



HEALTH SERVICES PLANNING AND REVIEW BOARD
CONCORD, NH

STATE HEALTH PLAN REPORT

December 2015

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Purpose

This report was approved by the Health Services Planning Review Board (HSPRB), and developed by a subcommittee of the HSPRB and interested parties to inform the New Hampshire (NH) legislature about Certificate of Need (CON) and related topics. New Hampshire's CON statutes are scheduled to be repealed in June of 2016. This report is submitted in lieu of a state health plan (SHP). This report does not take a position on CON, nor does it reflect the individual opinions of the HSPRB and staff.

State Health Plan

In 2014, the legislature added a requirement for the HSPRB to develop a SHP, but was silent on the scope and direction of the Plan and did not provide any additional funding to support this initiative. During the exploratory phase of developing a SHP, the HSPRB learned from various stakeholders that the state has developed a number of data sources and reports that provide information on the health status and delivery of health care in New Hampshire. Examples include census data, the New Hampshire Comprehensive Health Information System (NHCHIS), the NH Behavioral Risk Factor Surveillance System (BRFSS), NH Health Web Reporting and Query System (NH HealthWRQS), hospital discharge data, New Hampshire Vital Records Information Network Web (NHVRINweb), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and various reports and studies produced by state agencies and nonprofits. The opportunities available from these data and resources exceed those available in most other states. Additionally, projects such as the NH State Health Improvement Plan, a NH Department of Health and Human Services (NH DHHS)-Division of Public Health Services document, could serve as a building block for a SHP. The HSPRB recognizes that a SHP could be a strategy for integrating existing data, infrastructure, and intellectual resources.

The HSPRB is charged with making decisions affecting the size and scope of the State's health care delivery system, balancing four basic priorities: accessibility, sustainability, cost, and quality. Expectations for a SHP include developing a shared vision and strategy for integrating these priorities.

CON Background

State CON programs began in 1976 after the federal government passed the Health Planning and Resource Development Act of 1974. This action was taken because Congress believed that health facility construction projects were driving up health care costs and mandated that states establish a program to approve capital expenditures over a specified threshold. The NCSL website includes additional information on CON: <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>.

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NH CON

The HSPRB includes five members, and the Office of Health Services Planning and Review (HSPR) currently has two staff members. By statute, the commissioner of the Department of Health and Human Services (DHHS) shall provide staff and the HSPRB may also hire consultants, provided that such expenses shall not exceed \$500,000 annually. The annual budget has remained at \$500,000 since 1985, leading to erosion in analytical resources available during this time period. The HSPRB includes representatives from the New Hampshire Insurance Department, DHHS, as well as three public members whose occupation is not in the delivery of health care.

The HSPRB has existed since 1985 and meets approximately once a month. All meetings are open to the public. The office of HSPR is administratively attached to the NH DHHS and funded through fees assessed on hospitals and nursing homes.

When a project exceeds statutory thresholds, it is subject to the CON approval process. Projects may include:

- construction or modification of health care facilities;
- acquisition of new medical equipment; or
- new inpatient care beds and services.

The 2015 thresholds are:

- \$3,050,117 for any acute care facility project;
- \$2,033,411 for any other licensed health care facility project such as a nursing home, ambulatory surgical center, rehabilitation hospital, psychiatric hospital, specialty hospital, or outpatient clinic; and
- \$400,000 for equipment.

During the 2012 legislative session, substantial changes to the NH CON statutes were made to address regulatory limitations, such as project costs that had been excluded from CON review. The most significant changes were:

- including leasing arrangements in total costs;
- increasing the emphasis on cost effectiveness;
- development of a SHP; and
- reducing the size of the HSPRB and eliminating members representing regulated entities.

Projects are reviewed based on the need for the new facility or service, cost, health care quality, access, available care for the uninsured, and financial feasibility.

