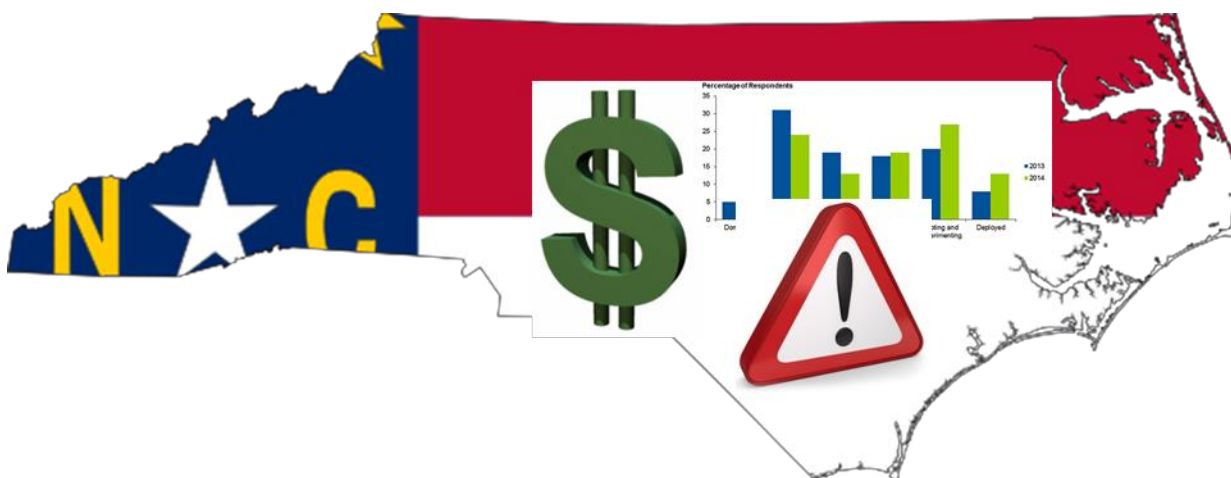


# FIRST, DO NO HARM



July  
2015

Analyzing the Certificate of Need Debate  
in North Carolina

## EXECUTIVE SUMMARY

Much of the debate over Certificate of Need laws has focused on market theories instead of measurable realities. In this report, Ascendient seeks to expand the perspective beyond a one-dimensional ideological view and get back to the numbers that matter.

Based on an analysis of facts and objective data, we conclude that any move now to deregulate North Carolina's healthcare system by reducing or eliminating the CON program would be premature and put already vulnerable hospitals at much greater risk as new entrants pick off their best patients without taking up the burden of indigent care.

Among our key findings:

- **CON regulations have not restricted the development of Ambulatory Surgery Centers (ASCs) in North Carolina.**

There are 44 ambulatory surgery centers in the state today—just three more than in 1996. But CON cannot be blamed, as the state's regulatory agencies authorized 72 unique ASCs over the last 20 years, proving that market forces—not regulations—are limiting growth.

- **North Carolina residents have ready access to regulated healthcare services.**

Based on current utilization, there is no evidence that North Carolinians are going without needed care. The additional hospital bed, MRI, or ambulatory surgery operating room capacity suggested by anti-CON advocates would be expensive and unnecessary. Economic disparities—not capacity deficits—drive access issues; there is no incentive to compete for uninsured patients.

- **States with CON show greater access to hospital care for the uninsured.**

The vast majority of patients in financial need do not need ambulatory surgery. The poor and underserved seek care at emergency rooms, delivery rooms, and primary care physician offices. House Bill 200's charity care requirements will not address these patients.

- **Cost comparisons between CON and non-CON states are muddy at best and cannot be used to argue conclusively for or against CON.**

Among the 36 states with CON laws, there are huge variations in enforcement, timing, triggering levels, political goals and the number of services regulated by CON. There is no statistically significant price difference—inpatient/outpatient adjusted price per patient discharge—between heavily regulated CON states and non-CON states.

- **Higher healthcare spending in CON states is likely driven by differences in population health.**

Heavily regulated CON states have a statistically significant higher rate of disease—such as cancer, COPD, and cardiovascular—than non-CON states.

- **Competition is not the solution for all the problems with American healthcare.**

The Bush-era FTC/DOJ report (2004) is cited often as a justification for reconsideration of CON programs, but it also concluded that increased competition would only succeed in conjunction with new payment methods to align provider incentives with patient interests.

# First, Do No Harm

## ANALYZING THE CERTIFICATE OF NEED DEBATE IN NORTH CAROLINA

### THE HIPPOCRATIC IMPERATIVE: “DO NO HARM” WHEN CHANGING NC HEALTHCARE LAWS

Physicians and legislators aren’t all that different. In both professions, the primary rule should be: “First, do no harm.” Unfortunately, changing the CON laws now would do a great deal of harm, indeed. North Carolina hospitals are already dealing with unprecedented changes in care delivery, technology, regulation and reimbursement. Ascendient projects that at least 1 in 4 hospital beds in use in our state today will be unneeded by 2025, and many of our hospitals will look dramatically different than their present form.

Healthcare transformation is fundamentally rewriting the laws of supply and demand in this industry, so rewriting the laws of competition at exactly the same time is a hugely risky proposition. Our healthcare system can continue to provide excellent care to all as long as the transition is orderly and evolutionary. Taking away the certainty and predictability of CON laws, however, is the kind of revolutionary change that will have unintended – and very expensive – consequences.

Within three to five years, emerging payment systems will be more fully understood, allowing hospitals to more realistically fine-tune their services and their budgets. At that point, the healthcare system in North Carolina can make the rational adjustments necessary to adapt to a world without CON.

Such an approach is consistent with the oft-cited Bush-era FTC/DOJ report, “Improving Health Care: A Dose of Competition.” While the July 2004 report encourages states to reconsider the efficacy of

Certificate of Need programs, it does so within a broader context that should not be ignored.

---

*“PAYMENT METHODS THAT GIVE INCENTIVES FOR PROVIDERS TO LOWER COSTS, IMPROVE QUALITY, AND INNOVATE COULD BE POWERFUL FORCES FOR IMPROVING COMPETITION IN HEALTH CARE MARKETS.”*

2004 FTC/DOJ

First, the report notes the inherent

features of US healthcare markets that limit competition. (See Sidebar 1.) While some of these barriers to free market competition—notably insulation by third party payors and lack of information—are being addressed through various measures, some such as EMTALA regulations and societal attitudes

show no signs of abatement. (EMTALA requires Medicare-participating hospitals that offer emergency services to provide a medical screening examination and stabilizing treatment when a request is made for examination or treatment for an emergency medical condition regardless of an individual's ability to pay.) Thus, barriers to free market competition in healthcare will persist.

