



CERTIFICATE OF NEED STUDY

SUMMARY REPORT

*Conducted and Prepared by Ascendient
for the Kentucky Hospital Association*



DATA FINDINGS AND CONCLUSIONS

For decades, proponents for and against CON laws have been battling over whose arguments and analyses are right and whether CON laws are good or bad, with neither side able to claim victory. It is difficult to draw definitive conclusions about the benefits, or lack thereof, of CON laws because there are so many complex variables associated with healthcare services, and it is impossible to isolate the statistical impact of CON from other variables. For one, any analysis that considers CON status as a binary choice—and most do—is grossly oversimplified. The degree of CON regulation and the timing of a repeal or change in CON status are but two of the factors that complicate the analysis. Despite these limitations, this study highlights the findings and conclusions resulting from an analysis of the supply, demand, utilization, efficiency, costs, and pricing of healthcare services, as well as other statistics, for all 50 states and the District of Columbia. Of particular interest is analysis between states without any Certificate of Need laws (“No-CON states”) and those more regulated states (“High- or Moderate-CON states”), which permits some inferences regarding how CON may enhance or impair healthcare services.

High/Moderate-CON states outperform No-CON states in access to, and prices of, healthcare services.

- High/Moderate-CON states have better **access**¹ to healthcare services than No-CON states as measured by median values, with double the number Medicare-certified ambulatory surgery centers per 1,000 square miles and nearly triple the number of hospitals and physicians per 1,000 square miles.

	High/Moderate-CON States	No-CON States
Hospitals per 100,000 [^]	1.6	2.0
Hospital Density (# per 1000 sq miles)*	2.5	0.9
Medicare-Certified ASCs per 100,000	1.0	2.0
Medicare-Certified ASC Density (# per 1000 sq miles)*	2.2	0.9
Physicians per 1,000 [^]	2.4	2.1
Physician Density (# per 1000 sq miles)* [^]	357.9	132.1

[^]Denotes measures for which the District of Columbia was excluded.

^{*}Denotes metrics that were statistically significant between High/Moderate-CON States and No-CON States.

Note: Data shown by degree of CON above are based on median values unless otherwise noted.

¹ In evaluating access to the “supply” of healthcare services, these statistics consider both the size of the population and its density, both of which are important to consider *in tandem*. Notably, some have argued that CON states do not have sufficient supply because they have less CON-regulated capacity per population (e.g., hospital beds) than No-CON states. However, these proponents fail to take into consideration that many of the No-CON states are some of the largest states geographically with some of the smallest populations, resulting in very sparsely populated states. As a result, many of these states require more capacity to serve the geographic area of the state, rather than more capacity to serve the size of the population. The sparsity of population in most No-CON states eliminates the “oversupply” that would occur in more densely populated states if they were supplied at the same ratio.



- High/Moderate-CON states have **lower prices** and provider costs than No-CON states. The median net price per inpatient discharge (wage and case mix adjusted) in No-CON states is nine percent higher than the median net price in High/Moderate-CON states. Even more compelling, the median provider cost per outpatient APC service is nearly 30 percent higher in No-CON states than in High/Moderate-CON states.

	High/Moderate-CON States	No-CON States
Net Price per Inpatient Discharge (CMI/WI Adjusted)	\$6,723	\$7,303
Provider OP Cost per APC Service (Weight Adjusted)	\$71	\$91

- High/Moderate-CON states, however, have **higher per capita health spending** than No-CON states, but that higher spending is driven by higher utilization—not higher prices—and the higher utilization is likely driven by poorer health status in High/Moderate-CON states.

	High/Moderate-CON States	No-CON States
Health Spending per Capita	\$8,029	\$7,651

- Population health** in High/Moderate-CON states is poorer than in No-CON states: there is a threefold difference between the average (and median) state health score of High/Moderate-CON and No-CON states and the average life expectancy in No-CON states is more than a year longer than High/Moderate-CON states.

	High/Moderate-CON States	No-CON States
State Health Score	-0.1	0.2
Life Expectancy [^]	78.3	79.6

Kentucky outperforms No-CON states by any number of measures.

