south carolina’s certificate of need program

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South Carolina Hospital Association
introduction

The South Carolina Hospital Association supports the Health Planning and Certificate of Need (CON) process because it is successful in controlling health care costs, reducing duplication of services, making services available where they otherwise might not be, and protecting communities’ investments in their health care facilities.

CON is a public safety net, ensuring rural citizens and the medically underserved that there are facilities available to them, strengthening emergency medical services, providing employment opportunities, and supporting economic development. Maintenance of a fair state health planning process is in the best interests of South Carolinians.

South Carolina’s CON law protects communities’ investments in their hospitals. By law, hospitals must provide certain services to any patient. By mission, hospitals frequently provide virtually any service to any patient. Financially viable hospitals are the state’s assurance of economical, readily available health care for all populations.

Opponents of state health planning and the CON process argue that market forces should determine whether and where new health services are established. They maintain that CON hinders competition and that market forces will protect communities against unnecessary duplication of healthcare resources. However, there is no competition for the uninsured.

history of con

During the Great Depression and World War II few new hospitals were built in the United States. Yet a large number of communities had no hospital, and many existing hospitals were quickly becoming obsolete. In response, individual communities began to organize planning and fund-raising efforts to build hospitals. Community planning efforts became particularly important in 1946 with the passage of the federal Hill-Burton Act, which provided federal subsidies for hospital construction and promoted local planning based on local needs.

The availability of Hill-Burton funds created a federally-sponsored, 30-year hospital bed construction boom. As a result state and federal governments found themselves faced with both skyrocketing medical costs and a continuing uneven distribution of medical services.

Under third party fee-for-service insurance agreements, which dominated health care financing, providers were reimbursed on a per diem basis and revenues were tied to the number of services provided. Also, providers suffered little risk of overbuilding because they were reimbursed for investment costs. These financial incentives to build and provide more services led to the first state certificate of need (CON) programs in the 1960’s and early 1970’s as states sought to control costs by regulating capital investments in health care.

During the 1970s the federal government encouraged states to control rising health care costs by managing the growth of health care services and facilities through health planning. In 1974, federal standards were established and federal funds were authorized to support state CON programs through the National Health Planning and Resources Development Act (P.L. 93-641). While some states implemented CON to contain costs, improve access, or monitor quality, others implemented a CON program simply to meet federal requirements. By 1980, all but one state (Louisiana) had a CON program.

In 1982, the federal government began to reduce its control and funding of state CON programs, giving states the freedom to set their own capital expenditure
review thresholds or to abolish their CON programs altogether. In 1986, the federal health planning law was repealed, removing the federal government from any role in state CON programs. Most states that repealed CON did so during the latter part of the 1980’s. Some states reported growth in services and buildings following repeal, while others noticed little change. In several of the states without a CON program, including Wisconsin, Kansas, Minnesota, and Colorado, numerous attempts have been made to reestablish CON over the years. Today, in spite of the lack of a federal mandate, thirty-six (36) states, the District of Columbia and Puerto Rico continue to have CON programs.

In South Carolina the list of projects requiring a CON has been revised and updated periodically over the years in an effort to make the program as effective as possible in controlling health care costs and assuring access to quality medical services to all South Carolinians.

definition and purpose of con

Certificate of Need (CON) is a regulatory review process that requires certain health care providers, such as hospitals and nursing homes, to obtain authorization from the state before making major capital expenditures, acquiring high cost medical equipment or expanding medical services. In South Carolina, the CON Program is governed by Section 44-7-110 through Section 44-7-340 of the South Carolina Code of Laws. Regulation No. 61-15 Certification of Need for Health Facilities and Services was promulgated to provide additional detail.

The purposes of CON are to:

- promote health care cost containment;
- prevent unnecessary duplication of health care facilities and services;
- guide the establishment of health facilities and services that will best serve public needs; and
- ensure that high quality services are provided in health facilities in South Carolina.