Examples of the specific criteria include:

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- Fixed MRI - applicant must be referring 1,500 procedures to a mobile unit, or must be able to demonstrate that it will provide 1,000 procedures the first year of operation.
- Acute care beds - total beds cannot exceed 2.5 beds per 1,000 people in the service area.
- Cardiac Catheterization - must be performed at a licensed facility with appropriate staff and transfer agreements in the case of an emergency.
- Cardiac Surgery - must provide supporting data that the minimum number of cardiac bypass and valve surgeries will be 250 procedures, and the approval of a project cannot drive another provider below 250 procedures – a number considered the baseline for a safe program.
- Megavoltage Therapy – must provide supporting data that show by the third year of operation a minimum of 325 patients or 6,500 procedures will be performed, and that an existing provider will not drop below this threshold as a result.

The following capital expenditures by health care facilities are exempt from CON:

- private offices or private clinics of physicians, dentists, or other practitioners;
- dispensaries and first-aid stations, located within business or industrial establishments;
- infirmaries owned or operated by education institutions;
- institutions or homes which provide remedial care or treatment only to residents or patients who rely solely upon treatment by prayer;
- facilities and services which are intended to serve only outpatients and which do not require construction of greater than the appropriate threshold level; and
- hospice houses.

A CON for a new health service can be issued when the HSPRB has created a standard of essential features relevant to the anticipated cost, access, and quality of the service. The standard must address the financial feasibility of the project and its impact elsewhere in the healthcare system. When the HSPRB develops a standard, it involves interested parties, including clinicians and scholars, in order to best assure patient safety and a reasonable balance of cost, access, and patient outcomes. This discussion is summarized as an RSA 541-A rule, given a public hearing and Joint Legislative Committee on Administrative Rules (JLCAR) review, and adopted by the HSPRB.

Current statutes contemplate that some services should be deemed competitive and not subject to CON. An example from the CON rules includes: "Possible competitive impact upon the availability of MRI services, existing vendors or other proposed vendors shall not be a basis for denying an application except for an application to install a fixed

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unit at a location in a small hospital service area that is not owned or operated by the hospital located in the small hospital service area.”

Many projects are brought to the attention of the HSPRB due to formal requests for a “not subject to review” (NSR) determination. The HSPRB receives these requests in order to provide clarity for the regulatory oversight of projects in the state. Some of the more typical questions include whether all of the appropriate costs have been considered and whether two projects should be considered as one.

In some cases, projects have been withdrawn after an application has been submitted.

Chart 1 shows the number of projects subject to CON reviewed by the HSPRB over the last ten years.

