LEGISLATIVE COMMITTEE MINUTES

HB389

Bill as Introduced

HB 389-FN - AS INTRODUCED

2015 SESSION

15-0423
01/04

HOUSE BILL ***389-FN***

AN ACT repealing the certificate of need moratorium.

SPONSORS: Rep. Tucker, Rock 23; Rep. Seidel, Hills 28; Rep. Kappler, Rock 3; Rep. Itse, Rock 10; Rep. Simmons, Hills 17; Rep. Baldasaro, Rock 5; Rep. C. McGuire, Merr 29; Rep. Rideout, Coos 7; Rep. Hill, Merr 3

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill repeals the certificate of need moratorium on nursing home and rehabilitation beds. Current law extends the moratorium until June 30, 2016. Under this bill, the moratorium would end on June 30, 2015.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

15-0423
01/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Fifteen

AN ACT repealing the certificate of need moratorium.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Certificate of Need; Nursing Home Beds; Rehabilitation Beds; Moratorium. Amend RSA 151-C:4, III(a) to read as follows:

III.(a) No new certificate of need shall be granted by the board for any nursing home, skilled nursing facility, intermediate care facility, or rehabilitation facility from the effective date of chapter 310, laws of 1995, department of health and human services reorganization act, through the period ending June 30, [~~2016~~] ***2015***. This moratorium shall also apply to new certificates of need regarding any rehabilitation bed in any type of facility, including rehabilitation hospitals and facilities offering comprehensive rehabilitation services. However, a certificate of need shall be issued for replacement or renovation of existing beds as necessary to meet life safety code requirements or to remedy deficiencies noted in a licensing inspection pursuant to RSA 151 or state survey and certification process pursuant to titles XVIII and XIX of the Social Security Act. In addition, a certificate of need may be issued for construction or renovation as necessary to repair or refurbish an existing facility, or to accommodate additional beds obtained by transfer to an existing facility. In the case of repair, refurbishment, or transferred beds, the resulting costs in excess of the current capital expenditure threshold as adjusted for inflation pursuant to RSA 151-C:5, II(f)(1) shall not be reflected in any state Medicaid rate. Any application for a certificate of need under this subparagraph shall indicate whether it is for a life safety code requirement or to remedy deficiencies noted in a licensing inspection or whether it is for repair or refurbishment of an existing facility or for transferred beds. If the application is approved, it shall be deemed that the board has agreed with the indicated reason for such application.

2 Effective Date. This act shall take effect upon its passage.

LBAO
15-0423
01/15/15

HB 389-FN - FISCAL NOTE

AN ACT repealing the certificate of need moratorium.

FISCAL IMPACT:

The Department of Health and Human Services and the New Hampshire Association of Counties state this bill, **as introduced**, may increase state and county revenue and expenditures by an indeterminable amount in FY 2016 and each year thereafter. There will be no fiscal impact on local revenues or expenditures.

METHODOLOGY:

The Department of Health and Human Services and New Hampshire Association of Counties state this bill repeals the Certificate of Need moratorium on nursing home and inpatient physical rehabilitation beds effective June 30, 2015. Under current law the moratorium ends on June 30, 2016. The Department states the nursing home bed formula, established under RSA 151-C:4, III. (b), specifies a Certificate Of Need shall not be granted if it will result in the total number of licensed nursing facility beds in the region to exceed 40 beds per each 1,000 persons aged 65 or older living in the region. The Health Services Planning and Review Board is responsible to review and approve requests for Certificates of Need. The Board annually determines the State's unmet need for nursing home beds, pursuant to Administrative Rule He-Hea 904.3(a). The Department details the most recent Board determination for nursing home bed need by county in the table below, which identifies an unmet demand of 1,188 beds.