#### SIDEBAR 1: BARRIERS TO FREE MARKET COMPETITION IN HEALTHCARE WILL PERSIST

1. **EXTENSIVE REGULATION** at both the federal and state level that affects how competition takes place in healthcare markets. Much of this regulation remains intact and will continue to limit competition (e.g., anti-kickback, self-referral, EMTALA, and medical malpractice).
2. **THIRD PARTY PAYORS.** "Insured consumers are insulated from most of the costs of their decisions on health care treatments. The result is that insured consumers have limited incentive to balance costs and benefits and search for lower cost health care with the level of quality that they prefer. A lack of good information also hampers consumers' ability to evaluate the quality of the health care they receive." *Thus, healthcare remains remarkably different from a "well-functioning market [that] maximizes consumer welfare when consumers make their own consumption decisions based on good information, clear preferences, and appropriate incentives."*
3. **INFORMATION PROBLEMS.** "The public has access to better information about the price and quality of automobiles than it does about most health care services. It is difficult to get good information about the price and quality of health care goods and services, although numerous states and private entities are experimenting with a range of 'report cards' and other strategies for disseminating information to consumers. Without good information, consumers have more difficulty identifying and obtaining the goods and services they desire."
4. **COST, QUALITY, AND ACCESS—THE IRON TRIANGLE.** "[I]n equilibrium, increasing the performance of the health care system along any one of these dimensions can compromise one or both of the other dimensions, regardless of the amount that is spent on health care....Nonetheless, trade-offs among cost, quality and access can be necessary....Good information about the costs and consequences of each of these choices is important for competition to be effective."
5. **SOCIETAL ATTITUDES.** "For most products, consumers' resources constrain their demand. Consumers and the general public do not generally expect vendors to provide services to those who cannot pay for them....By contrast, many members of the public and many health care providers view [and regulations such as EMTALA establish] health care as a 'special' good, not subject to normal market forces, with significant obligational norms to provide necessary care without regard to ability to pay."
6. **AGENCY RELATIONSHIPS.** "A large majority of consumers purchase health care through multiple agents—their employers, the plans or insurers chosen by their employers, and providers who guide patient choice through referrals and selection of treatments. This multiplicity of agents is a major source of problems in the market for health care services."

Source: "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004

Notably, the FTC's recent comment<sup>ii</sup> on North Carolina House Bill 200 fails to acknowledge what the 2004 report clearly recognizes—healthcare remains remarkably different from most markets. (See Sidebar 2 for other disconnects in the July 2015 FTC comment.) While the 2004 report describes the benefits of competition, it also declares: "Competition is not a panacea for all of the problems with American health care. Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover competition cannot eliminate the inherent uncertainties in health care, or the information asymmetries among consumers, providers, and payors. Competition will not shift resources to those who do not have them."

---

*"COMPETITION IS NOT A PANACEA FOR ALL OF THE PROBLEMS WITH AMERICAN HEALTH CARE"*

2004 FTC/DOJ

---

Second, the 2004 report concludes its executive summary with recommendations on how to improve competition in healthcare markets. "[C]ompetition remains less effective than possible in most health care markets, because *the prerequisites for fully competitive markets are not fully satisfied*...The Agencies recognize that *the work remaining to be done is complex and difficult and will take time*. A renewed focus on the prerequisites for effective competition, however, may assist policymakers in identifying and prioritizing tasks for the near future." [emphasis added] Those recommendations include:

*"Payment methods that give incentives for providers to lower costs, improve quality, and innovate could be powerful forces for improving competition in health care markets."*

*"Governments should reexamine the role of subsidies in health care markets in light of their inefficiencies and potential to distort competition....Competition cannot provide resources to those who lack them; it does not work well when certain facilities are expected to use higher profits in certain areas to cross-subsidize uncompensated care. In general, it is more efficient to provide subsidies directly to those who should receive them, rather than to obscure cross subsidies and indirect subsidies in transactions that are not transparent. Governments should consider whether current subsidies best serve their citizens' health care needs."* [emphasis added]

*"States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs."*

Although the report recommends reconsideration of states' CON programs, it does so in the context of other recommendations, notably to change payment methods and offer direct subsidies rather than the cross-subsidies (e.g., profit from surgery patients covers the cost of uninsured emergency room patients). New payment methods are being piloted across the country and across North Carolina that may ultimately be responsive to the recommendations of this report. Likewise, various methods to cover the uninsured have been implemented, though there remain significant numbers of uninsured that hospitals are committed (and required through EMTALA) to care for. New payment methods that incorporate rationale incentives into the healthcare market may resolve many of the concerns hospitals have regarding the dismantling of the CON program. The report states that, "Other means of cost control appear to be more effective and pose less significant competitive concerns." However, until those other means of cost control, such as new payment methods, are widespread and universally

adopted and the care for the uninsured addressed, the reduction or elimination of the CON program would be premature.

## SIDEBAR 2: FTC DISCONNECT

In his concurrence with the staff comment, Commissioner Wright cites a report by Georgia State University to support his assertion that “the stringency of the [CON] program is positively and significantly related to hospital costs.” [Notably, the CON-hospital cost relationship from this study cited by the Commissioner was based on *payments to providers*, not the providers’ actual costs, and payments only by private insurers. Over 40% of US hospitals’ revenue is attributable to Medicare, which sets its own prices irrespective of CON regulations.] What he fails to acknowledge, however, are the additional findings of this study. Particularly of note relative to House Bill 200: “The number of ambulatory surgery centers per capita in a market is positively related to price, consistent with the idea that the presence of ambulatory surgery centers increases the acuity level of hospital patients, and therefore, increases average inpatient costs.”

Similarly, Commissioner Wright cites a Health Research and Educational Trust study: “Lastly, a recent study focused on cardiac care found no evidence that CON laws are associated with higher quality care and that repealing CON laws is associated with more providers statewide and lower mean hospital volume for both coronary artery bypass graft (CABG) surgery and PCI.” Once again, however, he fails to note another key finding of the study: “Both CABG and PCI have significant fixed costs, and lower hospital volume [resulting from deregulation and lower volume per provider] has been associated with higher costs per patient for both of these procedures....Therefore, cardiac CON regulations may be successful in restraining cost growth, by limiting fixed cost investments in cardiac surgery to fewer facilities.”

The Georgia State report also notes that there are economic benefits to CON laws, which should be considered as well as the effects on competition.

*“CON laws create barriers to entry to a variety of health care services markets. As such, they convey monopoly power to incumbent health care providers. In general, economic theory suggests that unregulated monopolies have higher prices and lower quality than firms in more competitive markets. [Note: healthcare providers are not paid their “price” for a significant portion of their patient population, e.g., Medicare which sets its own price; therefore, the theoretical concern regarding monopoly pricing power has limited, and diminishing, applicability to healthcare providers.] However, competition may limit the ability of facilities to exploit economics [sic] of scale and scope. Economies of scale occur when costs are reduced as volume increases. Economies of scope occur when it is less costly to produce two services together than each service separately. If one or both of these conditions are present, then the increased costs and decreased quality associated with monopoly power may be offset by the decreased costs and increased quality of the economies of scale and scope. CON laws give health care providers the ability to take advantage of economies of scale and scope that can lower costs and increase quality. The basic question is which effect dominates and for which services.”*

## STATES OF CONFUSION: WHY THE COMPARISONS MAKE NO SENSE

Everyone is worried about the cost of healthcare, so when a national study<sup>iii</sup> purports to show that CON laws drive up those costs, thoughtful policymakers are bound to listen. But a truly thoughtful reading of the data reveals more questions than answers. While on the surface, costs in CON states may appear to be higher, a thorough analysis dismisses any such conclusion. In 2011, Ascendient completed an extensive state-by-state study of the impact of CON, including the analysis of nearly 40 variables such as supply/access to services, utilization, spending/pricing/costs, health status, provider performance, quality indicators. That study resulted in three significant conclusions.