Chart 1

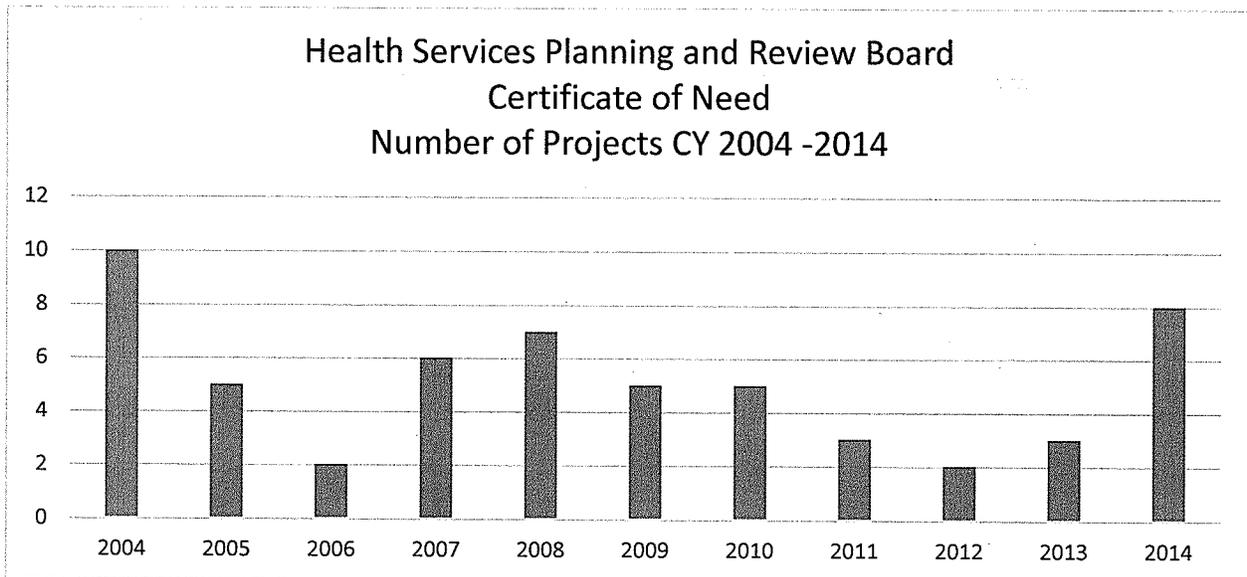


Chart 2 shows the breakdown of CON to NSR costs between 2007 and 2014. Traditionally, total costs reviewed in CON applications have been greater than the cost of NSR requests. This was reversed in 2013 and 2014 as many providers anticipated that the legislature would include leases in CON reviewed costs, so applicants requested NSRs requests for projects that would be subject to CON under current requirements.

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Chart 2

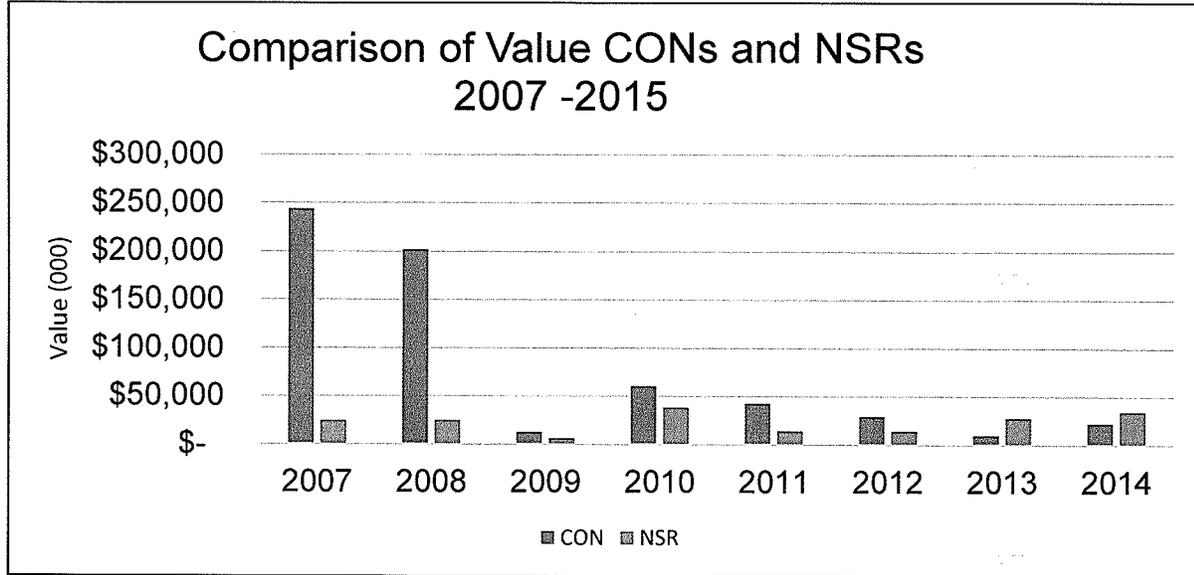
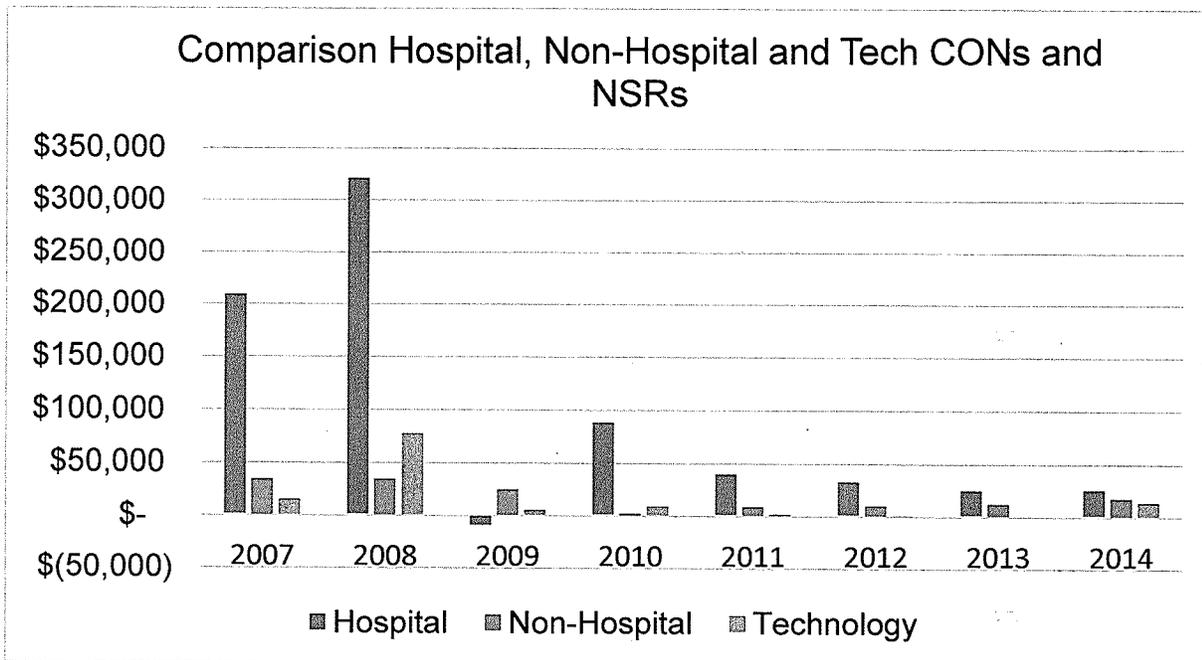