County	Number of Beds Needed (Over bedded)
Belknap	86
Carrol	112
Cheshire	10
Coos	(130)
Grafton	200
Hillsborough	62
Merrimack	(1)
Rockingham	681
Strafford	97
Sullivan	71
Total	1,188

The Department and Association state that if the moratorium is lifted and the unmet demand for nursing home beds was approved by the Board, state and county expenditures would increase by indeterminable amounts, in FY 2016 and each year thereafter. The Department and Association report that approval of the additional beds may result in new construction, renovations, and increased Medicaid costs for the State and counties. Fifty percent of Medicaid expenditures are paid with federal funds and the remaining fifty percent is paid with county and/or state funds. To the extent there is an increase in Medicaid costs, state and county revenue would also increase.

The Department states the fiscal impact of this bill on inpatient physical rehabilitation beds is indeterminable. The need formula for such beds is completed on a biannual schedule by the Board, pursuant to Administrative Rule He-Hea 702.01, which provides for twelve physical rehabilitation beds per 100,000 by region. The table below details the most recent calculation which shows two regions' bed needs are not met while three regions have more beds than stipulated by Rule. The Department notes inpatient physical rehabilitation beds are not subject to Medicaid reimbursement to the same extent that nursing home beds are.

Rehabilitation Region	2015 Population Estimate Per NH Office of Energy & Planning	Rehabilitation Bed Need (12 per 100,000)	Current Licensed Beds	Unmet Bed Need
Central	255,172	30.62	50	(19)
Northern	76,636	9.20	0	9
Seacoast	280,340	33.64	33	1
Southern	519,229	62.31	153	(91)
Western	199,459	23.94	86	(62)
Total	**1,330,836**	**159.70**	**322**	**(162)**

The Department states the Board is authorized to collect annual administrative fees from all owners of nursing home, inpatient physical rehabilitation, hospital, and other specialty beds not to exceed $500,000, based on the number of beds maintained by each facility. The Department indicates this bill may cause the fees paid by nursing homes to increase and the fees paid by hospitals and specialty facilities to correspondingly decrease.

Speakers

9:30 AM

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 389-FN Date January 29, 2015

Committee Health, Human Services and Elderly Affairs

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Rep Leon 14 Ridgeout		Coos 7		✓	
Rep Carr Seidel		Hills 28		✓	

Hearing Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 389-FN

BILL TITLE: repealing the certificate of need moratorium.

DATE: January 29, 2015

LOB ROOM: 205 **Time Public Hearing Called to Order:** 9:30 a.m.

Time Adjourned: 10:30 a.m.

(please circle if present)

Committee Members: Reps. Kotowski, LeBrun, Emerson, McMahon, Martel, Nelson, S. Schmidt, Stepanek, Guthrie, J. Ward, Donovan, Fothergill, MacKay, B. French, Deloge, Sherman, Ticehurst, Weber, Freitas, P. Gordon and Snow.

Bill Sponsors: Rep. Tucker, Rock 23; Rep. Seidel, Hills 28; Rep. Kappler, Rock 3; Rep. Itse, Rock 10; Rep. Simmonds, Hills 17; Rep. Baldasaro, Rock 5; Rep. C. McGuire, Merr 29; Rep. Rideout, Coos 7; Rep. Hill, Merr 3

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

***Rep. Pam Tucker - Sponsor - Presented testimony**
- **See #1 Written in Record.**

Rep. Carol MaGuire - No testimony written

***Leslie Melby – Written testimony - NH Hospitals**
- **#2 - Opposes HB 389**
- **Let the CON Board do their work.**

***Cynthia Carrier - Written testimony - #3 - No position**

Ellen Ann Robinson - Hillsborough – Handles finances - Opposes
- **Sees significant need for additional beds.**

Bob Dunn - Millimet – Dunn - No written testimony.
- **Explains the details of this intricate system - Opposes HB 389.**
- **Not dealing with free market in the case of the CON Board. State appropriates money – County signs the check.**

***Greg Moore – The attempt to dissolve CON Board has been heard over and over since 2011. Pushing the elimination forward each time. Written testimony #4.**

John Poirier – Absent - Opposes bill.

*John Prochilo – Written testimony #5. The norm is 12 beds per 100K - We are already overburdened. Opposes bill.

- No CON Board creates salary wars, specialized staff, tremendous competition.

Rep. Dan Itse - No written testimony. Supports the bill.