State CON programs vary widely in terms of purpose and the extent to which they regulate health services. Each state has different economic thresholds for requiring a CON, and the list of services requiring CON review varies from state to state. Differences among individual state programs also include the quality and timeliness of the State Health Plan and the rigor with which regulations are enforced. In states where the role of CON has been narrowed, the trend has been to streamline the process and raise the expenditure threshold to decrease the number of projects reviewed. In states where the role of CON has been broadened, certain actions previously exempted from CON have been included. For example, Michigan’s CON law was extended to all providers for 13 specific types of equipment or services. Typically, hospitals have supported these types of expansions because they place hospitals on a level playing field with other niche or specialty providers.


- CON Program
- No CON Program
- Partial CON Program

Ohio has CON only for nursing homes
The purposes of the South Carolina Certificate of Need law are to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services that will best serve public needs, and ensure that high quality services are provided in health facilities in the state.

South Carolina’s CON Program has been in effect since 1971. Regulation No. 61-15 requires the South Carolina Department of Health and Environmental Control (DHEC), with the advice of the South Carolina State Health Planning Committee, to prepare a State Health Plan for use in the administration of the CON Program. The DHEC Division of Planning and Certification of Need within the Bureau of Health Facilities and Services Development administers the CON Program.

The State Health Planning Committee

The State Health Planning Committee is composed of 14 members. Twelve are appointed by the Governor, with at least one member from each congressional district. Health care consumers, health care financiers (including business and insurance) and health care providers are equally represented. One member is appointed by the Chairman of the Board of DHEC, and the State Consumer Advocate is an ex-officio member. The State Health Planning Committee works with the DHEC staff to write the State Health Plan for use in administering the CON program and to submit it to the DHEC Board for final revision and approval.

The State Health Plan

At least once every two years, a revised State Health Plan must be submitted by DHEC staff and the State Health Planning Committee to the DHEC Board for adoption. The State Health Plan must include projections and standards for specified health services and equipment that have the potential to substantially impact health care cost and access. Planning standards incorporated into the State Health Plan are consistent with recommended medical and other professional standards. DHEC may not issue a CON unless the proposed project is in compliance with the currently approved State Health Plan.

The SC CON Law

Under current South Carolina law, an individual or health care facility is required to obtain a CON from DHEC before:

- constructing or otherwise establishing a new health care facility;
- adding one or more beds or changing the licensure classification of one or more beds;
- expending more than $2 million in capital on behalf of a health care facility;
- offering a new health service with an annual operating cost in excess of $1 million;
- acquiring medical equipment costing in excess of $600,000; or
- adding or substantially expanding a health service for which specific standards are prescribed in the State Health Plan.

To offer any of the following health services in South Carolina, an individual or health care facility must have a CON.

- Acute care
- Neonatal intensive care
- Ambulatory surgical facilities
- Cardiac catheterization
- Open heart surgery
- Linear accelerators
- Gamma knife
- Positron Emission Tomography (PET)
- Freestanding emergency services
- Psychiatric services
- Substance abuse
- Rehabilitation
- Nursing home
- Home health
- Inpatient hospice
CON requirements do not apply to all providers or to all health care projects in South Carolina. Following is a list of projects and providers not subject to South Carolina’s CON law:

- Offices of licensed private practitioners, whether for individual or group practice
- Non-medical projects, such as refinancing existing debt, roof replacement, parking garages, heating and air conditioning systems, and computer systems
- Kidney disease treatment centers
- Upgrades to facilities that do not include additional square feet or additional health services
- Replacement of similar equipment with comparable capabilities
- Purchases of or agreements to purchase real estate
- The acquisition, obligation of the capital expense or offering of an institutional health service solely for research
- Permanent reduction in bed capacity
- Facilities owned and operated by the federal government
- Federal facilities operated by the state
- Educational and penal institutional infirmaries for the exclusive use of their populations
- Facilities owned and operated by the South Carolina Department of Mental Health and the South Carolina Department of Disabilities and Special Needs except for the addition of total beds
- Change in ownership which does not result in increased depreciation or interest cost or lease cost greater than depreciation and interest cost added together or government reimbursement

DHEC evaluates and modifies the CON program and guidelines through legislation and policy implementation. The exemptions listed above have been made in an effort to streamline the approval process for certain services, minor construction and renovation projects by health care facilities. Project descriptions and cost estimates still must be submitted to DHEC for such exempted projects.
recent improvement in sc’s con law

Since 2006, significant changes have been made to both the South Carolina Administrative Procedures Act (APA) and to the CON statute to make the CON application and review processes more efficient and less costly for the applicants and for the affected parties. Following is a summary of some of those major changes.

