officer again incorrectly states that the Applicant did not quantify "the extent to which patients will be referred from general acute care hospitals to Encompass Danbury" when, in fact, Encompass Danbury did quantify the number of patient referrals expected from each Connecticut general acute care hospital. *See* OHS Exhibit II, p. 721, Table 2. Second, the Hearing Officer again attempts to support her erroneous claim that the Applicant did not quantify the patient referrals from general acute care hospitals by referencing Encompass Danbury's discussion that, based on its experience in operating IRFs across the country, that there are a number of factors (*e.g.*, individual patients' needs and circumstances, physicians' patient mix, and referrals from community agencies/services for specific types of patient injuries and illnesses) that affect patient referral patterns. While the Hearing Officer seems to reference these factors in an attempt to undermine the need for the project, it is Encompass Danbury's understanding of these very factors that ensures the hospital's and patient's success when Encompass enters a new market.

In correcting the foregoing errors, omissions and misinterpretations of evidence and the applicable law, OHS must find that the statutory decision criteria around clear public need and identification of affected populations and their need for the proposed service have been met.

D. The Applicant Has Established that Utilization of Existing Health Care Facilities Supports the Proposal & that the Proposal Will Not Result in an Unnecessary Duplication of Services (Conn. Gen. Stat. Sec. 19a-639(a)(8) & (9))

OHS claims that the Applicant has not met Sections 19a-639(a)(8) & (9) of the General Statutes, which require that the utilization of existing health care facilities support the proposal and that the proposal not result in an unnecessary duplication of services, because the Hearing Officer inappropriately concluded that Danbury Hospital has available capacity. However, Danbury Hospital's own data and plans and the Hearing Officer's summary of same belies that conclusion. For example, the Hearing Officer erroneously refers to the lack of a wait list at Danbury Hospital and that "Danbury Hospital's IRF did not operate at full capacity for the overwhelming majority of days during the last three fiscal years" while ignoring the fact that **Danbury Hospital's unit's average occupancy rate is high and increasing and for the most recent fiscal year far exceeded the 80% target occupancy rate in the SHP**. *See* FF10 & FF11 discussion above. At the same time, the Hearing Office notes that Danbury Hospital "has indicated that it has the ability to expand its IR unit if the need arises", which misrepresents the testimony of Danbury Hospital's President and its Medical Director of Inpatient Rehabilitation, who testified that **the hospital plans to expand its facility in FY 2022**, while seeking to maintain its status as the only provider of inpatient rehabilitation services in western Connecticut, despite its statements to the contrary that there is no need for additional beds.

Thus, not only did the Hearing Officer focus on the wrong metrics, but she ignored Danbury Hospital's own admission that because of its high utilization, the hospital plans to add IRF beds to its facility. *See* FF32 discussion above. Based on information in the record, it is clear that the Applicant and Danbury Hospital itself have both shown that the high utilization of Danbury Hospital, the sole IRF provider in western Connecticut, supports the proposal, which will not unnecessarily duplicate inpatient rehabilitation services.

Accordingly, OHS must find that the statutory decision criteria around utilization of existing facilities and that there be no unnecessary duplication of services have been met.

E. OHS Must Weigh Those Decision Criteria that Have Been Met and In Doing So Find that the Applicant Has Satisfied Its Statutory Burden

OHS has concluded (or must conclude) that a majority of the statutory criteria for the issuance of a CON have been met and, in doing so, must approve the proposal. While OHS is required to "take into consideration and make written findings" regarding each of the guidelines and principles set forth in Section 19a-639(a) of the Connecticut General Statutes, based on the plain and unambiguous language of the statute itself, the agency is **not required to find that each of the Section 19a-639 criterion has been satisfied as a precondition of CON approval**.[9] In fact, OHS's CON Guidebook acknowledges that "[s]ome criteria directly relate to different application more than others,"[10] meaning the weight afforded to each condition will vary from decision to decision.

[9] Courts have found that where a statute mandates consideration and written findings regarding multiple factors, the factors serve as guidelines for the court and are not statutory prerequisites each of which needs to be proven. *See e.g.*, In re Scarlett S., 2018 WL 44441133, at *23 (Conn. Super. Ct. August 13, 2018).
[10] Office of Health Strategy, *Certificate of Need Guidebook* at page 23 (February 2020), retrieved from: https://portal.ct.gov/-/media/OHS/CONfolder/CON-Guidebook-2020.pdf

Here, **OHS acknowledged that the Applicant has met the following applicable statutory decision criteria**:

- Sec. 19a-639(a)(4) – The project is financially feasible based upon the Applicant's demonstrated ability to fund the capital expenditure from existing cash, cash flow form operation, and funds available under its credit facility.
- Sec. 19a-639(a)(5) – The project improves the quality of health care in that it will bring a new, fully equipped, and staffed facility to the area with disease-specific accreditation and a goal of returning approximately 81% of its patients back to their homes. The project also enhances healthcare access, including for Medicaid recipients and indigent persons, by increasing the number of locally available IRF beds. Finally, the project is cost-effective given the Applicant's participation with Medicaid and Medicare and the fact that rates for services are limited by these payers.[11]
- Sec. 19a-639(a)(11) – The project will increase the diversity of providers and improve patient choice by adding a second option for inpatient rehabilitative care in the Danbury area.
- As discussed in Section IV.B. above, Sec. 19a-639(a)(6) of the General Statutes has also been met via evidence in the record concerning the Applicant's Financial Assistance Policy, as acknowledged by OHS throughout the Proposed Final Decision.