*Catherine Devaney - CEO Health South Rehab Hospital, Concord, NH. Written testimony. #6

Written testimony submitted - No Oral - #7

Respectfully submitted,

Rep. Bill Nelson, Clerk

Rep. Alan LeBrun
Acting Clerk

Checklist

	Date	Task
☐	HB 389	Repealing The CON MORATORIUM
☐		
☐ S	Rep. Pam Tucker - Sponsor. See #1	Presented Testimony WRITTEN in Record
☐		
☐ S	Rep Carol McGuire - No Testimony WRITTEN	
☐		
☐ O	Leslie Melby	- WRITTEN Testimony - NH Hospitals #2 opposes HB 389 let The CON board do Their Work.
☐		
☐ NP	Cynthia Carrier	WRITTEN Testimony #3 - No Position
☐		
☐ O	Ellen Ann Robinson	- Hillsborough - handles Finances Sees Significant Need for Additional beds.
☐		
☐ O	Bob Dunn	Milimet - Dunn - No WRITTEN Testimony Explains The details of This intricate System - opposes HB 389 Not dealing with free market in The case of The CON board. State Appropriates Money - County Signs The Checks
☐		
☐ S	Greg Moore	- The attempt To Dissolve CON board has been heard over And over since 2011 - Pushing The elimination Forward each time. WRITTEN Testimony #4
☐ O	John Poirier	- Absent.
☐ O	John Prochilo	- WRITTEN Testimony #5 The Norm is 12 beds per 100K - We are already overbundened. No CON board creates salary wars, specialized staff, Tremendous competition -
☐ S	Rep Dan Itse	- No WRITTEN Testimony.
☐ O	Catherine Devaney	- CEO Health South Rehab. Hosp. Concord. WRITTEN Testimony #6

WRITTEN Testimony submitted - No ORAL - #7

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 389-FN

BILL TITLE: repealing the certificate of need moratorium.

DATE: 1/29/15

LOB ROOM: 205 **Time Public Hearing Called to Order:** 9:30

Time Adjourned: 10:30

(please circle if present)

Committee Members: Reps. Kotowski, LeBrun, Emerson, McMahon, Martel, Nelson, S. Schmidt, Stepanek, Guthrie, J. Ward, Donovan, Fothergill, MacKay, B. French, Deloge, Sherman, Ticehurst, Weber, Freitas, P. Gordon and Snow.

Bill Sponsors: Rep. Tucker, Rock 23; Rep. Seidel, Hills 28; Rep. Kappler, Rock 3; Rep. Itse, Rock 10; Rep. Simmonds, Hills 17; Rep. Baldasaro, Rock 5; Rep. C. McGuire, Merr 29; Rep. Rideout, Coos 7; Rep. Hill, Merr 3

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Testimony

Entered in Testimony #7
by ORG.

mainstreet®
development | health | investments

January 28, 2015

DEMOLISH THE "NURSING HOME" – TRANSFORMING CARE FOR AGING AMERICANS

By Zeke Turner, founder and CEO, Mainstreet

Dear Members of the Committee on Health, Human Services and Elderly Affairs,

My name is Zeke Turner, founder and CEO of Mainstreet. I am writing to you today to urge you to vote "yes" on HB 389-FN and end the 20-year moratorium on certificates of need for nursing homes in New Hampshire.

Mainstreet is a Carmel, Indiana-based company and we develop, finance and jointly-operate best-in-class health care properties. Our award-winning Next Generation® properties focus on transitional care, also known as post-acute care. If you're not aware, we've been involved in legislative battles like yours. We've successfully defeated efforts to place a moratorium on nursing homes in our home state. Sadly, we are once again fighting for consumer choice in Indiana this year as more protectionist legislation has been filed.

Today, Indiana is one of a more than just a handful of states in the country that does not have any restrictions on the building and licensing of new non-Medicaid nursing home beds. Roughly half of the states in the country allow for some form of skilled nursing development. The freedom to build has enabled us to grow into our current role as the industry leader of transitional care. I encourage you to follow Indiana's lead and welcome in the coming wave of health care.