***First, there is no clear delineation between states that have CON and states that do not have CON, muddying any attempt at determinative analyses.***

While it is clear which states have CON laws at any given time and which do not (see Figure 1), the variation in degrees of regulation between the CON states is significant. For example, some regulate only a few post-acute level services (e.g., Ohio and Nebraska), while others (e.g., North Carolina and Mississippi) regulate most healthcare services. Program variability is substantial (see Figure 2) and directly affects any analysis simply between CON and non-CON states.

**Figure 2**

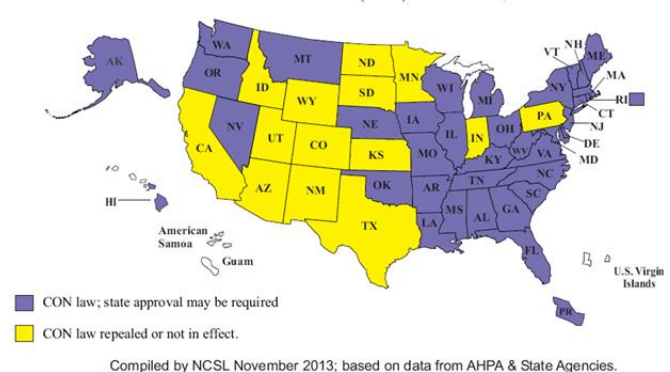


©Ascendient 2011; based on NCSL's list of regulated services by state

locale, terrain, and geographic issues that few other states contend with. Utah has the lowest per capita spending—perhaps because of a high concentration of population with religious restrictions on caffeine, smoking, and alcohol.

**Figure 1**

State Certificate of Need (CON) Health Laws, 2013



Moreover, some states ended their CON programs in the 1980s, others in the late 1990s, and still others have had on-again, off-again CON programs. Thus it is not possible to know which facilities and services existed or were developed with or without CON regulation and what impact that has on utilization and spending variables.

Finally, there are states with unique circumstances that potentially skew any simple analysis. Alaska has the highest per capita spending of all 50 states—perhaps because of health issues with the indigenous population or perhaps because of



Because of these differences, Ascendient’s subsequent analyses focused on the statistical differences between non-CON states and heavily regulated CON states.

***Second, there is no price difference between heavily regulated CON states and non-CON states.***

While the raw numbers may appear to be higher in heavily regulated CON states, there is no statistically significant difference in either inpatient or outpatient average prices<sup>1</sup>.

<b>Table 1<sup>iv</sup></b>	<b>Average of Non-CON States</b>	<b>Average of Heavy CON States</b>	<b>Statistically Significant?</b>
<b>Adjusted Net Price per Inpatient Discharge</b>	\$7,072	\$7,646	No
<b>Adjusted Net Price per Outpatient Visit</b>	\$421	\$460	No

***Finally, higher per capita spending in heavily regulated CON states cannot be isolated to the existence of CON and is more likely the result of health-related factors.***

<b>Table 2<sup>v</sup></b>	<b>Average of Non-CON States</b>	<b>Average of Heavy CON States</b>	<b>Statistically Significant?</b>
<b>Health Spending per Capita</b>	\$4,982	\$5,676	Yes
<b>Life Expectancy</b>	79.2 years	77.9 years	Yes

Yes, there is a statistically significant difference in per capita health spending between heavily regulated CON and non-CON states. However, with no difference in inpatient and outpatient prices between states as shown in Table 1, the difference in actual per capita spending must be associated with higher utilization of services in heavily regulated CON states than non-CON states. (Note: Total per capita health spending includes: hospital care, physician care, pharmaceuticals, long-term care, dental services, home health care, medical durables, and other health and personal care.) There are statistically

<sup>1</sup> Some studies, such as the Georgia State University study cited in FTC Commissioner Wright’s recent concurrence, have noted an association between CON regulation and higher *private* inpatient costs. On average, over 40% of US hospitals’ inpatient revenue is attributable to Medicare. Medicare, along with other government payment sources, sets fixed prices for hospital care; thus, price competition is simply not a factor for a significant, and growing, portion of the hospital patient population.

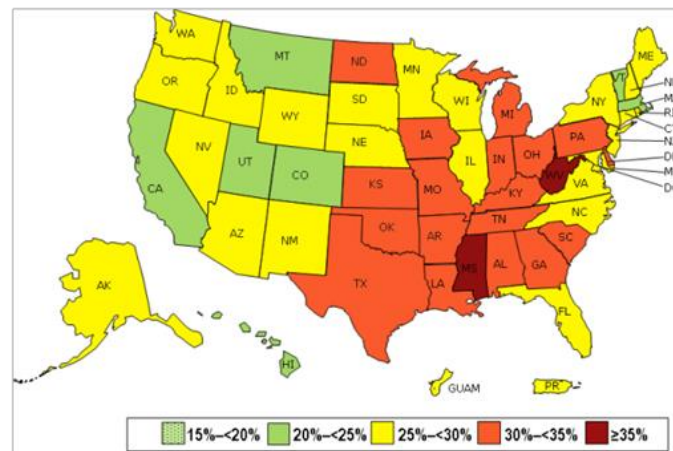


significant differences that are more likely the actual drivers of the utilization and resulting spending differences between the states—not CON.

- Life expectancy in non-CON states is longer than heavily regulated CON states as shown in Table 2, suggesting a healthier population in non-CON states.
- Most, though not all, of the states with the highest obesity rates are CON regulated states. (See Figure 3<sup>vi</sup>) Conversely, most of the non-CON states have lower obesity rates. (Obesity has been shown to increase healthcare costs by at least 40%<sup>vii</sup>.)

Figure 3

**Prevalence\* of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2013**



- Most important, heavily regulated CON states have a statistically significant higher rate of disease than non-CON states, including incidence of cancer, chronic obstructive pulmonary disease, and cardiovascular disease as shown in Figures 4, 5 and 6.

