NCHA
North Carolina
Healthcare Association

2023 NCHA Legislative Brief

Certificate of Need

The Certificate of Need law ensures that hospitals and health systems maintain the resources to provide high-value care to all in our communities. NCHA supports the Certificate of Need program and adapting the program to address the state's evolving healthcare needs.

North Carolina is one of 35 states with a Certificate of Need (CON) program to coordinate planning of new healthcare services, including construction projects, to specifically meet the needs of communities across our state. Those that have repealed CON laws have instituted various legislative moratoria.[1]

Context & Insights

The ultimate goal of CON programs is to use data-driven need methodologies to equitably distribute healthcare services across the state while ensuring quality services. Thus, the law ensures access to care for medically underserved populations and prevents oversupply that can lead to higher healthcare costs for patients. North Carolina's robust annual planning process ensures need methodologies are continuously improved and meet the needs for North Carolina's growing population. The State Health Coordinating Council (SHCC) is responsible for the development of the State Medical Facilities Plan, reviewing provider applications for healthcare services, and monitoring ongoing construction projects for healthcare services. The SHCC is a 24-member group of volunteers appointed by the Governor and includes private physicians, business leaders, and community and industry representatives.

Hospitals do not operate in a traditional free market environment: they have a moral and legal obligation to care for all regardless of the patient's ability to pay. Furthermore, payments for healthcare services by insurance and government payers vary widely from service-to-service and payor-to-payor. This system of payment creates the wrong incentives in a fee-for-service model. With these economic realities, hospitals rely on certain procedures, such as elective surgical procedures and high-end imaging, to balance losses from many other acute care services. In fact, many hospitals are able to provide vital, life-saving services that are not reimbursed to cost such as trauma center designated services, emergency services, children's and women's health services, and behavioral health, because other service lines cover at least a portion of the losses.

Hospitals with Emergency Departments are the only entities in the United States federally required to care for every person who enters their facilities. CON reform and how the legislative language and rules around it are finalized could affect hospitals differently, but our modeling shows that if Medicaid expansion and HASP are both passed, it will lessen the financial burden on hospitals. NCHA proposes that any changes to the certificate of need process take place over time and only after Medicaid Expansion and HASP are fully implemented. NCHA estimates that the total financial impact of this CON reform proposal would be more than $700 million dollars a year, however, if the General Assembly passes legislation that includes both Medicaid Expansion and HASP, there is a projected

net gain for hospitals and health systems, positioning hospitals to step up and fund Medicaid Expansion.

Key Advocacy Messages

Repealing CON laws has been proven to reduce access to care for rural and under-served patients, further widening disparities in care.

Repealing CON would clear the way for "niche healthcare businesses" that offer services with profitability as their top priority rather than community need. States with repealed or significantly weakened CON programs have demonstrated a swift and chilling impact on the available healthcare services in vulnerable communities:

- After Texas repealed its CON laws, the number of rural acute care hospital closures spiked, from three hospital closures in 1985 to 11 closures in 1987 and 12 closures in 1989.[2]
- Hospital closures and service cutbacks have occurred in full-service hospitals in the Youngstown, Ohio area, while surgical specialty hospitals and ambulatory surgery centers have been growing since Ohio repealed its CON law.
- Texas has one of the highest number of free-standing emergency department providers in the country. However, these providers have not improved access to emergency services in underserved parts of the state. Rather, providers are concentrated in urban, well-resourced communities.[3]
- Indiana repealed the entire CON program in 1999. However, due to lack of services in rural parts of the state, a law was passed in 2018 to reinstate portions of the CON program. [4]

In rural areas, community hospitals have served as a vital safety net – for patients and other healthcare providers – during disasters such as hurricanes and the coronavirus pandemic (COVID-19). In some states, healthcare profiteers have undercut rural hospitals by strategically locating themselves to draw business across county lines and even state lines, leading to the erosion of hospital services in communities.[5]

The CON process has right-sized healthcare resources in our state, keeping costs contained and care accessible in communities.

States with strong CON programs, including North Carolina, have better access to healthcare services, measured by median values, with strong CON states having more than double the number of Medicare-certified ambulatory surgery centers and physicians and nearly double the number of hospitals per 1,000 square miles.