Since the initial passage of the current moratorium back in 1995, the way health care is delivered to seniors has dramatically changed. A key paradigm change has emerged that shifts the traditional institutional hospital model to a patient-focused *hospitality* model. Most nursing homes today, built decades ago, embody the hospital model where the focus is on efficiency, cost containment and delivery of medical care. Food is prepared for large groups, in large cafeterias at set times, with limited choice. Rooms and bathrooms are shared and privacy and dignity are generally lacking. In the new hospitality model, however, the focus is on providing for the guest. The guest eats when and what they want, they're entertained and they have as much privacy as they need.

Incredibly, the average nursing home was built in 1973, 42 years ago! Now consider that in 1973, the average life expectancy was 67 years for men and 75 years for women. In 2010, that figure jumped to 76 for men (9 more years) and 81 for women (6 more years). That's a phenomenal difference.

But that's just the beginning of the story. Today's seniors aren't just living longer, they're living *younger.* Baby boomers will cringe at being called "senior" because they don't in any way *feel* senior. Today's baby boomers are active, social and tech-savvy. Many are still working, often by choice.

So when this vibrant, social person enters a nursing facility that looks like a hospital – with crowded cafeterias, bad food, fluorescent lighting, depressing isolation and boredom – it's no wonder they are immediately turned off. In fact, 81 percent of today's boomers say they would rather die than stay in a nursing home. Yet

despite this mass rejection, the core functions of nursing homes – rehabilitation and care – are still vital and necessary to health and well-being.

Fortunately, a solution to this massive gap between what exists in the marketplace and what consumers demand is emerging. Developers across the country, including Mainstreet, are creating and building a new generation of properties that combine the care and rehabilitation consumers need with the services, amenities and properties they desire.

The biggest change in these properties is a functional one: A new emphasis on short stays over long-term residence. Mainstreet's Next Generation® properties focus on transitional care that allows guests to receive intensive acute and rehabilitative care on a short-term basis. The result has guests returning to their homes after a short 4-5 week stay and returning to their normal lives.

Imagine a "nursing home" with a full beauty salon, putting greens, pubs and cafes. Imagine a nursing home where there's a lively Super Bowl party in the theater, with guests' grandchildren playing in the playroom next door. Imagine ordering a pizza at midnight, learning the ins and outs of Facebook during computer classes, or having a cocktail or glass of wine before dinner. If these details and activities sound a lot like normal life, that's exactly the point. Baby boomers simply aren't willing to give up their lives or their interests. And why should they?

New properties also provide a huge economic impact on the communities that they serve. On average, a Mainstreet development represents a total investment of $15 million to each community. And over a span of 10 years, the average Mainstreet development has an estimated economic impact of $132 million.

New development also brings new jobs. On average, a 100-bed property will create 120 permanent, good paying jobs and another 350 construction jobs. That is more than 400 people gainfully employed and contributing to society and local communities in a meaningful way.

At the state level, new properties also ease the burden on Medicaid funding by only serving Medicare and private pay individuals. With the focus on short-term care, the average patient stay of 4-5 weeks is within Medicare reimbursement requirements, removing the long-term burden on the state for continued care. In this way, new nursing properties supplement less expensive assisted living and home health care options by allowing guests to receive a lower level of care in their own home.

With the combined forces of an exploding demographic, strong consumer demand, old and decaying facilities, and meaningful job creation, one might expect these new hospitality properties to be popping up all over the place. But that's not the case. Roughly half of the states in the U.S. have existing laws restricting or outlawing construction of new hospitality properties. These laws artificially hamper innovation and create protections for the existing and outdated nursing homes, at the expense of the consumer. These laws need to change.

Baby boomers started hitting age 65 on Jan. 1, 2011. Since that day and every day for the next 15 years, 10,000 baby boomers will reach that milestone. The marketplace must be ready to meet that need. The time to act is now and it starts by removing the 20-year-old moratorium in your great state.

Mainstreet would you happy to continue a dialogue with this committee as HB 389-FN moves forward.

Thank you.

