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Rising Costs Alter Process For Creating New Facilities

Developments indicate changes to existing system are at hand.

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FOR NEARLY 40 years, the Certificate of Need process has provided stability for the health care system of New York State. Within the last two years, pressure brought about by escalating health care costs, particularly in the sector paid for by the State of New York, have created a situation where possession of a Certificate of Need will no longer guarantee the future existence of health care facility providers.

New York State has one of the most detailed and rigorous Certificate of Need programs in the United States. This program was inaugurated by the passage of Article 28 of the Public Health Law in 1969.[1] The Certificate of Need law begins with a "Declaration of Policy and Statement of Purpose," that "hospital and related services are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the state … the department of health shall have the central, comprehensive responsibility for the development and administration of the state's policy with respect to hospital and related services, and all public and private institutions, whether state, county, municipal, incorporated or not incorporated, serving principally as facilities for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition or for the rendering of health related services shall be subject to the provisions of this article." PHL §2800.

The law was enacted at a time when the concept Certificate of Need was gaining great currency in the United States. Many states, particularly in the North and East, had adopted Certificate of Need programs at about the same time as New York. The purpose of the Certificate of Need law is to rationalize the use of resources so that there will not be an uncontrolled growth of facilities and services, which could lead to an excess of supply and consequent defaults and bankruptcies. Proponents of Certificate of Need believe that government must be involved in the process to be sure that only facilities which meet a demonstrated "public need" are constructed and licensed.

The National Health Planning Act, P.L. 93-641, was adopted in 1974 mandating that each state have a Certificate of Need program, and that all states create a designated state health planning and development agency (SHPDA) to interface with the federal government and administer such program. New York State set up the Health Planning Commission to act as an SHPDA.

The Reagan administration demanded repeal of the National Health Planning Act, and Congress complied. The result was that many states, particularly in the south and west, abandoned their Certificate of Need programs. While the New York State Health Planning Commission was folded into the Health Department, New York State's Certificate of Need program has continued unimpeded despite the abandonment of the concept by the federal government and many other states.

Section 2801 of the Public Health Law defines the term "hospital" to include not only general hospitals, but also nursing homes, dental clinics, rehabilitation centers, diagnostic and treatment centers, ambulatory surgery centers and others. The requirements for a CON application is triggered in three principal ways: establishment of new facilities; construction in facilities, including change in mode of service; and change of ownership of existing facilities without change in service. In each of the foregoing, state Department of Health or Public Health Council[2] approval is required pursuant to the statute PHL §§2801-(3)a, 2802.

Public Need

If an applicant wishes to become established as a "hospital" or there is to be a change of ownership, this activity must be approved by the Public Health Council. The Public Health Council consists of 15 members including the Commission of Health ex officio, and meets six times per year to review applications placed before it by staff of the Department of Health. Section 2801-a(3) provides: "the Public Health Council shall not approve a Certificate of Incorporation or application for establishment unless it is satisfied insofar as applicable as to (a) the public need for the existence of the institution…; (b) the character, competence and standing in the community of the proposed incorporators, directors, sponsors or stockholders or operators;…. [or] (c) the financial resources of the proposed institution and its source of future revenues; …."

This provision therefore sets up a test involving public need, character, and finances for any individual or corporation desiring to operate any health facility apart from a private practice office in the State of New York. While such events as the nursing home scandals of the late 1970s have focused public attention on character and competence issues, and a specific statute, PHL 2806(5), was set up to bar persons convicted of a felony from operating nursing homes, recent focus has been on the issue of public need, particularly in view of developments which have highlighted the Department of Health's contention that there is significant excess capacity of both general hospitals and nursing homes in New York State.

Cost Control

From the perspective of the governor and the state health department, an important element of the determination of "public need" for health facilities is its impact on the state budget. It has long been considered axiomatic in the health care industry that institutions will strive to fill

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vacant beds to obtain additional income to offset their largely fixed or inelastic expenses for plant costs and workers' salaries. When considering new construction or expanded capacity this often turns into "if you build it, they will come" with attendant increased costs to the payors.

One of the significant payors is New York State, which (together with its local government units) must absorb approximately 50 percent of the total Medicaid costs. The link between excess capacity and increased costs is especially clear in the long term care system where the Medicaid program statewide pays for approximately 75 percent of the patient days spent in skilled nursing facilities (the percentage of Medicaid days is even higher in New York City). The Medicaid rate for long term care facilities, calculated by the Department of Health according to a formula found at 10 NYCRR Part 86-2, includes a component that (with few exceptions for some old "grandfathered" facilities) reimburses the operator with a factor in the per diem rate for the historical cost of construction of the facility. Thus, state officials are wary of approving additional facilities and, significantly, given the aging of the current nursing home stock, approving replacement facilities as well.