- In fact, North Carolina has more hospitals per 1,000 square miles than Texas.[3]
- Unlike states without CON, North Carolina has a more equitable hospital bed distribution within mid-sized communities (rural suburban, suburban, and large suburban).[3]
- CON was not a barrier for providers during the COVID-19 pandemic and subsequent public health emergency. In fact, CON helped hospitals add approximately 5,000 beds for surge capacity to meet patient needs.
- CON opponents frequently reference the discrepancy between the need methodologies for psychiatric and substance use disorder inpatient beds and the actual community need as a reason CON is ineffective. The SHCC recognized the inaccuracies and eliminated the need methodologies. Providers seeking to develop behavioral health inpatient services will need to demonstrate the need for additional services to the SHCC and the SHCC will continue to safeguard quality care that is driven by community need, not company profits.
- According to a Mercatus report, CON has resulted in 12,900 fewer hospital beds in the state. However, the inpatient utilization data does not support the claim for such a drastic increase in hospital beds; in 2019, licensed beds had a 56% occupancy rate and adding beds per Mercatus' formula would bring the occupancy rate down to 36%, a true over-saturation of an expensive healthcare resource that would most likely drive prices up for patients. Plus, the estimated cost to develop hospital beds under the Mercatus projections is $12.9 million.[3]

North Carolina's strong CON program attracts and keeps the hospital and healthcare industry in the state, one of the state's largest employers.

- Nationally, North Carolina is ranked number one for

business.[6]

- Hospitals and health systems generate a total of $37.8B in state gross domestic product $22.4B in labor income across North Carolina which supports nearly 395,000 jobs across both the hospitals themselves and the various industries with which they interact.
- In 2021, North Carolina hospital and health systems provided $1.2B in charity care and has one of the highest rates of individual uninsured in the country. Given these challenges, CON is a necessary component to attract and maintain healthcare business in our state.[10]

Although CON opponents state otherwise, CON has not curtailed the growth of healthcare services, particularly ambulatory surgical centers, in the state.

- When measured by population density, North Carolina has a higher rate of ambulatory surgical centers (ASCs) than Texas.[3]
- In 2015, there were 44 ASCs across the state despite the fact 72 unique ASCs have been authorized by SHCC between 1995 – 2015, indicating that other factors – not the CON process - are at play for the number of ASCs in communities.[7] In fact, North Carolina's ASCs have grown across the state to 57, with many more under development.[3]

Repealing North Carolina's CON law will likely raise healthcare costs, not lower them.

- North Carolina hospitals operate efficiently at one of the highest occupancy levels in the country.[3]
- States with strong CON programs, including North Carolina, have lower hospital prices than states without CON programs. North Carolina's net prices for inpatient discharges is $1,000 less than the median price for states without CON.[3]
- A prime example of how repealing CON laws raises the cost of healthcare is what happened to Georgia, Ohio, and Pennsylvania when they removed services from CON programs. All three states experienced faster growth in per capita expenditures for hospitals and physician services that outpaced the average U.S. growth over the same time period. Of note, all three states' expenditures were growing at a rate lower than the U.S. growth rate when their CON programs were in place.[3]
- Multiple studies, including reports by the GAO, have shown that physician-owned imaging centers (a profitable service line) have generally led to increased self-referrals (especially for patients who are less severe and more profitable), higher rates of ordering imaging scans, and overall higher utilization, some of which has been found to be inappropriate.[3]
- Studies have shown that North Carolina's Certificate of Need legislation has actually reduced the number of image scans patients with low back pain receive without increasing the probability of future low back pain or reducing the quality of care, but has reduced medical spending by roughly $400 per patient.[8]

The COVID-19 pandemic has highlighted the importance of the CON law.

- Statewide, hospitals lost about $1 billion a month because of the elimination of profitable non-urgent procedures and spending on COVID-19 preparations. This dramatic loss in revenue happened within a matter of weeks, putting a strain on operations, especially at hospitals with already thin margins and low cash-on-hand reserves. This demonstrates the delicate balance of services needed to sustain a hospital and the potential risks of removing services from CON.
- While a 2020 Mercatus report projected states with CON programs would have a higher likelihood of ICU bed shortages during the COVID-19 pandemic, not only did NC not have a shortage of ICU beds, but the CON program was also able to quickly add an additional ~5,000 beds to hospitals ahead of the surge.[9] Furthermore, California and Texas, two states with no CON programs, experienced significant ICU bed shortages, further demonstrating CON was not a barrier during the COVID-19 public health emergency.

Sources

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Questions?

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