A Review of Certain Health-Care System Characteristics in States with and without Certificate of Need

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Healthy Living/Health Services Subcommittee
Virginia Joint Commission on Health Care
September 9, 2015

Background

Cabinet Secretary of Health and Human Resources requested assistance in locating specific information on Certificate of Public Need/Certificate of Need (COPN/CON) programs and the impact on the health care system in the states where the program was repealed.

The following report is a comparative analysis using population data and health care expenditures by state using source documents from the Centers for Medicare and Medicaid Services (CMS) and the US Census Bureau.

The list of data and article sources can be found at the end of the report.

2

Report Organization

The report is organized as follows:

- ✓ Characteristics of the Health Care Delivery System and Certificate of Need;
- ✓ Components of the Virginia COPN program as defined within the Code of Virginia;
- ✓ Charts displaying changes to the health care system over time using per capita calculations and by aggregating data in states with and without CON programs.

3

Disclaimer

It is difficult to draw any conclusions about what happens when a CON program is ended in a state.

There were and continue to be significant changes in the health care system, all in an attempt to control costs, improve access to care, and improve quality.

A more thorough analysis weighing each of the changes in the health care system against the results displayed in this report is needed.

The results in this report are observational; there is no intent to imply causation.

4

Characteristics of the Health Care Delivery System and Certificate of Need

Move toward Outpatient Treatment and Managed Care

In the mid-1980s, Medicare changed the way it reimbursed for inpatient hospital services from "reasonable cost" to Diagnostic Related Groups (DRGs). Private payers and some Medicaid programs adopted the new system over time along with many of its subsequent changes.

In 2008, Medicare began paying for an array of facility based outpatient services provided in ambulatory surgical centers (ASCs) that were traditionally provided on an inpatient basis in hospitals.

Managed care was broadly adopted by all of the health payer sectors as a way to control costs and administer services.

5

Characteristics of the Health Care Delivery System and Certificate of Need

History of Certificate of Need Programs (CON)

The Hill-Burton Act (1946), a hospital and health center construction and grant program, was the impetus for the creation of CON programs.

States were required to designate planning agencies to review community health plans where construction loans and grants were being requested and granted. In exchange for receiving a grant or loan, a health care entity had to agree to serve everyone (community service) and to serve a certain percentage of those who could not afford to pay for health care (uncompensated care).

The Hill-Burton program expired in the mid-1970s. When a new program took its place, Congress mandated state health planning.

6

Characteristics of the Health Care Delivery System and Certificate of Need

History of Certificate of Need Programs (cont.)

Private and public health service payers implicitly required "planning" through reimbursement policies as health care entities sought to recover long term capital and debt costs.

- During the 1960s, many Blue Cross plans did not reimburse entities for the interest and depreciation expenses associated with "unapproved" capital projects.
- In 1972, Congress tied a portion of Medicare and Medicaid reimbursements to "approved" capital projects.

Federal enforcement, penalties, and sanctions were never imposed on entities for violating federal policy.

By the early 1980s, states began to repeal their CON laws.

In 1986, Congress repealed the federal requirement that states perform health planning (P.L. 99-660, Sec. 701).

7

Characteristics of the Health Care Delivery System and Certificate of Need

Community Benefit and Charity Care

In addition to the uncompensated care requirements rooted in the Hill-Burton Act, non-profit health care providers have access to a number of federal, state and local tax policies and reimbursement programs that require participating hospitals to provide community benefits and charity care in order to receive tax benefits and federal funds specifically allocated for uncompensated care.

- Property tax, state and local income tax, and state and local sales tax relief.
- Medicare and Medicaid include programs specifically designed to pay hospitals for a portion of the charity and uncompensated care that they provide.

The Affordable Care Act includes a section requiring nonprofit hospitals to conduct community health needs assessments and adopt implementation strategies to meet those needs at least once every three years. Hospitals that do not comply with the new regulations also risk losing their tax exemptions altogether.

8

Review of Other Studies

A 2009 study, of CON and its impact on hospital beds from 1985 to 2000, found that CON programs reduce the number of hospital beds by 10% and hospital expenses by 2%.

- The same study cited other work that suggests that any money saved by hospitals is re-invested into other areas of hospital operations, negating any savings.

A 1998 study of hospitals and health care spending found that mature CON programs may improve access to care but "there is little empirical evidence to document results." Other findings include: little impact on quality of care; 5% per capita savings in acute care over time but no overall savings per capita; a 2% reduction in bed supply but an increase in the cost per admission and hospital profitability.

A 2014 Florida study included a quote from another state where the CON program was repealed. The state official being interviewed reported that the repeal of the CON program was not seen as correlating with changes in his state's health care system. He said other variables were more likely to be responsible for changes and cited population shifts, the aging population, outdated health care infrastructure, new medical technology, mergers, and state and federal funding shifts.