Considering the nature of the criteria that were met in this case – specifically, those related to quality, access to care including for Medicaid recipients and indigent persons, cost-effectiveness of care, diversity of providers and patient choice – OHS is compelled find that the

[11] Note also that Encompass Danbury is a more cost-effective alternative to Danbury Hospital, as discussed in reponse to FF30 above.

Applicant has carried its burden by a preponderance of evidence and approve the CON. Add to this the fact that, as articulated in Sections IV.A., IV.C., and IV.D. above, the Applicant has in fact met all of the statutory criteria for issuance of a CON, including those around consistency with the Plan, need and duplication of services. Moreover, the very fact that the Applicant has met Sections 19a-639(a)(4) and (5) regarding quality, accessibility, cost-effectiveness, and the financial feasibility of the proposal require OHS to make the logical and reasonable finding that there is also need for the proposed hospital. In light of the foregoing, there is no question that this CON should be approved, and that Encompass Danbury should be allowed to establish an IRF in Danbury that will significantly enhance the state's healthcare delivery system.

F. The Proposed Final Decision and the Process Utilized by OHS to Arrive at that Decision Is Based on Substantial Procedural Errors and Irregularities That Deprived the Applicant of Due Process

The Proposed Final Decision is based upon substantial procedural errors and irregularities, which will form the basis for an administrative appeal if a Final Decision is issued denying the Applicant's CON request. These errors and irregularities, which deprived the Applicant of due process, include, but are not limited to, the following:

- The agency's decision to redesignate a Hearing Officer on two separate occasions, once between the public hearing and closure of the record, and again before a Proposed Final Decision was issued, was a prejudicial procedural error. The redesignated Hearing Officer who issued the Proposed Final Decision did not observe the hearing in person and in real-time such that she could adequately assess witness and public commenter credibility, ask clarifying questions and request additional evidence as necessary, and issue a proposed decision that accurately and completely reflects information in the administrative record. Nor did she request any clarifying or supplemental information

from the Applicant when she was appointed Hearing Officer shortly after joining the agency and just a few weeks before the Proposed Final Decision was issued. This deprived the Applicant of its right to a fair hearing and decision based on that hearing and the totality of the record.

- After taking nearly a year-and-a-half to hold and close the public hearing, OHS missed the statutory deadline for issuance of a decision in this matter. Per Section 19a-639a of the General Statutes, a decision is due within 60 days of the date on which the hearing record is closed. Here, the hearing record was closed on January 11, 2022, which means a decision was due by March 12, 2022. The decision was issued on September 21, 2022, **193 days past the deadline**. This deprived the Applicant of its right to a prompt hearing and a timely decision.

V. Requested Relief

In light of the foregoing, the Applicant respectfully requests the following relief:

- That OHS revise the various Findings of Fact listed in Section III. above (Exceptions) and any language within the Discussion section of the Proposed Final Decision based on erroneous or omitted factual findings.
- That OHS determine that each of the applicable statutory decision criteria for issuance of a CON has been met, as set forth in Section IV. above.
- That OHS issue a Final Decision approving the Applicant's request for CON approval to establish a 40-bed IRF in Danbury.

In the alternative, Encompass Danbury is amenable to discussing a negotiated settlement with OHS that addresses any remaining concerns with its proposal.

VI. Conclusion

Based on the foregoing, and considering all of the evidence in the administrative record of this matter, the Applicant has met its burden of establishing that the proposal to establish a 40-bed IRF in Danbury meets the statutory criteria for issuance of a CON. As noted earlier in this Brief, OHS concedes that the Applicant's proposal is in the best interest of patient care; that the proposed hospital will improve the quality of healthcare, as well as the accessibility of IRF services for all patients including Medicaid recipients and indigent persons; that the proposal is financially feasible and cost-effective; and that the proposed Encompass Danbury hospital will improve the diversity of IRF providers in the Danbury area, where the only existing provider is Danbury Hospital, giving patients meaningful choice of providers as the CON laws require. For the reasons discussed herein, the agency is also compelled to conclude that there is a need for the proposal, even considering utilization of existing providers, and that it complements the services provided by Danbury Hospital rather than unnecessarily duplicating those services. The proposal is also consistent with virtually all (if not all) of the stated goals of the Plan. The reliable, probative, and substantial evidence in the administrative record supports approval of the proposal and does **not** support the Hearing Officer's recommended denial of the CON. To deny the CON Application would be arbitrary and capricious and an unwarranted exercise of discretion by the agency.

Accordingly, the Applicant respectfully requests that the Acting Executive Director review this file *de novo*. Considering the reliable, probative, and substantial evidence in the administrative record, which unequivocally favors approving the Applicant's request, the Acting Executive Director should issue a Final Decision approving the CON Application. In the

alternative, the Applicant is willing to engage in settlement discussions with the agency to address any remaining concerns.

Respectfully Submitted,

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