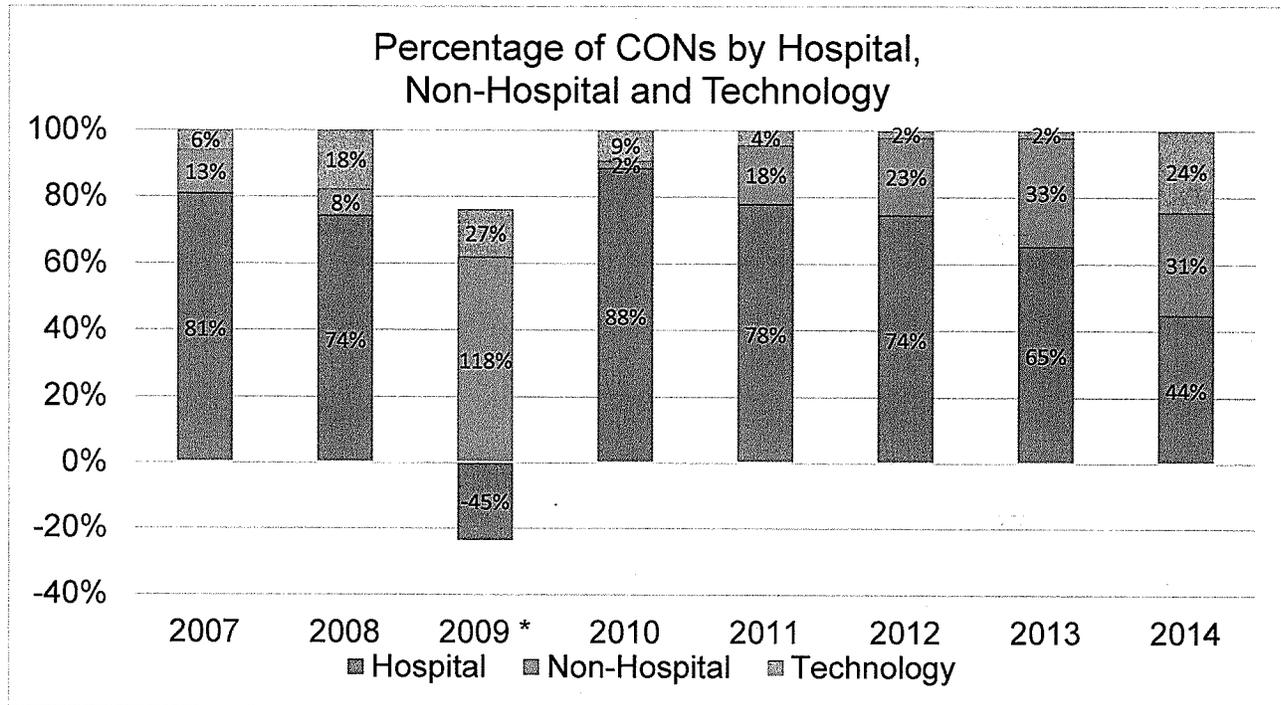
Chart 3 and 4 show the combined totals for CONs and NSRs, separated by project type.