- Kentucky provides better access** to most healthcare services than No-CON states. Kentucky has a higher rate of hospitals per 100,000 population than the median of No-CON states. In addition, Kentucky has nearly three times the number of hospitals per 1,000 square miles than the median of No-CON states, nearly two times the number of physicians per 1,000 square miles, and approximately the same number of Medicare-certified ASCs per 1,000 square miles. Of note, Kentucky has more hospitals per 1,000 square miles than California or Texas.



	Kentucky	No-CON States
Hospitals per 100,000	2.3	2.0
Hospital Density (# per 1000 sq miles)*	2.6	0.9
Medicare-Certified ASCs per 100,000	0.8	2.0
Medicare-Certified ASC Density (# per 1000 sq miles)*	0.9	0.9
Physicians per 1,000	2.1	2.1
Physician Density (# per 1000 sq miles)*	237.8	132.1

As noted above, population density plays an important role in assessing true access to care. Mercatus² suggests that the Kentucky CON program has resulted in 5,782 fewer hospital beds, among other findings, based solely on a comparison of the rates of hospitals per 100,000 population. The broad geography and low density of many of the No-CON states creates a need for a higher number of hospitals to serve a smaller population, simply to cover the geographic expanse of these states. In other words, just because Wyoming (a No-CON state) has five hospitals per 100,000 does not mean that Kentucky’s access is insufficient with only two hospitals per 100,000. In fact, when density is factored in, Wyoming only has 0.3 hospitals per 1,000 square miles, while Kentucky has 2.58.

Moreover, according to the 2017 Kentucky Annual Hospital Utilization and Services Report, Kentucky has 11,165 licensed acute care hospital beds with a total capacity to provide more than 4,000,000 inpatient days of care each year. Kentucky hospitals used those beds to provide 2,281,712 inpatient days of care in 2017, meaning that hospital beds statewide are occupied only 56 percent of the time. 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 would be at least \$1.5 million per bed. To create the 5,782 beds cited in the Mercatus report would require a \$8.6 billion expenditure, when existing beds are already unused nearly half the time. Based on the statewide average payer mix, providers would be looking to Medicaid to recoup at least \$2 billion of that unnecessary capital expense. Moreover, like communities across the US, Kentucky’s inpatient utilization rates have been declining over the last decade—a trend that is expected to continue. If KY were to add the beds that Mercatus suggests, it would have the 13th highest number of acute beds in the US, while ranking 26th in total population. Any suggestion that Kentucky is missing nearly 6,000 hospital beds is simply preposterous.

- **Kentucky has lower prices and costs** than No-CON states. Kentucky’s net price per inpatient discharge is 16 percent lower than the No-CON states’ median and lower than each No-CON state—in fact, it has the **sixth lowest net price per inpatient discharge in the US**—while its provider cost per outpatient service is almost 40 percent lower. Similarly, an analysis by Kaiser State Health Facts shows that Kentucky’s hospitals have among the lowest average adjusted expenses per inpatient day in the US. Specifically, its not-for-profit hospitals’ average expenses per inpatient day was the

² Koopman, C. and Stratmann, T., “Certificate-of-Need Laws: Implications for Kentucky,” Mercatus on Policy, Mercatus Center, George Mason University, May 26, 2015.



tenth lowest in 2016 and 2017; its for-profit hospitals' expenses were among the 20 lowest in the US³.

- At the same time Kentucky is providing better access and lower prices/costs, the state also serves a **more vulnerable population**. Kentucky's population is older, poorer, and less healthy than those in No-CON states. Kentucky's median household income is lower than each of the No-CON states; the median household income in No-CON states is nearly 30 percent higher than in Kentucky. Kentucky's mix of Medicaid inpatients is 20 percent higher than the No-CON states' median. The life expectancy of Kentuckians is lower than No-CON states' median by more than three years: 76.3 compared to 79.6. Kentucky's state health score is the 7th lowest in the US and lower than all but one No-CON state (Arizona).