Application and Review Process Improvements

- Better defines when CON review is required and removes some items from CON review entirely.
- Reduces and limits DHEC staff’s review time to 120 days, which can only be extended to 150 days if a public hearing is required.
- Prohibits certain communications by state and federal elected officials with DHEC staff once a CON application has been filed.
- Requires that during the review process, a person provide written notice to DHEC staff indicating that he is an affected person and stating any opposition to an application. Otherwise, he cannot request a review by the DHEC Board nor can he bring a lawsuit challenging the proposed project.
- To reduce paper processing, all CONs are now valid for 1 year, and extensions can be granted for up to 9 months each.

Contested Cases and Appeals Process Improvements

- Uniform procedure for contested cases and appeals for all administrative agencies, including DHEC, was established by ACT 387 in 2006. This streamlined the handling of contested cases by the DHEC Board.
- Further definitions of a timeline to request a final review by the DHEC Board, and if desired by the Administrative Law Court, were added by Act 278 in 2010.
- Act 278 also significantly limits the number of witnesses, depositions, interrogatories, requests for admission, and requests for production when a contested case is brought to the ALC.
- The ALC is now required to issue a final decision within 18 months.
- So that the judicial process is not simply used to delay a project, Act 278 added new requirement to post a bond up to $1.5 million if a decision is appealed to the SC Court of Appeals. If the Court affirms the ALC decision, or dismisses the case, the bond is automatically awarded to the party whose project is being appealed.
- Both the ALC and the Court of Appeals are authorized to award damages and attorney fees and costs to a party whose project was delayed by a frivolous appeal which is done for delaying.
lessons from other states

South Carolina should heed the lessons of other states that have abolished or seriously modified their CON laws. The results include closing of community hospitals, the proliferation of new services by investors, and increased use of expensive health services.

**Minnesota**

Minnesota eliminated CON in 1984, replacing the law with a moratorium on the construction of new hospitals and expansion of existing hospital bed capacity. Provisions in the 1994 MinnesotaCare law require health care providers to report all major capital spending commitments exceeding $1 million to the state for retrospective review, which assesses the project's appropriateness in terms of its impact on health care cost, quality, and access. In 2006, rising concern about the growth in medical facility investment and its impact on health care cost and utilization led Minnesota's legislature to request a study of the facility construction and expansion approval process. Several bills have been introduced to better regulate facilities as a result.

**Pennsylvania**

Pennsylvania allowed its CON statute to sunset in 1996, somewhat by accident. Since then, the number of niche providers, including imaging centers, specialty services, and ambulatory surgery centers, has increased dramatically, and the growth of services and technology has resulted in increased utilization and spending.

- Since 2000, the number of ambulatory surgery centers licensed in Pennsylvania has risen from 104 to 245.
- Forty-eight of those centers opened during the same year and patient visits during that period jumped 83%.
- Pennsylvania’s ambulatory surgery utilization rates are 36% higher than the national average.
- Visits to ambulatory surgery centers increased 83% from 2001 to 2003.
- Legislation to reestablish CON has been introduced in both the Pennsylvania House and Senate.

**Florida**

In 2004, Florida implemented the most significant CON reform since 1986. The single most important component of the reform was a provision preventing the licensure of niche and specialty hospitals. CON was eliminated for interventional cardiology and open heart surgery, but legislators concerned about the continued proliferation of niche providers set in place certain quality standards that must be demonstrated by all providers offering these services. The law also eliminated CON for burn units, as well as for additional acute care, mental health, and neonatal intensive care beds at existing hospitals. Legislation passed in 2008 further streamlines the CON process and includes a “loser pays” provision to discourage lawsuits designed to delay the launch of new facilities.
Ohio

Ohio repealed its CON program in 1995 for all facilities, services, beds, capital, and equipment, except for long term care facilities. Services including cardiac catheterization, open heart surgery, obstetrics and newborn, radiation therapy, pediatric ICU, solid organ transplantation services, bone marrow and stem cell transplant programs are now subject to quality review, similar to a licensure program. Ohio has seen significant expansion of capacity for previously regulated services and facilities, while critical money-losing services have suffered. Within just four years of deregulation in Ohio:

- 15 hospitals located in low-income areas closed;
- the number of imaging centers in Ohio increased by 748%, from 27 to 229;
- the number of ambulatory surgery centers increased 563%, from 27 to 179, and the majority of new ambulatory surgery centers are being built in affluent and growing suburbs, and are physician-owned;
- the number of non-hospital-based mobile or freestanding MRIs increased from 23 to 126 in 30 months, and another 65 notices of intent were filed.