9

Select Virginia State Code Provisions of Interest

Virginia Code refers to CON as Certificate of Public Need (COPN).

The Virginia Department of Health collects application fees for the COPN program. COPN fees are delineated in Code §32.1-102.2 and are set at 1% of the value of the construction/ purchase or no less than $1,000 and no more than $20,000.

The Virginia Code links the approval of a COPN application to the applicant's ability to provide reduced fees and indigent care for consumers who cannot afford to pay for services.

The Code also links the renewal of state licenses to an applicant's compliance with the COPN agreement.

Fiscal Year	CON Fee Collections
FY 2009	$337,137
FY 2010	$867,000
FY 2011	$822,599
FY 2012	$648,192
FY 2013	$841,215
FY 2014	$539,751
FY 2015	$764,573

Source: Virginia Performance and Budgeting Report System, Expendwise.

10

Health Care Services Regulated by State CON Programs

The health care services regulated by state CON programs are different depending on the state.

The table to the right shows the top 16 of the 31 different health care services that are regulated by state CON programs.

As shown, 2 of the top 3 services that fall under most state CON programs are acute care hospital beds and ambulatory surgical centers.

Regulated Services	Number of States
Nursing Home Beds/LTC Beds	36 +DC
Acute Hospital Beds	27 + DC
Ambulatory Surgical Centers	27
Long Term Acute Care (LTAC)	26 +DC
Cardiac Catheterization	26
Psychiatric Services	26
Open Heart Surgery	25
Rehabilitation	25
Neo-Natal Intensive Care	23
Radiation Therapy.	23
ICF/MR	22
Organ Transplants	21
Positron Emission Tomography (PET) Scanners	20
Sub./Drug Abuse	19
Home Health	18
Hospice	18

Source: http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#Program

11

CON Programs Discontinued in 15 States

According to NCSL, 15 states have discontinued their CON programs: 11 states ended their programs during the 1980s, 3 states during the 1990s, and 1 state in 2011.

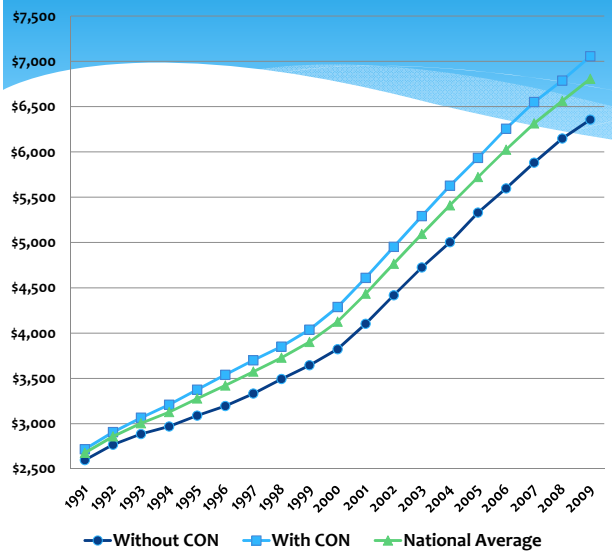
The following charts display and compare per capita health expenditures in states with CON to states without CON from 1991 through 2009. The date range was chosen to allow for enough time to capture any changes in per capita expenditures.

CON Ended	States	
1983	Idaho	New Mexico
1984	Utah	
1985	Arizona Minnesota	Kansas Texas
1987	California	Colorado
1988	South Dakota	
1989	Wyoming	
1995	North Dakota	
1996	Pennsylvania	
1999	Indiana	
2011	Wisconsin	

Source: NCSL, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#Program

12

Per Capita Health Expenditures 1991 - 2009



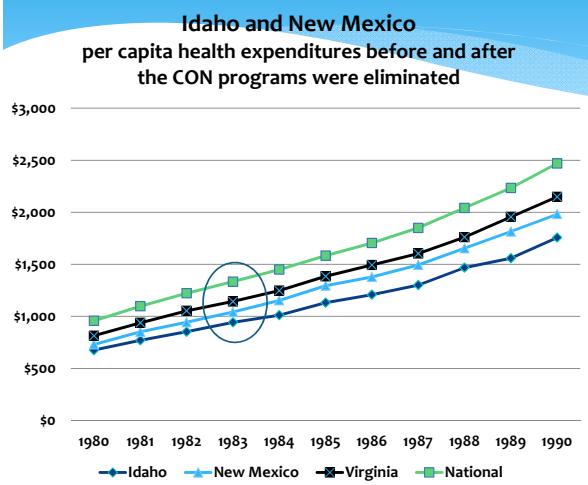
The chart to the left and the subsequent charts were created by calculating the per capita personal health expenditures in each state, grouping the states by those that ended their CON programs and those that did not within the decade that the programs changed based on the NCSL table in the previous slide.