	Kentucky	No-CON States
% Population 65+	16.0%	15.4%
Median HH Income	\$45,369	\$58,146
Life Expectancy	76.3	79.6
State Health Score	-0.6	0.2
% Inpatient Discharges Medicaid	20.9%	17.1%

Kentucky outperforms neighboring No-CON state Indiana.

Indiana is not comparable to Kentucky. Based on a review of thirteen demographic and socioeconomic factors, Indiana is comparable to Kentucky in only three (as measured in the context of most comparable among all 50 states). Nevertheless, the geographic proximity of the two states, coupled with its status as the only No-CON state contiguous to Kentucky, creates a natural inclination to compare the two states, whether appropriate or not. The following findings highlight the differences between Kentucky and Indiana that suggest Kentucky's current status as a Moderate-CON state is beneficial to its citizens.

Kentucky's population is more rural, less healthy and more economically challenged than Indiana's.

- Kentucky is more rural than Indiana. Indiana's median household income is almost 25 percent higher than Kentucky's. Life expectancy in Indiana is more than a year higher than Kentucky.

Kentucky's health services are generally well supplied compared with Indiana.

- Kentucky's rate of hospitals and physicians per 100,000 are higher than Indiana's. Thus, relative to the size of the population, Kentucky has more hospitals and physicians than Indiana does.

³ <https://www.beckershospitalreview.com/finance/average-hospital-expenses-per-inpatient-day-across-50-states.html>



Kentucky's health services are better distributed among its population than Indiana's.

- Kentucky's rural residents have better access to hospitals than Indiana's. Kentucky's hospital beds are fairly well distributed to its population. In contrast, Indiana's hospital beds are skewed more heavily to its urban community, at the expense of rural communities.

Kentucky's healthcare is less costly than Indiana's.

- Kentucky's net inpatient payments per hospital discharge are more than \$1,000 lower than Indiana's. If Kentucky were like Indiana, payers would pay nearly \$600 million more per year for inpatient care. Despite its lower health and economic status, Kentucky's per capita healthcare cost is lower than Indiana's.



RISKS OF CON REPEAL IN KENTUCKY

Hospital Closure in Kentucky's Vulnerable Communities

Kentucky is one of the most rural states in the US (the tenth most rural population in the US). A disproportionate share of hospital closures over the last decade have been small rural facilities. Like other rural states, many of Kentucky's rural counties, in particular, are already at risk for hospital closures and/or reduction in services, and any CON repeal is likely to be another nail in the coffin of these already fragile hospitals. According to the NC Rural Health Research Program⁴, eight of Kentucky's rural hospitals are at high-risk of financial distress. According to the Program's highly predictive model, rates of rural hospital closure increase significantly for hospitals identified as high risk⁵.

Using the considerable research compiled by the NC Rural Health Research Program, as well as other data sources, this study assesses which of Kentucky hospitals are most vulnerable today. In all, at least thirteen hospitals are considered most vulnerable to closure. All are the sole provider in their respective communities, and their closure would result in no local access to hospital and emergency services. Closure of these hospitals would mean the loss of 2,500 jobs with salaries and other economic benefits of \$240 million, and nearly 1,000 inpatients *each day* that would have to find hospital care elsewhere.

⁴ Thomas SR, Pink GH, and Reiter KL. Geographic Variation in the 2019 Risk of Financial Distress among Rural Hospitals. (April 2019) North Carolina Rural Health Research Program, UNC Chapel Hill. Available at: <https://www.shepscenter.unc.edu/programs-projects/rural-health/projects/north-carolina-rural-health-research-and-policy-analysis-center/publications/>

⁵ Thomas SR, Pink GH, and Reiter KL. Trends in risk of financial distress among rural hospitals, 2015 to 2019 (April 2019). North Carolina Rural Health Research Program, UNC Chapel Hill. Available at: <http://www.shepscenter.unc.edu/download/18557/>

Kentucky's Vulnerable Communities

Tier One Hospitals: "Most Vulnerable"