An example makes the reasons apparent. A 200-bed nursing facility built in 1969 would have cost approximately $2 million to construct. Such a facility, built to meet long discarded codes, would have small rooms which might house as many as four patients, insufficient lounge and recreational areas, woefully inadequate therapy space, and no provision for the computer-based technology needed to maintain medical record rooms and business offices. Clearly such a facility would be obsolete by today's standards. However, to replace that facility today will require construction costs of $45 million to $50 million. The bulk of such costs would be borne by the Medicaid program in its reimbursement of capital costs, over time, to the operator in the Medicaid rate. It should not be surprising, therefore, that the Department of Health imposed an informal, but nevertheless real, "moratorium" on replacement facilities in 2003. Despite some indications that the moratorium may be lifted in the near future, at this time it is still in place.

The linking of capacity with costs to the state was the driving force behind the more formal "moratorium" imposed on applications for long term care beds by the New York State health department in August 2000. This moratorium affected not only new applications to be submitted thereafter, but also pending and even approved applications which had not started construction for which public need had been found under the existing methodology. The moratorium was to exist until a new revised public need methodology (found at 10 NYCRR §709.3) could be developed and approved.

The new need methodology, which was adopted in December 2003 and became effective in the spring of 2004, did not create a radical change in the public need figures, but added a provision which said that if the occupancy of existing facilities in the county where the new nursing facility was proposed was lower than 97 percent, "there shall be a rebuttable presumption that there is no need for any additional residential health care facility beds in such planning area …." 10 NYCRR §709.3(f)(3). There is a provision which sets forth seven "local" factors which may be used by an applicant to attempt to overcome this rebuttable presumption. 10 NYCRR §709.3(h). Notwithstanding this opportunity, almost every one of the then-pending applications, including those which had been previously approved under the former methodology, were subsequently disapproved on the basis that there was no public need for the project.

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Similarly, hospital construction costs are reimbursed to the hospitals by the state Medicaid program. The Department of Health Regulations, 86 NYCRR §86-1.30, provide that the Medicaid rate shall reimburse hospitals for the interest incurred and amortization of cost of capital improvements, and pay a factor for return on invested equity. Although the percentage of hospital patient days paid for by Medicaid is not as high as for nursing facilities, the enormous expense of hospital construction modernization and high technology equipment makes hospital capital reimbursement a significant cost factor for the state budget. Thus, it is clear that those concerned with balancing the state budget have fixed upon the CON process, particularly the construction of new facilities, as a point of attack in an effort to limit growth in state expense.

One activity designed to inhibit construction of additional capacity, or replacement facilities, is the policy determination recently announced by the Department of Health that sponsors of construction projects will need to contribute 25 percent of the total cost in "sponsor's equity," eliminating the previous practice of 90 percent financing of construction. The Federal Housing Authority (FHA) program of financing of health facility construction contained in §232 of the National Housing Act, 12 USCA 1701w, permits 90 percent financing, which has generally been used by most non-profit and many proprietary health facility operators.

FHA financing may still be used but the Department of Health will require that no more than 75 percent of the total approval project cost be borrowed (apparently there are exceptions to this requirement which must be determined on a case-by-case basis). This policy has been implemented without benefit of regulatory change. To date there has been no court challenge to the department's action.

Medicaid Reform Task Force

In the fall of 2003, concern about increased Medicaid costs led the State Senate to create a "Medicaid Reform Task Force." The task force conducted public roundtable meetings and open discussions, and gathered information from, inter alia, industry and public interest sources. Among its recommendations was that there be a review of the Certificate of Need process. The report stated:

> Various changes and trends in the health care system, including increased competition in the marketplace and increased instances of need for restructuring, merit a comprehensive reexamination of the structure and circumstances of the CON process in order to assure that it best meets the State's public health policy needs and the needs of the current health care environment. This examination should include the identification and correction of aspects of the process which may currently hamper the system's cost efficiency, as well as those which upon revision could otherwise further facilitate such efficiency. Senate Report, page 17.

The Senate Task Force report called for what it termed "right-sizing" of nursing homes, subject to cost-effectiveness and access tests. Right-sizing appears to be a euphemism for decertifying beds, to eliminate "excess" capacity. The Senate report suggested the decertified beds could be converted to other service categories such as assisted living, long term home health care programs or adult day care. Senate Report, page 25. At the same time, the governor entered the mix by assisting in the creation of a "Health Care Reform Working Group" chaired by Steven Berger, a former

commissioner of social services and former executive director of the Port Authority of New York and New Jersey. The Working Group issued an interim report on Jan. 13, 2004, and a final report on Nov. 17, 2004 .

In the January report, the key recommendation with respect to the size of the system was in the area of long term care. The Working Group recommended an overhaul of the way the Department of Health used the CON process to actively control the system. The report again used the term "right-sizing." Pressure for cost driven "right-sizing" continues despite the obvious demographics, noted in the Working Group's January report, which suggests an explosion in the number of persons over 65 in the next 10 to 15 years, as the "baby boomers" approach senior citizen status.