Figure 4  
Cancer Incidence

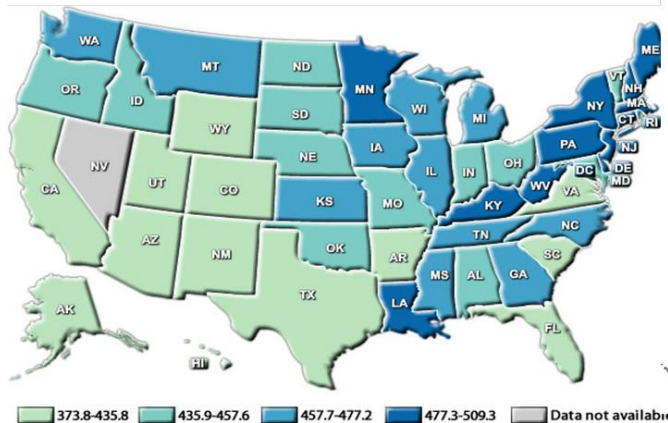
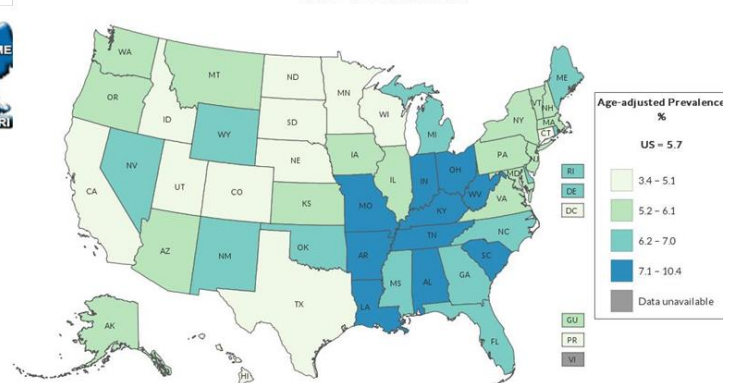


Figure 5  
COPD Prevalence

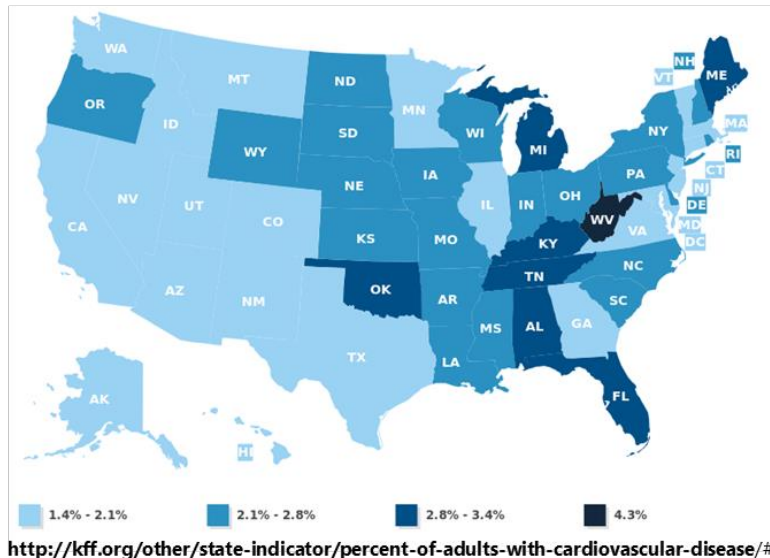


\*Source: U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999–2011*. Atlanta, GA: Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; 2014. Available at: [www.cdc.gov/uscs](http://www.cdc.gov/uscs).

Data Source: BRFSS  
Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health, Chronic Disease Indicators [online]. 2014 [accessed Jun 09, 2015]. URL: <http://nccd.cdc.gov/cdi/>

Figure 6

## Percent of Adults with Cardiovascular Disease, 2013

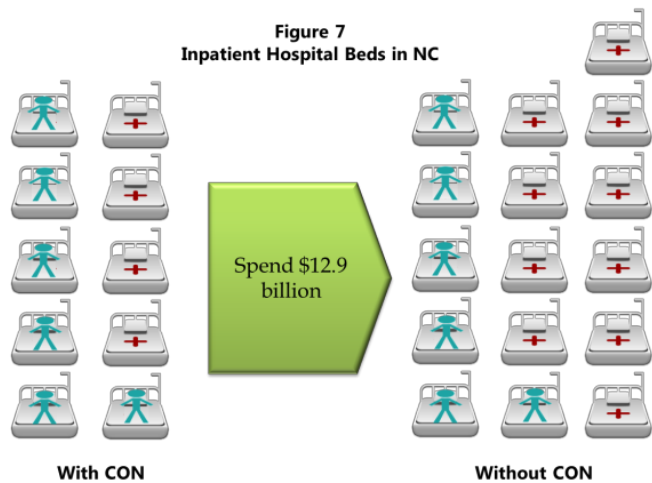


Admittedly, the recently touted report from the Mercatus Center at George Mason University<sup>viii</sup> does not consider “*other factors affecting health care costs, such as competition among hospitals, availability of doctors, market dominance by large health insurance carriers, or overall patient health.*”<sup>ix</sup> Clearly, overall population health has a significant influence on healthcare spending across the US and cannot be divorced from any analysis of healthcare costs.

*THERE ARE STATISTICALLY SIGNIFICANT DIFFERENCES  
THAT ARE MORE LIKELY THE ACTUAL DRIVERS OF THE  
UTILIZATION AND RESULTING SPENDING DIFFERENCES  
BETWEEN THE STATES—NOT CON.*

## A SOLUTION IN SEARCH OF A PROBLEM: WHY NC'S HEALTHCARE SHORTAGE IS AN ILLUSION

National figures aside, what's the real health of the healthcare system here in North Carolina? The Mercatus report suggests that the North Carolina CON program has resulted in 12,900 fewer hospital beds, among other findings. According to the *2015 State Medical Facilities Plan (2015 SMFP)*, North



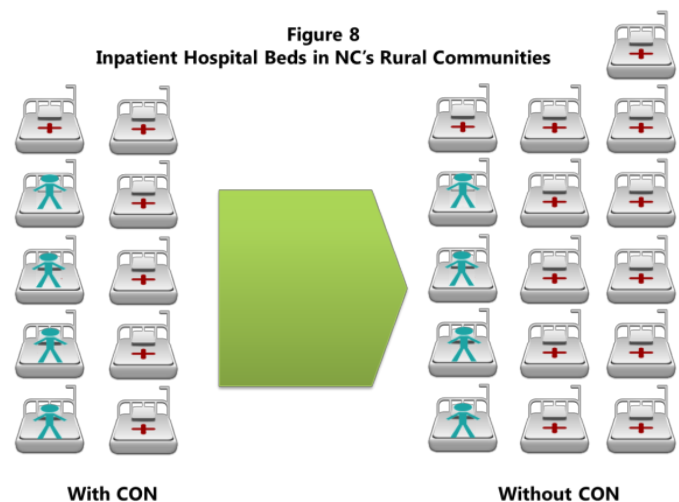
Carolina has 21,541 licensed acute care hospital beds with a total capacity to provide almost 8,000,000 inpatient days of care each year. North Carolina hospitals used those beds to provide 4,373,077 inpatient days of care in 2013, meaning that hospital beds statewide are occupied only 56 percent of the time.

