North Carolina Healthcare Association

2024 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 (CON) and adapting the CON program to address the state's evolving healthcare needs.

North Carolina is one of 35 states with a 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 Those that have repealed CON laws have instituted various legislative moratoria.[1]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 with Emergency Departments are the only entities in the United States federally required to care for every person who enters their facilities. 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 payors vary widely from service- to-service and payor-to-payor. 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.

In 2023, the North Carolina General Assembly enacted legislation modifying North Carolina's CON program. On March 27, 2023, Governor Roy Cooper signed House Bill 76, allowing North Carolina to become the 40th state to expand Medicaid.[1] HB 76 also approved the NCHA-crafted Healthcare Access and Stabilization Program (HASP) which provides much needed financial support to rural hospitals and enables hospitals to pay for the non-federal share costs of expansion. Changes to the certificate of need law were also included in the bill as part of a negotiation compromise to pass Medicaid expansion.

These CON law changes will be phased in over the next several years as follows:

- **Effective immediately:**
  - Psychiatric beds and facilities as well as chemical dependency treatment beds and facilities are removed from CON review.

- The diagnostic center CON threshold was increased from $1.5 million to $3 million. As previously, the threshold is based on the fair market value of the equipment or the cost of the equipment, whichever is higher.
- The threshold for replacement equipment increased from $2 million to $3 million. A provision was added to adjust the threshold annually based on inflation.
- An exemption was added for licensed home care agencies to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to children under age 21 in compliance with federal Medicaid requirements.

- **Effective two years after the first issuance of HASP payments, which is Nov. 21, 2025, the following would be removed from certificate of need review:**
  - DHHS-licensed ambulatory surgical centers (ASCs) that are in a county with a population of greater than 125,000 based on the 2020 census and commit 4% of their total earned revenue to charity care.
- **Effective three years after the first issuance of HASP payments, which is Nov. 21, 2026, the following would be removed from certificate of need review:**
  - MRI machines in counties with a population of greater than 125,000.

Key Advocacy Messages

Eroding key aspects of 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. CON law amendments could threaten the survival of community hospitals if they are not implemented carefully:
  - 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 natural and man-made disasters and public health emergencies. 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] North Carolina is the 2nd largest rural population in the country behind Texas and we must sustain our hospitals, which treat a large portion of the state.
- When Georgia repealed CON for single specialty ASCs in 2008, over 180 single specialty ASCs were built within the first year alone. As a result, of the nine Georgia hospitals that closed within 2008 – 2014, all but two had multiple single-specialty ASCs developed around the hospital. (Ascendient, 2022).

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.

- Hospitals and health systems generate a total of $40.3B in state gross domestic product and $29.6B in labor income across North Carolina, which supports nearly 500,000 jobs across both the hospitals themselves and the various industries with which they interact.[6]
- In 2022, North Carolina hospitals and health systems provided $1.1B in charity care.[7] Also, North Carolina has one of the highest rates of individuals uninsured in the country. Given these challenges, CON is a necessary component to attract and maintain healthcare business in our state. [8]

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

- When measured by population density, North Carolina has a higher rate of ambulatory surgery 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.[9] As of April 2024, North Carolina ASCs have grown across the state to over 70, with more under development.[10]
- When Georgia repealed CON for single specialty ASCs in 2008, state surgical volume per population increased by 60% within the first year and an overall increase of 43% by 2014. Most of the increase in surgical volume is attributed to the increase in single-specialty ASCs, in which over 180 new single specialty ASCs were developed within the first year of repeal. (Ascendient, 2022)

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.[11]

Key Advocacy Messages

1. Certificate of Need State Laws, National Conference of State Legislatures. https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

2. "Texas Rural Hospital Closures (1965-2018)," prepared by the Texas Organization of Rural and Community Hospitals for the State of Texas, accessed online on Sept. 28, 2018. https://capitol.texas.gov/tlodocs/85R/handouts/C4102018062813001/98d9e223-176e-4953-8864-ac94ece1f91c.PDF

3. CON Analysis and Impact Study, Ascendient Healthcare Advisors, April 2021.

4. National Council of State Legislatures, "States Modernizing Certificate of Need Laws". https://www.ncsl.org/research/health/states-modernizing-certificate-of-need-laws.aspx

5. Certificate of Need Research and Impact Analysis, Ascendient, January 2017

6. 2022 NC's Hospitals and Health Systems Economic Impact Report, North Carolina Healthcare Association, 2022. https://www.ncha.org/wp-content/uploads/2022/12/NCHA_Economic_Impact_Report_22-1.pdf

7. North Carolina Healthcare Association 2022 Community Benefit Infographic, 2023. https://www.ncha.org/wp-content/uploads/2023/10/Community_Benefit_Infographic_2022.pdf

8. 'The State of Healthcare in North Carolina: 2022 Impact Report,' North Carolina Healthcare Association, 2022.

9. "First, Do No Harm", Ascendient Healthcare Advisors, July 2015

10. Ambulatory Surgical, Licensed by the State of North Carolina. Department of Health and Human Services - Division of Health Service Regulation (April 2024). The count of ASCs excludes locations with only endo rooms.

11. "Certificate of Need Regulation and Hospital Behavior: Evidence from MRIs in North Carolina," Bryan J. Perry, Center for Healthcare Economics and Policy, Nov. 1, 2017. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3225741

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