Indiana

Indiana enacted CON laws in 1980 and terminated them in 1996, reenacted them in 1997 before terminating them again in 1999. Since then, the CON debate has languished in the state’s General Assembly and at the county level. Four counties with county-owned hospitals enacted a moratorium on new health service construction, and lawsuits were filed in U.S. District Court against three of these counties by other hospitals and developers. County officials claimed they needed to make sure their county-owned hospitals remained viable in the face of more development. They also argued that specialty providers wanted to enter their turf and cherry-pick profitable services. To illustrate that, county officials pointed to the fact that between 2000 and the middle of 2002, four heart hospitals and one orthopedic hospital opened, were under construction or were in the planning stages in Indianapolis—a metropolitan area of 1.6 million people. They feared the loss of these profitable services would endanger their ability to provide other services such as emergency rooms, trauma centers, and neonatal intensive care. Developers contended the counties are protecting monopolies and did not have the power to enforce such restrictions. In 2005, a federal court ruled against one county’s attempt to protect its community hospital, declaring that only the state has the right to license and regulate hospitals.

Missouri

Missouri phased out significant portions of its CON program in 2001, leaving only nursing homes, residential care beds, long-term acute beds, and the construction of new hospitals subject to CON review. This resulted in so many proposals for facilities that a backlog ensued. Legislation to further restrict the CON process, restrict the development of specialty hospitals and repeal CON has been introduced in recent years, but has not been successful. In 2006, the Missouri Senate formed an interim committee to evaluate CON, and the state maintains its program today.

Georgia

In Georgia, the State Commission on the Efficacy of the Certificate of Need Program recommended that CON be maintained and improved after spending 18 months examining the role of CON. The final Commission report issued in December 2006 stated, “The Commission has been able to reach consensus on a number of ways to improve upon Georgia’s Certificate of Need Program. However, sharp disagreement remains with regard to a number of areas of regulation, most notably, regulation of ambulatory surgery centers and free-standing imaging centers.”

why south carolina needs a strong con program

Free Market Forces are Ineffective in Health Care

Health care is delivered in a highly regulated environment, making free market forces ineffective in controlling costs. Hospitals are the only “businesses” that are required to serve everyone regardless of their ability to pay for the services. Also, the government sets prices of hospital services by deciding what to pay for care provided Medicare and Medicaid patients. Consumers who have health insurance don’t make buying decisions alone. Physicians and insurers often influence where a patient will receive tests or treatment, and price is not a factor in most decisions. When a person is facing an emergency or life-threatening illness, his first thought is about getting the care he needs, not about how much that care will cost or who will pay for it.
CON Helps Protect Access to Services

Hospitals lose money on some services, and make money on other services. Cancer treatment, orthopedics, cardiology, outpatient services and imaging are profitable product lines. On the other hand, hospitals lose money on obstetrics and gynecology, pediatrics, internal medicine, trauma and emergency medicine, mental health, and community health. Hospitals can afford to offer these services that lose money because revenue from the other services helps cover the losses, as well as their charity costs.

CON ensures the financial health of safety net hospitals caring for South Carolina’s communities by restricting the development of “boutique hospitals” or those in business to offer lucrative services to insured patients. When boutique hospitals siphon off the community hospital’s insured patients and refuse to offer low-revenue services, safety net hospitals are forced to provide a higher percentage of low-revenue procedures, substantially compromising their ability to provide charity care.