Chart 3



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Chart 4



* Change of scope resulted in lowered project cost (see CON AC 06-06 Monadnock Community Hospital)

Licensing and the Office of HSPR

The state has two programs that regulate health care institutions: licensing and CON. The Bureau of Licensing and Certification (BLC) within DHHS has the responsibility to license most types of health care facilities, and is separate from the offices that oversee licensing of medical professionals. Licensing is a quality control measure and examines the safety of the building, operational policies and procedures at the facility, and the adequacy of patient recordkeeping.

The Office of HSPR carries out the work of the HSPRB, and the HSPRB operates by establishing administrative rules on the need and distribution of health care services. Applications are reviewed under the criteria set forth in the statutes and administrative rules. The staff prepares an analysis for the HSPRB's review, a public hearing is held, and the HSPRB makes a decision on the merits of the application.

Prior to obtaining a license, the applicant will need to obtain a CON or NSR determination.

NH Statutes indicate which health care facilities are required to obtain a license. Included are acute care and rehabilitation hospitals, home health providers,

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laboratories, ambulatory surgery centers, urgent care facilities, residential care, and adult day care facilities.

General Trends

During the recession, hospital building and redevelopment slowed, but the movement toward services off campus continued. Changes to payment models and the emphasis on population health management are progressing, further influencing the health care delivery system structure. According to a 2015 survey by the American Hospital Association:

“Nearly 67 percent of survey respondents said they are either repurposing health care facilities or currently assessing space for other needs (27 percent and 41 percent, respectively). Top current repurposing projects were outpatient facilities at 34 percent, and medical office space at 31 percent.”

Expensive technology continues to develop and is becoming more available. A good example is the “da Vinci surgical system,” a robot assisted surgery machine produced by Intuitive Surgical. The cost of the equipment is about two million dollars, and annual maintenance costs can exceed two hundred thousand dollars. Despite a lack of evidence showing better patient outcomes, several of the hospitals in NH have acquired the da Vinci machine, and some have indicated to the HSPRB that they intend to purchase a second.

Health care provider consolidation, primarily through cooperative arrangements, continues in New Hampshire. These arrangements may create the opportunity for better coordinated care and efficient use of health care resources, but also raise concerns about higher prices due to market allocation and fewer choices for consumers. The HSPRB has not been charged with evaluating the outcomes of provider collaborations, but RSA 151-C:1 indicates that “the state has an interest in promoting and stimulating collaboration among providers in the health care marketplace as a means of managing the increases in health care costs.”

Discussion of CON and Competitive Free Markets

The structure of the CON laws and regulations are an imperfect solution to regulating infrastructure in the current health care system, but most industry experts support a public process that evaluates major expansion projects. A large percentage of health care organization costs are fixed, so a reduction in patient volume does not reduce overall expenditures proportionally. CON essentially serves as a barrier to over development of new facilities and services when most competitive forces of a typical free market do not exist.