The January report demanded implementation of "a new CON review process, which is designed to incentivize providers to develop service continuums that facilitate the treatment of patients in the least restrictive, most appropriate and cost effective settings…" January report, page 15. It called for benchmarks which would "provide higher rankings (toward approval) for applications, and should include consistent high levels of quality care and patient outcomes. Additional credit should be provided (or subtracted, as the case may be), based upon the relative consistency of the proposed service mix … by encouraging expansion of New York State's supply of less-intense, less-restrictive care facilities, moving toward a more community and home care based approach and away from an institutional based system. These new factors should be assessed through an RFP process." Thus, the Working Group would change the CON process from one which is applicant driven, to one where applications are accepted only when government first perceives a need for additional facilities, and then invites applicants to compete to meet the need. This is a level of government management which is unprecedented in New York State.

The report also recommended change in the capital reimbursement system to replace the "pass through" system with one which would develop regional "per-bed" prices, and phase this system in over 10 years to "allow for a manageable transition." Despite this clear call to reform the capital reimbursement system, the administration has not developed legislation to modify the capital cost reimbursement for hospitals or nursing homes. As will be discussed below, the administration's efforts seem to be focused on "right-sizing." On the subject of right-sizing, the January report estimated that there was an excess of between 6,000 and 10,000 skilled nursing beds in the state.

The final report of the Working Group, dated Nov. 17, 2004, created substantial interest and concern in the health care community. This report focused on the "Hospital and Outpatient Industry" and recommended that "the state develop measures to reduce excess hospital capacity, and adopt alternative models for hospitals to insure access to quality care in all communities is maintained." The report observed that changes in medicine have created an "out-migration" from hospitals, leaving excess capacity in the industry. The "perpetuation of ineffectiveness at weaker, unneeded hospitals directly contributes to the rising costs of health care."

Accordingly, the Working Group recommended, inter alia, that the state develop measures to reduce excess hospital capacity. Recognizing that many hospitals have substantial debt, and that closing an institution can involve significant short term costs, the Working Group recommended creation of a "Hospital Right-Sizing Assistance Program" to provide financing to assist in closing or restructuring hospitals. The report did not recommend scrapping the CON program, stating that there is a "continued need for CON review as a means of guarding against excess capacity and increased costs in the health care system." November Report page 12. However, the Working Group advocated "structuring" of the CON process. Accordingly, the Working Group recommended, inter alia, that the state develop measures to reduce excess hospital capacity.

Independent Commission

With the Senate report and Working Group reports as background, the Legislature, while passing the 2005/2006 Budget Bill, acted in a fashion which could greatly alter assumptions about Certificate of Need which have been held for nearly 40 years. The Budget Bill, Chapter 61 of the Laws of 2005, created the "Commission on Health Care Facilities in the 21st Century." This is an independent commission whose purpose will be to identify and authorize closing of hospitals determined to be unnecessary or having "excessive capacity."

The commission will have 18 full members, 12 appointed by the governor, two by the Senate Majority Leader, one by the Senate Minority Leader, two by the Assembly Majority Leader and one by the Assembly Minority Leader. In addition, for these purposes the state is divided into six regions and there will be six regional members appointed for each of the regions, two by the Governor, two by the Senate Majority Leader and two by the Assembly Majority Leader. These regional commissioners will be involved only in determinations of the particular region for which they are appointed. The commission is to hold a series of public hearings and other deliberations. It is expected to make recommendations on which hospitals in the State of New York should be closed by the end of 2005.

The recommendations will have the force of law if the governor does not veto any of the recommendations and the Legislature fails to act to modify such recommendations. This mechanism would appear to place in the hands of private individuals the ability to revoke the Certificate of Need granted pursuant to Article 28 of the Public Health Law, or modify or limit the certificate in the case of a partial closing or "right-sizing" of any given facility. Persons in Albany have likened the process to the military base closings carried out by the federal government some years ago. It is anticipated that there will be much public involvement and political pressure to keep open any of the facilities targeted by the commission for extinction.

The commission's authority may well be challenged in the courts by any hospital identified for closure. While the language of the task force reports and the legislative language creating the commission has been couched in terms of increasing quality of care, it is evident that economics is the driving force. There is no proven correlation between a hospital which operates at less than full capacity and poor quality care.

Conclusion

The Certificate of Need program has served the people of the State of New York well for nearly 40 years. The fact that facilities have had to demonstrate that there is a need, that they would be financially sound and that the operators were people of good character has enabled regulatory officials and the public to have confidence that the health care needs of the state were being met by organizations which had satisfied such tests in the review process.

It would appear that cost pressures have forced state officials to consider a drastic revision of the system in order to limit spiraling costs. The effect will be to take the establishment of hospitals out of an administrative arena and place it squarely into a clearly political playing field.

1. New York Public Health Law (PHL) McKinney's Title 44, Sections 2800ff.

2. An administrative body within the health department established by PHL §220. The Public Health Council has final decisional authority over Establishment applications.