13 Hospitals




 Population
210,588

 Other Economic
Benefit
\$102 million

 Employees
2,517

 Inpatients/Day
972

 Salaries
\$138 million


 ED Visits
97,723

Tier Two Hospitals: "Vulnerable"

15 Hospitals




 Population
274,792

 Other Economic
Benefit
\$115 million

 Employees
2,423

 Inpatients/Day
1,101

 Salaries
\$138 million

 ED Visits
146,702

Combined Impact

 Population
485,380

 Salaries
\$276 million

 Inpatients/Day
2,074

 Employees
4,940

 Other Economic
Benefit
\$217 million

 ED Visits
244,425

Parameters Shared by Tier One and Tier Two Hospitals: - Within Range of NC Rural Health Research Program's Closure Profiles for number of hospital beds, RUCA score, and population size; - Have an FSI® status of "Fair" or "Poor"; - Were the sole hospital in the county;

Tier One hospitals are not part of a larger system whereas Tier Two hospitals are part of a larger system.



Healthcare “Urbanization”

As noted above, Kentucky has one of the most rural populations in the US. Rural residents are typically older, poorer, more dependent on public insurance, and in worse health than urban residents, and may be disproportionately impacted by rural hospital financial distress and closure¹. Kentucky’s hospitals serve a more vulnerable population than most any other state:

- Kentucky’s median household income is the 4th lowest in the US, and its percentage of population below poverty is the 4th highest.
- Kentucky has the 11th highest rate of Medicaid inpatients in the US.
- Kentucky’s State Health Score, as measured by the United Health Foundation, is the 7th lowest in the US.

These most vulnerable citizens will be disproportionately affected by service reductions, hospital closures, and the “urbanization” of healthcare.

CON repeal appears to contribute to the urbanization trend. According to a study⁶ of the Indianapolis metropolitan area completed by the Center for Studying Health System Change, the repeal of Indiana’s CON law has allowed hospitals to freedom to expand—in affluent suburban communities.

The experience in Indiana is representative of the urbanization of hospital bed distribution in other No-CON states. Of the ten No-CON states with some urban population, 80 percent skew hospital bed distribution to urban communities at an average of 5.4 percent higher, at the expense of rural and/or suburban communities. These distribution statistics indicate that when not regulated, healthcare services tend toward urban centers, providing reduced access for those who live in rural communities, a likely phenomenon if Kentucky were to repeal its CON laws. As an example, if Kentucky’s hospitals were distributed in the same patterns as its physicians currently are, Kentucky would have only 33 rural hospitals, rather than the 78 it has today⁷.

Cost of Healthcare “Urbanization”

In addition to the work of the NC Rural Health Research Program, other studies have examined the impact of hospital closures in rural areas and the resulting urbanization of healthcare access. Kaiser Family Foundation examined the impact of three rural hospital closures, one each in Kentucky, South Carolina, and Kansas. The study⁸ found, in part, among these communities:

“similar economic and demographic trends that contributed to the closures. They cited high poverty and uninsured rates in rural communities, high rates of Medicare and Medicaid coverage, and declining populations. In each community, poverty rates were

⁶ Katz, Aaron, Grace Anglin, Emily Carrier, Marisa K. Dowling, Lucy B. Stark, and Tracy Yee, Indianapolis Hospital Systems Compete for Well-Insured, Suburban Patients, Washington, D.C.: Center for Studying Health System Change, December 2011.

⁷ According to this study’s data, 76.5% of Kentucky’s hospitals are located in rural communities, compared to 60.5% of its population, a +16.0 skew. In contrast, only 33% of Kentucky’s physicians are located in rural communities, a -27.5 skew. If only 33% of Kentucky’s hospitals were located in rural communities, it would have only 33 rural hospitals.

⁸ <https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/>



higher than state and national averages and median incomes were lower, and the population was shrinking.”

The study went on to find that access to care, particularly emergency care, was greatly diminished as a result of the hospital closures.