While the Mercatus report implies a shortage of 12,900 beds, there is no evidence that North Carolinians are going without needed inpatient care because of a lack of bed capacity at hospitals. Thus, if North Carolina were to

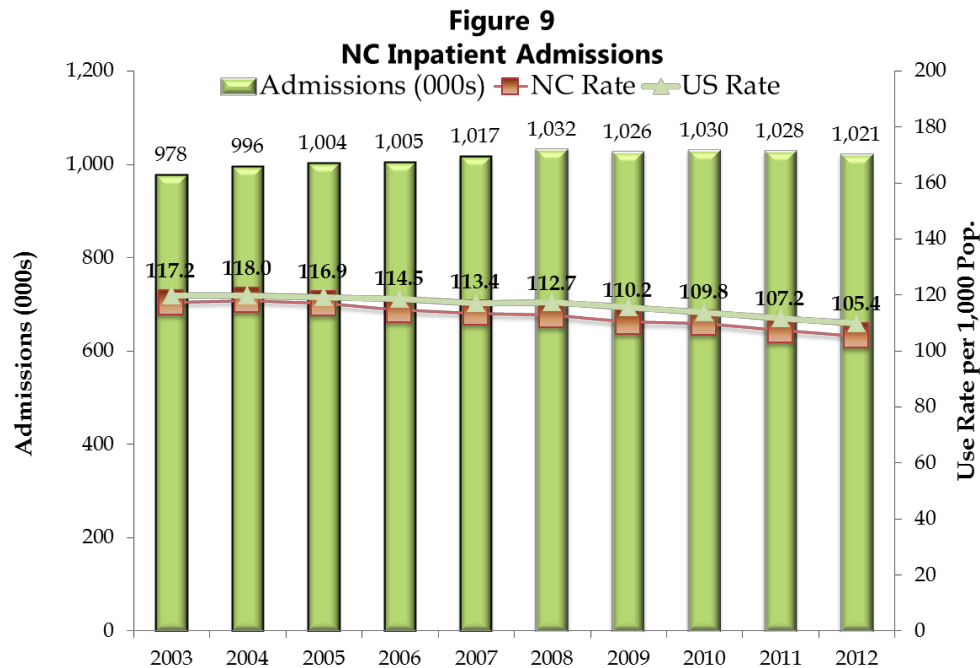
increase its bed capacity by the 60 percent suggested by Mercatus, North Carolina's hospital beds would be occupied only 35 percent of the time. (See Figure 7.)

Additional hospital beds, particularly when developed in new construction with the necessary support services, require significant capital expense; a rough estimate used in healthcare planning is at least \$1 million per bed. To create the 12,900 beds cited in the Mercatus report would require a \$12.9 billion expenditure, when existing beds are already unused nearly half the time.

This waste would be exacerbated in rural counties, where only 40 percent of beds today are occupied. Under the Mercatus no-CON scenario, only 1 in 4 beds in rural North Carolina would be occupied. (See Figure 8.)



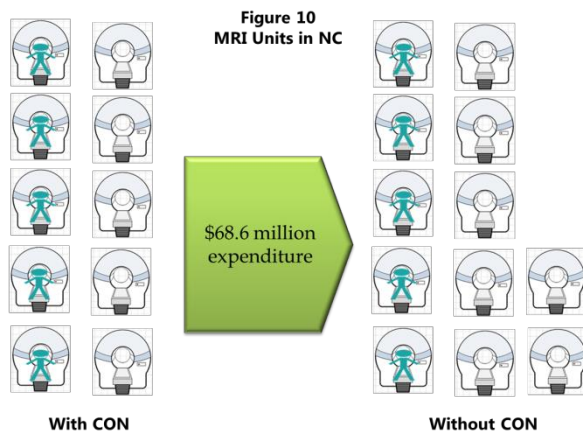
Moreover, like communities across the US, North Carolina's inpatient utilization rates have been declining over the last decade—a trend that is expected to continue, if not accelerate—with transformational changes in care delivery and healthcare reimbursement.



Source: 2014 AHA Hospital Statistics.

Similarly, the Mercatus Study found that the CON program in North Carolina had resulted in 49 fewer hospitals offering MRI services. This appears entirely illogical as there are only six acute care hospitals in North Carolina that do not offer MRI services either through a fixed unit or a mobile service. (See Sidebar 3.)

Moreover, North Carolina MRI units (fixed and mobile) are underutilized. According to the *2015 State Medical Facilities Plan*, the 262 MRI units in the state (fixed equivalents) provided 932,700 adjusted procedures in 2013 or 3,565 adjusted procedures per MRI unit.



According to the *2015 Plan*, the annual capacity of an MRI unit is 6,864 adjusted procedures, indicating that statewide MRI capacity was utilized at just over 50 percent of capacity in 2013.

If 49 additional MRI units were added to the state, North Carolina's MRI units would be utilized at only 44 percent of capacity. A rough estimate for the cost of a MRI unit is \$1.4 million. Using that figure, the Mercatus report suggests a \$68.6 million

expenditure is needed to add to the number of MRI units in North Carolina that are already unused nearly half the time.

To put the Mercatus report's conclusions in perspective, annual statewide hospital costs totaled \$19.4 billion in 2010<sup>x</sup>. The Mercatus report's conclusions suggest that nearly \$13 billion—or more than two-thirds of total annual hospital costs statewide—should be spent on unneeded capacity.

The proponents of anti-CON legislation argue that increased competition will reduce costs, but provide no indisputable evidence of this relationship. If the Mercatus report's presumptions were to materialize, the elimination of the CON law would lead to increased capital spending for unneeded healthcare capacity, which will inevitably increase costs to the system overall.

---

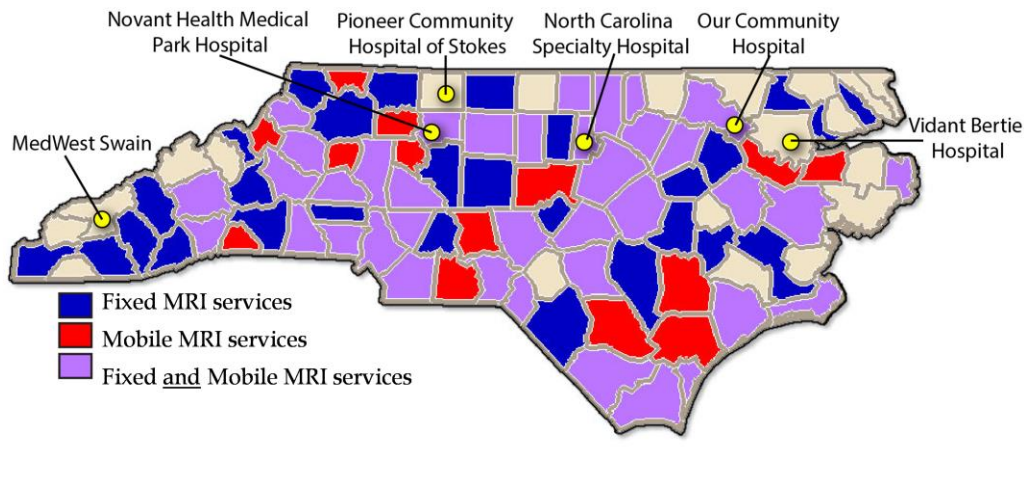
*THE MERCATUS REPORT'S CONCLUSIONS SUGGEST THAT NEARLY \$13 BILLION—OR MORE THAN TWO-THIRDS OF TOTAL ANNUAL HOSPITAL COSTS STATEWIDE—SHOULD BE SPENT ON UNNEEDED CAPACITY.*

---

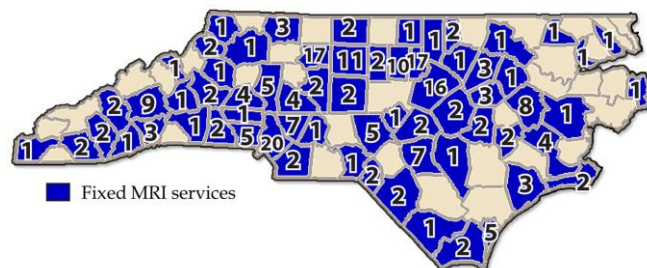
### SIDEBAR 3: NORTH CAROLINIANS' MRI ACCESS

As noted on the map below, only six general acute care hospitals in North Carolina do not offer MRI service. Two of those hospitals are specialty surgical hospitals and are located in urban counties with at least one other hospital that offers MRI services.