Fourteen states ended their CON programs between 1980 and 2000.

This graph, which represents the changes to per capita health expenditures from 1991 through 2009, shows that while the trend in health care expenditures was increasing at about the same rate for each group of states there is a separation in the per capita expenditures for each group.

13

Per Capita Personal Health Expenditures Before and After CON Discontinued in Idaho and New Mexico in 1983

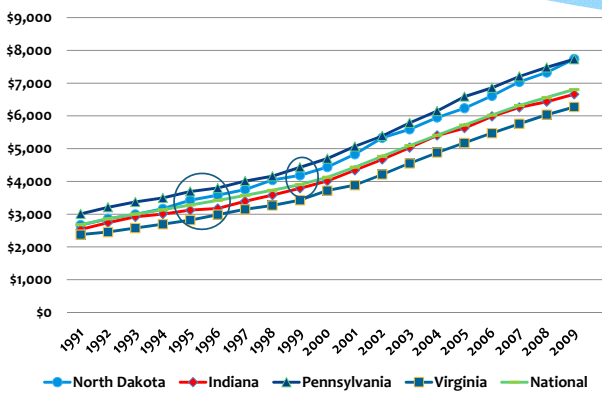


The graph to the left displays two states that ended their CON programs in 1983.

The graph indicates that both states' per capita health expenditures were below the national average at the time they ended their programs and there was no marked change in the growth or decline of the per capita expenditures after the CON program was eliminated.

14

Per Capita Personal Health Expenditures Before and After CON Discontinued in Three States in 1990s



The graph to the left indicates that both North Dakota's (1995) and Pennsylvania's (1996) per capita health expenditures were above the national average at the time they ended their CON programs and there was no marked change in the growth or decline rates of the per capita expenditures after the CON programs were eliminated. Indiana's per capita health expenditures mirror the national per capita health expenditure trend line.

15

Availability of Hospital Beds and Ambulatory Surgical Centers in States with and without CON Programs

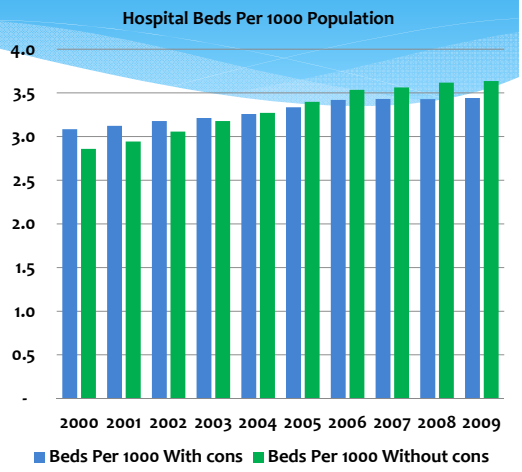
Hospital Beds

Between 2000 and 2009, 27 states and the District of Columbia regulated hospital beds through CON programs.

The charts to the right show the number of hospital beds per 1,000 state population for the 27 states and DC with hospital CON programs compared to the 23 states without a hospital CON program.

The time period represents changes after the majority of CON programs were eliminated between 1980 and 1999.

The table shows that the number of hospitals beds per 1,000 in states without hospital CON programs increased over time. By 2009, states without hospital CON programs had an average of 3.6 beds per 1000 compared to 3.4 beds per 1000 in states with a hospital CON program.



CMS: Hospital 2552-96 Cost Report Data files

16

Shift to Outpatient Care

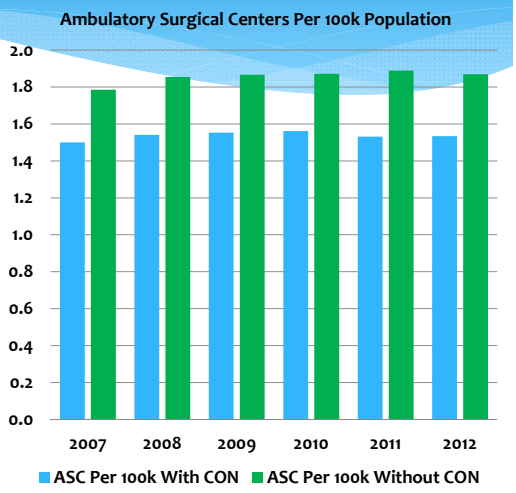
Ambulatory Surgical Centers

As mentioned previously, in 2000 and 2008 Medicare made changes in outpatient reimbursement methodologies to encourage providers to expand the use of outpatient treatment services and to control if not reduce escalating Medicare costs.