In 2003, Congress imposed an 18-month moratorium on the development of new physician-owned specialty hospitals due to concerns about their negative impact on community hospitals. In 2005 and 2006 reports to Congress, the Medicare Payment Advisory Commission (MedPAC) found that physician-owned specialty hospitals treat fewer severely ill patients and concentrate on particular DRGs which are relatively more profitable. The report also found these specialty hospitals are often located in states without CON laws, are less likely to have emergency departments, and treat a lower percentage of Medicaid patients.

Also, in states without CON, providers tend to reduce services to rural, inner city, and high/special needs areas and locate in more affluent, profitable areas. Currently all CON applications in South Carolina must include detailed plans of access to care for the indigent population.

CON is especially critical to the financial viability of South Carolina’s small, rural hospitals. While it helps ensure access to quality care for all residents of South Carolina, its repeal would create new barriers to care for indigent patients. Small hospitals serving rural areas are much more vulnerable to specialty providers than larger hospitals in more urban areas because rural hospitals tend to have a higher ratio of Medicaid and uninsured patients and fewer paying patients. If you want to see a hospital in a small community close or become a burden on local taxpayers, then do away with CON.
CON Helps Safeguard Quality of Health Care Services

CON helps maintain service quality by limiting the number of locations in which specialized and high risk medical procedures may be performed. CON encourages the development of specialized regional health care services, which leads to more cases per provider, better treatment outcomes (e.g., lower mortality), more cost-effectiveness, and the development of more comprehensive and capable service programs.

After allowing its CON law to expire in 1996, Pennsylvania experienced dramatic growth in the number of open heart surgery programs, which increased from 35 to 62. However, the volume of cases per hospital dropped from 499 in 2000 to 330 in 2006. Fewer than the 450 bypasses per year were recommended by the Leapfrog Group, a national coalition of employers working to improve quality of health care.

Researchers at the University of Iowa studying more than 900,000 cases of open heart surgery found that the volume of procedures per program was 84% higher in CON states and the odds of death were 22% lower for patients receiving coronary artery bypass graft (CABG) surgery in states with CON regulation as compared to similar patients in non-regulated states. Mortality rates were lower in CON-regulated states during the entire six-year period and in each year covered by the study. According to this study, the difference between CON and non-CON states is nine preventable deaths for every 1,000 procedures. Based on their conclusion, South Carolina’s CON program is saving the lives of 54 bypass patients each year.

CON Helps Contain Health Care Costs

Many business leaders regard hospital expansions and the proliferation of high-cost technology as a primary reason health care costs are increasing. CON discourages the proliferation of duplicative facilities, services and equipment. Some argue that deregulating health facility and service expansion will trigger free market forces of supply and demand and lead to lower costs; however, three major automobile manufacturers — General Motors Corporation, Ford Motor Company, and DaimlerChrysler Corporation (now Daimler AG)—have found that not to be true based on experiences in states that have varying degrees of CON regulation. Independent studies conducted by all three of these multi-state corporations with similar benefit plans consistently found that the costs of health care per person were significantly less in states with CON than in states without CON.

For instance, Ford Motor Company reported that their health care costs in Indiana and Ohio, both of which eliminated CON coverage for most services, were consistently higher than in other states where they operate. Also, costs in Michigan, which has had a CON program since 1972 covering a wide range of services, consistently were among the lowest. Kentucky and Missouri, which also have had CON programs covering a wide range of services, also had low relative costs.
This consistent correlation between CON and lower costs was quite notable because the pattern was the same across a range of different services. This was true for the broad but differing categories of hospital inpatient and outpatient services, as well as the focus on CABG (an inpatient surgical procedure) or on MRI (a diagnostic service, mostly done on an outpatient basis).

While the GM populations served and the benefits and cost-saving provisions are quite similar in all four states, their health care costs were highest in Indiana—a state with no CON regulation—and lowest in New York—a state with stringent CON regulation.

Researchers at Dartmouth Institute of Health Policy and Clinical Practice have concluded that regions with the greatest number of facilities and resources also have higher costs. Furthermore, research has shown that more care does not necessarily translate to better care and can actually increase the risk of medical errors and overexposure to harmful elements.

**conclusion**

The empirical evidence is clear. While CON is not a perfect system, it is the best approach available to protect community resources and safeguard access to care and quality of services. Therefore, the South Carolina Hospital Association strongly supports the continuation of our state’s CON program.