The plurality of counties in North Carolina, 38, have access to both fixed and mobile MRI services. An additional 28 counties have access to fixed MRI and another 14 have access to mobile MRI.



Many of those counties with fixed MRIs have access to multiple units.

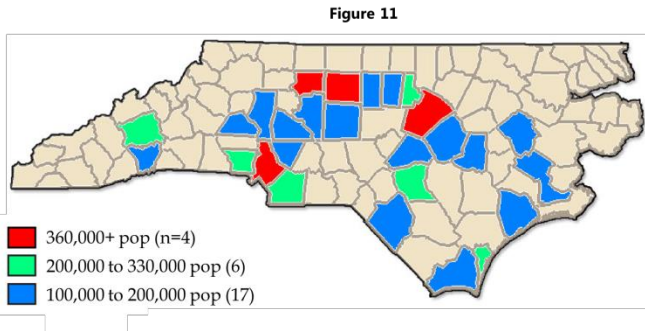


There are 20 counties in North Carolina that do not have access to MRI services (either fixed or mobile) per the *2015 State Medical Facilities Plan*. As shown in the first map above, all of these counties are adjacent to at least one county with MRI services. (Currituck is adjacent to Dare County via Highway 158.) Of these 20 counties, only four have general acute hospitals (Bertie, Stokes, Swain, and Northampton counties). Although Hoke County is included in the list of 20 because it did not offer MRI services in 2013, FirstHealth Hoke Community Hospital is now open and offers MRI services. Of the remaining 15 counties without MRI services or a hospital, all have populations of less than 25,000.



# HEALTHCARE HAVES & HAVE-NOTS: COMPETITION & CHOICE AROUND

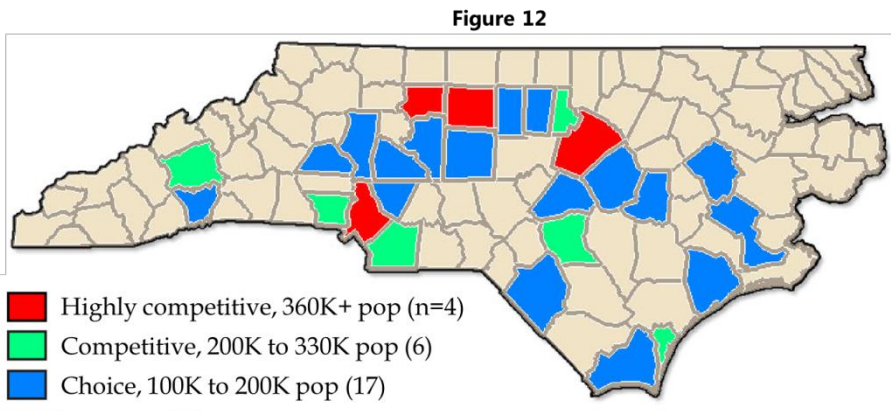
Those seeking to repeal CON laws for operating rooms and ambulatory surgery centers justify their position by insisting that North Carolina’s most populous counties need additional competition to affect cost, quality, and access. But a closer look at the 27 counties most affected by House Bill 200—those with populations of more than 100,000—reveals a plethora of competition and choice already exists.



There are 27 counties in North Carolina with a population over 100,000 people (see Figure 11) and 14 of these counties have one or more freestanding ambulatory surgery centers (“ASCs”). (Note freestanding ASC as discussed herein means an ambulatory surgery center that is licensed by the North Carolina Division of Health Service Regulation as an ambulatory surgery center; as such, it is reimbursed for services under a payment methodology different from hospitals, and the definition does not include facilities licensed as part of a hospital or that bill services under a hospital provider number.)

Each of North Carolina’s four most populous counties has two or more freestanding ASCs and represents a highly competitive ASC market. (See Figure 12, counties in red.)

- Mecklenburg (seven freestanding ASCs)
- Wake (six existing freestanding ASCs, one approved but not yet operational)
- Guilford (six freestanding ASCs)
- Forsyth (two freestanding ASCs)



Highly Competitive Markets	Hospitals	Hospital Outpatient Surgery Centers	Freestanding ASCs	Total
# of ORs	312	38	94	444
% Utilization	68.2%	48.5%	47.2%	62.0%

These counties are distinguished by large population centers that are sufficient to support two or more integrated health systems. In total, these four counties have 444 operating rooms, more than 20 percent of which are located in freestanding ASCs. However, as noted in the chart above, utilization of the freestanding ASC rooms is the lowest among the three categories and less than 50 percent overall. (Note hospital outpatient surgery centers are those that are located in a physically separate building from the hospital but are licensed and billed under the hospital.)

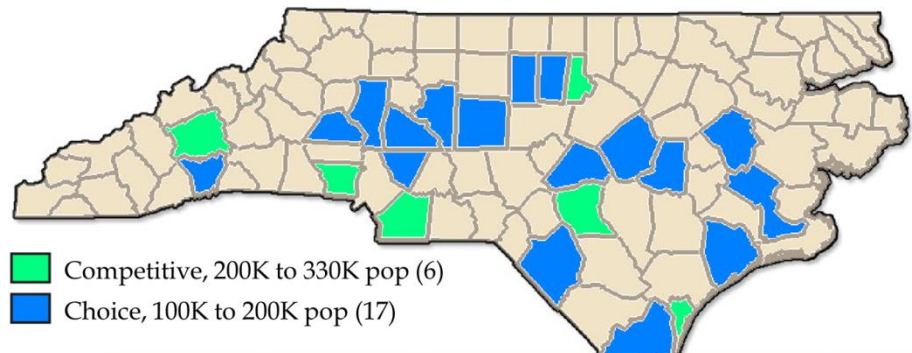


Six North Carolina counties have populations between 200,000 and 330,000 and represent competitive ASC markets. (See Figure 13, counties in green.) Each of these markets has at least one freestanding ASC.

- Cumberland (one)
- Durham (one)
- Buncombe (three)
- New Hanover (one)
- Union (two)
- Gaston (one)

Except for Gaston County, all have competitive facilities providing outpatient surgery, either through freestanding ASCs and/or hospital outpatient surgery centers.