The need for increased availability of emergency services in the wake of a hospital closure is not easily met in rural communities, often requiring more and lengthier transports out of the community at the same time the cost of staffing a rural EMS service with paid staff can range from \$200,000 to \$750,000 a year⁹. In addition to a reduction in access, the Kaiser Family Foundation study found that hospital closures result in job losses and can have other economic effects, which in turn can make it more challenging for rural communities to attract employers.

Case Studies of CON Repeal

Given all the factors that make a conclusive argument for or against CON nearly impossible to make, coupled with the myriad of differences between all the states, it is likewise difficult to surmise the exact impact of CON repeal in Kentucky. However, there are facts from states that have partially or fully repealed CON more recently than the national repeal decades ago that indicate what potential repeal might mean for Kentuckians.

Georgia repealed CON for single-specialty ASCs in 2008. After CON repeal for single-specialty ASCs, the number of ASCs in Georgia increased by more than 280. The application of Georgia’s post-CON repeal experience to Kentucky (as measured by the number of ASCs per 100,000 population) suggests that the state would likely see an increase of nearly 100 ASCs over a 10-year period, with most of that growth occurring within five years. Beyond the aggregate increase of almost 100 ASCs, the application of Georgia’s experience by geography to Kentucky indicates that the majority of these additional ASCs would be in rural counties, with 62 additional ASCs in rural counties creating an ASC in almost every rural community—and adding more risk to Kentucky’s vulnerable hospitals.

Pennsylvania repealed its CON laws in 1996. An analysis starting in 2001 demonstrates that the number of ASCs in Pennsylvania increased by more than 150 from 2001 to 2010. The application of Pennsylvania’s post-CON repeal experience to Kentucky (as measured by the number of ASCs per 100,000 population) suggests that the state would likely see an increase of more than 80 ASCs over a 9-year period. (Note that data for the Pennsylvania experience begins in the fifth year of CON repeal, rendering a conservative estimate for what Kentucky might expect.) Beyond the aggregate increase of more than 80 ASCs, the application of Pennsylvania’s experience by geography to Kentucky indicates that the vast majority of these additional ASCs would be in rural counties, with 76 additional ASC in rural counties.

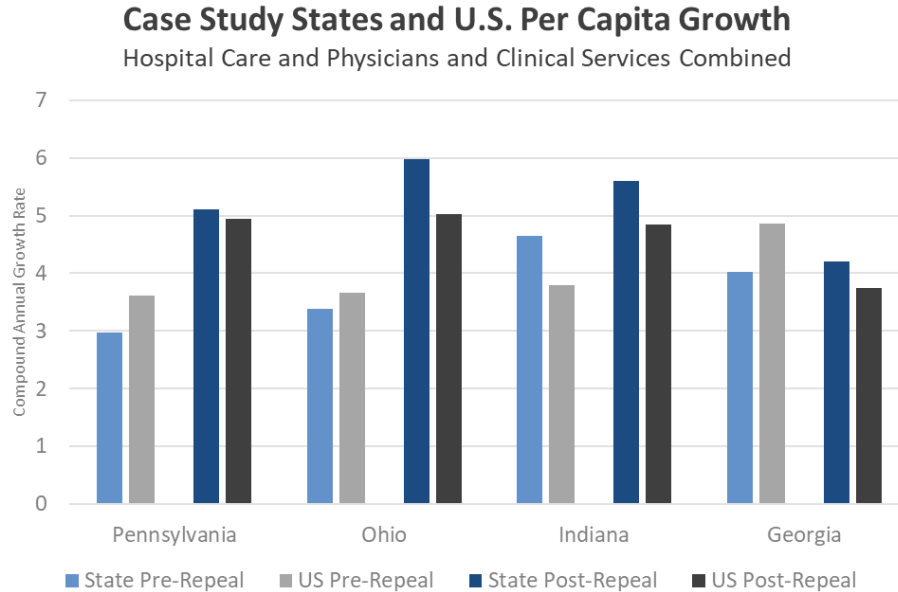
Ohio repealed CON in a phased approach from 1995 to 1998. In the three years following CON repeal, Ohio lost at least 14 hospitals, or 15% of its supply¹⁰. Assuming a similar rate of hospital closure in Kentucky would result in the loss of 11 Kentucky hospitals within a three-year period post-repeal.