The reimbursement changes led to an increase in the number of ambulatory surgical centers nationally.

The chart to the right compares the number of ASCs per 100k state population in states with and without CON programs.

The table indicates that there are almost 2 ASCs per 100,000 people in states without a CON program compared to approximately 1.5 ASCs in states with a CON program.



CMS Provider of Services Current Files, 2014

17

Ambulatory Surgical Centers- Location

CON programs can approve or deny an application from an entity but they do not have the ability to require an entity to locate where the entity is considered "to be needed." In a report to Congress, the Medicare Payment Advisory Commission found that 91.0% of ASCs are located in urban areas.

ASCs located in Georgia: 2007 to 2012				
Year	GA – Atlanta	GA – Savannah	Rest of the State	Georgia
2007	146	21	82	249
2008 *	152	24	87	263
2009	157	25	83	265
2010	171	26	85	282
2011	172	27	84	283
2012	172	27	83	282
Change	26	6	1	33
% Change	17.8%	28.6%	1.2%	13.3%
* *changed ASC program*				

CMS Provider of Services Current Files, 2014.

Most Medicare-certified ASCs are Urban and For Profit		
ASC type	2007	2012
Urban	91%	91%
Rural	9%	9%
For Profit	96%	97%
Nonprofit	4%	3%

Report to the Congress: Medicare Payment Policy. March 2014, page 127

In 2008, Georgia, which maintains a CON program, dramatically changed its CON regulations for ASCs to allow more centers to enter the market. While the number of ASCs increased in the state, it appears the entities located in urban areas of high population and not necessarily statewide.

18

Discussion

When reviewing CON programs it is important to consider all of the factors and industry characteristics that have taken place since the 1980s and continue to occur within the health care system. Market forces and large scale reimbursement policy changes need to be studied and weighed in conjunction with the changes made within CON programs.

19

Data Sources

Data Sources

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CMS Provider of Services Current Files, 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/index.html and http://www.healthindicators.gov/Indicators/Ambulatory-Surgical-Centers-number_10033/Profile/Download.

National Conference of State Legislators Certificate of Need website: http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspxBushnell

National Health Expenditures: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsProvider.html. (Most current data available for National Health Expenditures by State.)

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20

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21

Per Capita Health Expenditures: 2009

		Health Spending per Capita	State Has a CON Program
1	District of Columbia	$10,349	Yes
2	Massachusetts	$9,278	Yes
3	Alaska	$9,128	Yes
4	Connecticut	$8,654	Yes
5	Maine	$8,521	Yes
6	Delaware	$8,480	Yes
7	New York	$8,341	Yes
8	Rhode Island	$8,309	Yes
9	New Hampshire	$7,839	Yes
10	North Dakota	$7,749	**No**
11	Pennsylvania	$7,730	**No**
12	West Virginia	$7,667	Yes
13	Vermont	$7,635	Yes
14	New Jersey	$7,583	Yes
15	Maryland	$7,492	Yes
16	Minnesota	$7,409	**No**
17	Wisconsin	$7,233	Yes
18	Florida	$7,156	Yes
19	Ohio	$7,076	Yes
20	South Dakota	$7,056	**No**
21	Nebraska	$7,048	Yes
22	Wyoming	$7,040	**No**
23	Missouri	$6,967	Yes
24	Iowa	$6,921	Yes
25	Hawaii	$6,856	Yes
26	Louisiana	$6,795	Yes
27	Kansas	$6,782	**No**
28	Washington	$6,782	Yes
29	Illinois	$6,756	Yes
30	Indiana	$6,666	**No**
31	New Mexico	$6,651	**No**
32	Montana	$6,640	Yes
33	Michigan	$6,618	Yes
34	Kentucky	$6,596	Yes
35	Oregon	$6,580	Yes
36	Mississippi	$6,571	Yes
37	Oklahoma	$6,532	Yes
38	North Carolina	$6,444	Yes
39	Tennessee	$6,411	Yes
40	South Carolina	$6,323	Yes
41	**VIRGINIA**	**$6,286**	Yes
42	Alabama	$6,272	Yes
43	California	$6,238	**No**
44	Arkansas	$6,167	Yes
45	Colorado	$5,994	**No**
46	Texas	$5,924	**No**
47	Nevada	$5,735	Yes
48	Idaho	$5,658	**No**
49	Georgia	$5,467	Yes
50	Arizona	$5,434	**No**
51	Utah	$5,031	**No**
	United States	**$6,815**	**N/A**

http://kff.org/other/state-indicator/health-spending-per-capita/