Figure 13



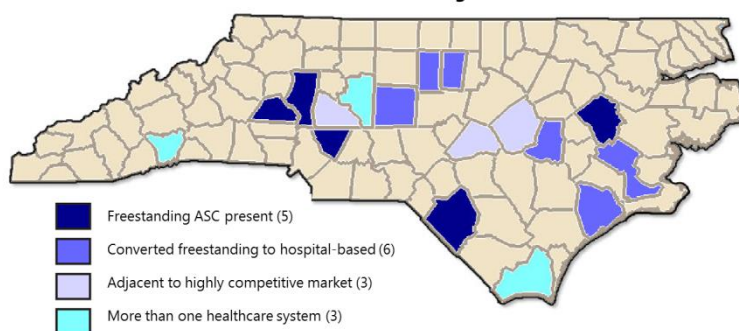
Competitive Markets	Hospitals	Hospital Outpatient Surgery Centers	Freestanding ASCs	Total
# of ORs	167	21	41	229
% Utilization	68.4%	72.4%	60.4%	67.3%

These counties each have a large integrated healthcare system. At the same time, competition exists for ambulatory surgery. Of note, Union and Gaston counties are within the Charlotte, NC MSA alongside Mecklenburg County. This cluster affords the residents of this MSA significant choice and competition for ambulatory surgery. Likewise, Durham is adjacent to the already highly competitive Wake County market. In total, these six counties have over 200 operating rooms, with nearly 20 percent located in freestanding ASCs. Once again however, utilization of the freestanding ASC rooms is the lowest among the three categories.

Of the remaining 17 counties with populations greater than 100,000, all currently have or have had choice with regard to healthcare services and ambulatory surgery. (See Figure 14.) Five of the

seventeen have freestanding ASCs that are operating, in addition to the choice of hospital-based services. Another six of the seventeen had a freestanding ASC at one point in time (five actually operated an ASC and one was approved to operate but never gained investor interest), but converted to hospital-based operating rooms after

Figure 14



Choice Markets	Hospitals	Hospital Outpatient Surgery Centers	Freestanding ASCs	Total
# of ORs	243	25	33	301
% Utilization	59.7%	40.9%	60.0%	58.2%

reportedly less than desired financial results for the investors. Three are adjacent to highly competitive markets in the Charlotte or Triangle regions, offering extensive competition for ambulatory surgery.

Three, although without a freestanding ASC, have more than one local healthcare system offering a choice of providers for area residents.

Many of these counties are just large enough to support a single medium-sized hospital. In today's healthcare environment these medium-sized hospitals face considerable challenges and as a result, many in North Carolina (and nationwide) have chosen to partner with larger systems (hospitals in Cabarrus, Johnston, Alamance, Harnett, and Rowan counties) in order to continue to remain viable for their local communities. Others (Onslow and Craven) have publicly acknowledged discussions underway regarding future partnerships.

Because of their population base, these healthcare systems try to provide a broad range of services so that patients can receive community-based primary and secondary care without needing to travel to outside of their county. Many services within these healthcare systems are cross-subsidized, as any number are not financially viable. Under the current reimbursement structure, surgery provides a profitable revenue stream that enables these hospitals to offer other services, like emergency care, that are not profitable but are vital to the community. These hospitals are important economic engines to their communities and provide significant community-wide health benefits. They are often the provider of last resort, the healthcare safety net.

## LOOKING BACK TO SEE AHEAD: HISTORY PROVES THAT REPEALING CON IS NO GUARANTEE OF MORE SURGERY CENTERS

Despite the clamoring for more ambulatory surgery centers in North Carolina, examining our 20-year history with ASCs shows that a change in CON law will guarantee nothing in terms of new, viable ASCs. In the 20 year span since the first ASC inventory was included in the *1996 State Medical Facilities Plan*, there have been a total of 72 unique ASCs licensed or CON-approved in North Carolina (excluding GI endoscopy facilities). (See Sidebar 4.)

Notwithstanding the plethora of approvals and development of ASCs over the last 20 years, not much has changed at the end of the day: North Carolina had 41 licensed ASCs in 1996 and North Carolina

has 44 licensed ASCs (or CON-approved) in 2015. The mix of single specialty versus multi-specialty (excluding the three single specialty demonstration projects) has remained roughly 60/40, although the number of orthopedic single specialty centers has grown while the number of GYN has declined.

**Figure 15**

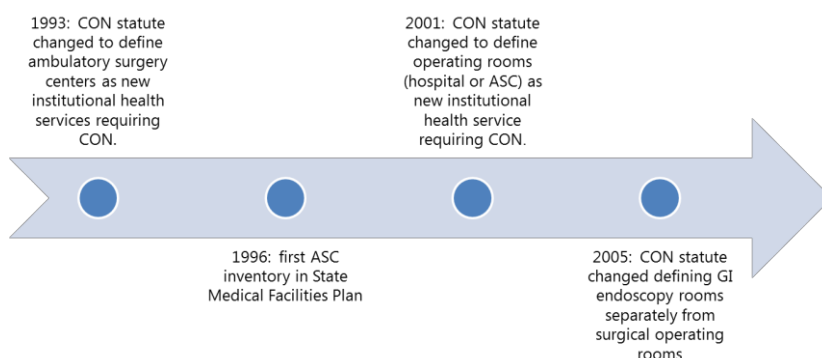


Figure 16: NC ASCs in 1996

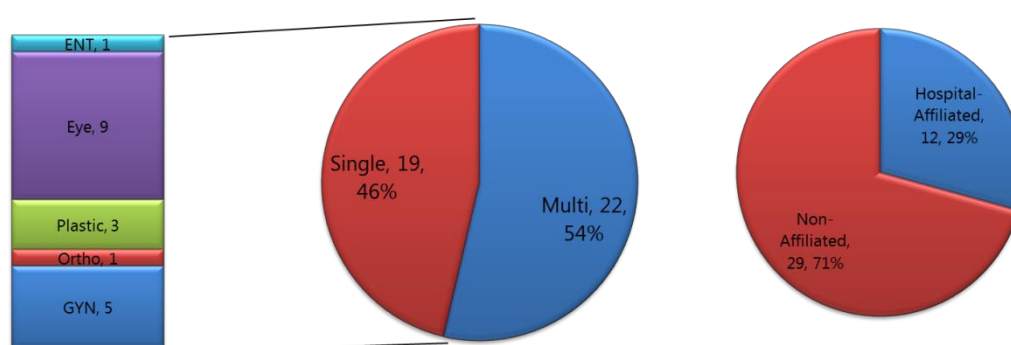
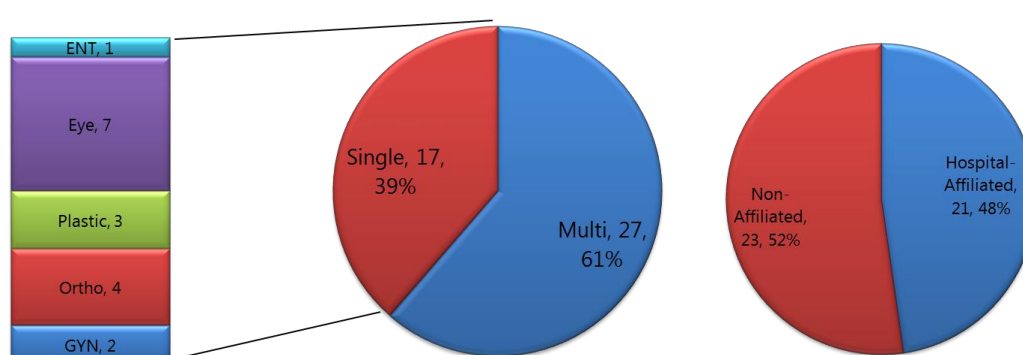


Figure 17: NC ASCs in 2015



What is notably different between the ASC inventory of 1996 and that of 2015?