⁹ <https://www.ruralhealthinfo.org/rural-monitor/ems-self-determination/>

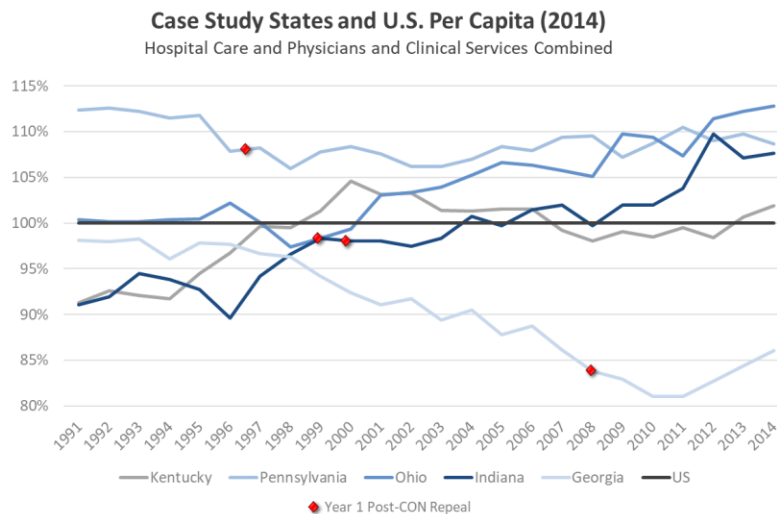
¹⁰ Please note the source used for this analysis reports the loss of hospitals with obstetric programs; thus, the total number of hospitals lost could have been higher than the 14 noted here.



In each of the three case study states—Ohio, Pennsylvania, and Georgia, plus the neighboring, No-CON state of Indiana—per capita health expenditures for hospital and physician services grew at a higher rate in the years since CON repeal than the US average growth rate over the same period of time.¹¹



While Kentucky’s per capita expenditures for hospital and physician services have moderated around the US average for more than a decade, as shown on the chart below, the average experience of these states that have fully or partially repealed CON strongly suggests that Kentucky’s per capita costs would increase at a rate 16 percent above the national growth rate with the repeal of CON.



¹¹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html>



Kentucky as a No-CON State

If CON were repealed in Kentucky it is not reasonable to assume that the state's statistics as examined in this study would immediately shift to those of No-CON states. However, an analysis of Kentucky as mirrored by the No-CON state statistics does provide an indication of the direction in which these factors are mostly likely to move. Key among those would be the loss of 12 hospitals, based on the number of hospitals per 100,000 and Kentuckians (and their payers) would pay \$600M more per year for inpatient services.

CON Repeal is Risky and Premature

Since the advent of the country's modern healthcare system in the middle of the last century, healthcare has never, and likely will never, operate as free market. Elimination of CON laws does not change this fact. Moreover, healthcare transformation is poised to fundamentally alter the landscape of healthcare in the US, including how care is paid for and how care is delivered. Rewriting the laws of competition via CON repeal simultaneous to transformation is a hugely risky proposition, especially for vulnerable communities and safety net providers. Our healthcare system can continue to provide excellent care to all as long as the transition is orderly and evolutionary. Particularly in states with more vulnerable populations like Kentucky, premature repeal of CON is likely to have unintended – and very expensive – consequences.

Such an approach is consistent with the oft-cited Bush-era FTC/DOJ report, "Improving Health Care: A Dose of Competition."¹² 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, including a discussion of the inherent features of US health care markets that limit competition. "[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."*

¹² "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004.



Although the report recommends reconsideration of states' CON programs, it does so in the context of other recommendations, notably to change payment methods and to offer direct subsidies to those who cannot afford care rather than the cross-subsidies inherent in today's system (e.g., profit from surgery patients covers the cost of uninsured emergency room patients).