A competitive free market relies on consumers making rational decisions using their thorough knowledge about the cost and value of products from multiple sellers each

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with different costs and qualities and from different locations. With the most complex and expensive treatments, health care consumers know little about the specifics of costs and quality, and therefore rarely play the active role required of them by competitive free markets.

Since patients and physicians are not well-informed about quality and cost, health care institutions end up competing for well-insured patients based on what these individuals believe are indicators of quality, such as the availability of new technologies and posh amenities. The consequence is often an oversupply of infrastructures, which create incentives for unnecessary and even detrimental treatments. Any oversupply of infrastructures also increases the cost of each treatment. Moreover, new infrastructures with attractive amenities may leave existing facilities with under-insured patients.

Consider, for example, the implications of an unexpected “competitor” that doubles the supply of services in a market already adequately supplied by established institutions. If the competitor offers new amenities or technology, it will attract well-insured patients even if the technology offers no health benefits. Faced with competition unrelated to health outcomes, the existing organization has two options, to match the amenity escalation (at higher costs) or to deal with reduced patient volume and revenues by lowering costs and quality. As both the new and existing organizations struggle to increase or maintain facility utilization rates, consumers end up paying for unnecessary care.

CON disadvantages include both the regulatory costs borne by the State and providers, and the potential that regulatory limitations might inappropriately restrict the supply of new services and technologies. In truly competitive industries, a CON-like regulatory process would create monopolies in which suppliers would offer an inferior product at a higher price. Without CON, competitors would be free to enter and exit the market without the regulatory accountability that exists today, and informed consumers would have the opportunity to select the most preferred mix of goods and services based on cost and quality.

Because patients do not have the knowledge required to make the free market work, and because many hospitals and other provider organizations often dominate a patient service area, NH has relied on CON to determine whether a new product or service is warranted, and if the provider has adequately addressed patient access, quality, and cost concerns. Relying on the free market to determine the fate of a project requires patients to make value based decisions about cost, quality, and access, including when to decline the product or service based on the expense.

Some competition exists even with a CON system in place. As competitors have entered the market and insurance benefit designs have changed, several traditionally

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profitable hospital services have recently moved outside of the hospital walls. These include laboratory, radiology, and surgery services that are not typically regulated by CON. CON does not exist to regulate the expansion of services that are considered competitive.

Questions for the Future

As the NH legislature considers legislation in response to the scheduled repeal of CON laws, there are several key questions that should be asked. Some of those questions include:

- What responsibility do consumers, providers, insurers, and communities have in developing and maintaining a high quality health system, and how do they fulfill that responsibility?
- What level of transparency is needed for policymakers to make informed health care related decisions?
- Is there a role for government in the regulation and planning of large expenditure health care projects in the state?
- Who should be responsible for the translation of health care data into knowledge for policymakers and the public in New Hampshire?
- Should ensuring access to health care for low income populations be left up to the free market?
- Is it acceptable to have differing levels of care and access depending on the resources of a patient?
- Are there unrealized opportunities for an improved regulatory structure?
- Is there value in developing a state health plan, or shared vision for the state? If so, what should it include and who should be responsible for developing the plan?
- Is there an appropriate mechanism in NH for encouraging providers to offer a service that is not financially profitable, or to patients that are unable to pay?
- Should it be permissible for a health care provider to pursue or accept only the most profitable patients?
- Is there value in a public evaluation process for large health care expenditures in NH?
- Absent the HSPRB, are there sufficient regulations in place to address the quality, safety, access, and cost of the health system?

Summary

Like most states, New Hampshire uses a CON process with the goal of balancing cost, access, and quality in the health care delivery system. The CON regulatory structure

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has changed substantially in recent years, and has done so without an expansion of dedicated resources. Our health care system continues to change dramatically and we continue to face access and affordability challenges. Transparency of our system has improved greatly, but it continues to function very differently than a competitive free market. Opinions vary on what constitutes the ideal health system, an acceptable cost, and who should play a key role in making these decisions. Legislatures will continue to struggle with these questions for many years.