- 21 of today's freestanding ASCs are hospital affiliated, as opposed to only 12 in 1996. Of those 21, many are joint ventures between not for profit hospitals and physicians.
- Of the original 41 ASCs in 1996, 14 no longer exist—10 of those were sold to hospitals and the operating rooms converted to hospital-based.
- Of the 17 ASCs developed in the 20 years since the 1996 inventory that remain in the 2015 inventory, only four were developed as freestanding, nonhospital-affiliated ASCs (two single and two multi-specialty). Eight of the 17 were developed by converting hospital operating rooms into freestanding ASCs; of those, 7 are hospital-physician joint ventures. The other five were developed as freestanding ASCs with new operating rooms and are hospital-affiliated; at least one of those is reportedly a joint venture with physicians.
- Of the 14 ASCs developed since 1996 that do not exist in the 2015 inventory, 10 were either proposed as freestanding, hospital-physician joint ventures but never developed or were actually developed but converted to hospital-based facilities because of declining physician investor interest.

What our 20-year history clearly tell us is that we have had regulatory approval and opportunity to develop and fully utilize nearly double the number of ASCs we started with in 1996, yet the inventory at

---

*NOTWITHSTANDING THE PLETHORA OF APPROVALS AND DEVELOPMENT OF ASCS OVER THE LAST 20 YEARS, NOT MUCH HAS CHANGED AT THE END OF THE DAY: NORTH CAROLINA HAD 41 LICENSED ASCS IN 1996 AND NORTH CAROLINA HAS 44 LICENSED ASCS (OR CON-APPROVED) IN 2016.*

---

the end of the day has not really changed. Attempts to develop freestanding ASCs in communities that could not support them have failed.

Many freestanding ASCs that once existed were sold off to local hospitals that absorbed those operating rooms into their

hospital-based inventory. While non-hospital affiliated ASCs remain, there is a clear growing trend toward hospital-affiliated ASCs including those that are joint ventures with physicians *in communities that can support such facilities*. These facts, along with available capacity within existing facilities, emphasizes that North Carolina's CON laws have not artificially restrained the development of needed ASCs.

#### **SIDEBAR 4: All the ASCs**

Of those 72 unique ASCs:

- 27 were part of the original 1996 inventory and remain in operation today
- 14 of the original 1996 inventory no longer exist—10 of those sold to hospitals and operating rooms converted to hospital-based.
- 17 were added after 1996 and remain in operation today—all but four are hospital-affiliated and/or hospital-physician joint ventures
- 14 were added after 1996 but do not exist in the 2015 inventory of operating facilities
  - 10 received CON approval but have not been licensed for operation. Of those 10 with CON approval, six proposed to be freestanding ASCs as joint ventures between hospitals and physicians—and all appear to have abandoned the project reportedly for most because of a lack of interest by physician investors. Development appears to remain pending for three of the 10 with CON approval, and one was never developed as proposed but converted to hospital-based operating rooms.
  - Three were developed and initially operated as freestanding ASC hospital-physician joint ventures, but converted to hospital-based facilities reportedly because of declining interest by physician investors.
  - One was developed as a freestanding ASC then sold and converted to hospital-based.

## **GUARANTEED RISK, UNCERTAIN REWARD: WHO WILL BEAR THE COST OF INDIGENT CARE WHEN CON REPEAL GOES AWRY?**

House Bill 200's charity care requirements are inconsistent with those employed by hospitals, insufficient in scope, and misunderstand the economic issues in these healthcare markets. Even a bona fide commitment to provide at least seven percent of total revenue as charity care at new ASCs is just that, a commitment to provide charity care for one small subset of total healthcare needs of a community. The vast majority of patients in financial need do not need ambulatory surgery. The poor and underserved seek care at emergency rooms, delivery rooms, and primary care physician offices. The commitment in House Bill 200 will do nothing to address these patients. Moreover, the Georgia State University report cited in FTC Commissioner Wright's concurrence found that "markets with CON regulation tend to have more self-pay admissions per uninsured than markets in non-CON states. This suggests an association between increased access to hospital care for the uninsured and CON regulation."

If more and stronger ASCs are the goal of House Bill 200 or if greater competition is the goal of Senate Bill 702, neither history nor the "invisible hand" of the marketplace would seem to offer much certainty. What is certain, however, is that vulnerable hospitals will be put at much greater risk as new entrants pick off their best patients without taking up the burden of indigent care—a burden that the 2004 FTC/DOJ report acknowledges should be addressed. When these hospitals fail – and some of them will certainly do so – the costs will ripple throughout the state's healthcare system.

- <sup>i</sup> "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004.
- <sup>ii</sup> "FTE Staff Comment, and Concurring Comment of Commissioner Wright, Regarding North Carolina House Bill 200, Which Would Exempt Diagnostic Centers, Ambulatory Surgical Facilities, and Psychiatric Hospitals from Certificate of Need Regulation," July 2015.
- <sup>iii</sup> Patrick Rivers, Myron Fottler, and Jemima Frimpong, "The Effects of Certificate-of-Need Regulation on Hospital Costs," *Journal of Health Care Finances* 36, no. 4 (2010): 1–16.
- <sup>iv</sup> Ascendient analysis of *Almanac of Hospital and Operating Indicators*, Ingenix, 2011.
- <sup>v</sup> Ascendient analysis of *State Health Facts*, The Henry J Kaiser Family Foundation. <http://kff.org/statedata/>.
- <sup>vi</sup> Behavioral Risk Factor Surveillance Systems, CDC. \*Prevalence estimates reflect BRFSS methodological changes started in 2011. These estimates should not be compared to prevalence estimates before 2011.
- <sup>vii</sup> Finkelstein, E., Trogon, J., Cohen, J., and Dietz, W. "Annual Medical Spending Attributable To Obesity: Payer- And Service-Specific Estimates" *Health Aff September/October 2009 vol. 28 no. 5 w822-w831*
- <sup>viii</sup> Koopman, C. and Stratmann, T., "Certificate-of-Need Laws: Implications for North Carolina," Mercatus on Policy, Mercatus Center, George Mason University, February 2015.
- <sup>ix</sup> "Study finds NC health care regulations drive up costs" *The News & Observer*, February 13, 2015.
- <sup>x</sup> State of the State, 2011. North Carolina Hospital Association



## ASCENDIENT

Ascendient is a Top 50 healthcare strategy, planning and feasibility firm with offices in Chapel Hill, North Carolina and Washington, D.C. Since its founding in 1994, the firm has offered fresh approaches and innovative solutions to clients in both the public and private sectors. Working exclusively with health and healthcare organizations, Ascendient is dedicated to helping its clients envision and embrace a transformed future that will fundamentally alter every corner of the industry. [www.ascendient.com](http://www.ascendient.com)