#3 Cynthia Carrier

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH SERVICES PLANNING & REVIEW BOARD

29 HAZEN DRIVE, CONCORD, NH 03301-6504
603-271-4606 1-800-852-3345 Ext. 4606 Fax: 603-271-4141 TDD Access: 1-800-735-2964

Debra Grabowski
Chairperson

January 28, 2015

RE: HB389 – Repealing the certificate of need moratorium

FROM: Cynthia Carrier, Managing Analyst
Office of Health Services Planning and Review
29 Hazen Drive
Concord, NH 03301

Dear Committee Members:

My name is Cynthia Carrier and I am the Managing Analyst (Manager) for the Office of Health Services Planning and Review (HSPR), and staff to the Health Services Planning and Review Board. HB389 proposes to repeal the Certificate of Need moratium effective June 30, 2015 as found in RSA 151-C:4, III-a. As you know, the HSPR Board is charged with the administration of the CON program as established by RSA 151-C. Accordingly the Board is also charged with determining the need for additional nursing home beds in the State pursuant to an accompanying section of this same statute – RSA 151-C:4, III(b). You have already been given the Board's determination of need for additional nursing home bed needs as part of the fiscal review of this bill; this need was calculated according to the statutory formula found in RSA 151-C:4, III(b): 40 beds/1,000 population age 65 and over for each long term care service area (this is each NH County). The result is a need for 1,188 beds overall. Per the formula, 8 of the 10 counties would need additional beds with Rockingham County seeing a need for some 680 additional beds.

Such need would likely result in additional construction and renovation dollars to accommodate such beds. It will also likely result in an increase of Medicaid costs for the state to the extent that such beds are Medicaid-certified.

The HSPR Board would like to suggest that this esteemed Committee, in its deliberation on this bill, also consider the need to amend RSA 151-C:4, III(b) as it relates to the statutory need formula. This formula has been in existence for more than 2 decades and is worthy of a second look to determine whether it accurately reflects today's reality. Some options to consider are:

(1) Raising the age number from 65 to 75 in order to reflect a more appropriate average age of persons residing in nursing homes;
(2) Reducing the bed to population number to reflect at least the actual experience of 35 beds per 1,000 population age 65 and over;
(3) Raising the age number and lowering the bed to population number together; or
(4) Developing a new statutory need formula.

Alternatively, this Committee could remove the need formula altogether; this would then require the HSPR Board to determine the need formula by rule.

In 2010 the HSPR Board considered the development of a revised need formula for nursing home beds – we would be happy to provide a copy of this work to the Committee if interested.

Thank you for considering my comments. I would be happy at this time to provide any technical or historical information regarding this need formula and/or the HSPR Board at this time.

STATE OF NEW HAMPSHIRE
DIVISION OF PUBLIC HEALTH SERVICES
HEALTH SERVICES PLANNING AND REVIEW
ESTIMATED 2015 BED NEED FOR A DELINEATION OF TEN COUNTIES
BASIS: 40 BEDS/1000 POP. AGED 65+ (PER HE-HEA-904 AND RSA 151-C:4, III(b))

Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds				He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
			County	NH	ECU	TOTAL			
Belknap County:									
Alton						-			
Barnstead						-			
Belmont						-			
Center Harbor						-			
Gilford						-			
Gilmanton						-			
Laconia				171		171			
Meredith				131		131			
New Hampton						-			
Sanbornton						-			
Tilton						-			
County Home			94			94			
Total Belknap County	**12,052**	**482**	**94**	**302**	**-**	**396**	**86**	**17.84%**	**33**

STATE OF NEW HAMPSHIRE
DIVISION OF PUBLIC HEALTH SERVICES
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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds County	Licensed Beds NH	Licensed Beds ECU	Licensed Beds TOTAL	He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
Carroll County:									
Albany						-			
Bartlett						-			
Brookfield						-			
Chatham						-			
Conway				87	45	132			
Eaton						-			
Effingham						-			
Freedom						-			
Harts Location						-			
Jackson						-			
Madison						-			
Moultonboro						-			
Ossipee						-			
Sandwich						-			
Tamworth						-			
Tuftonboro						-			
Wakefield						-			
Wolfeboro				104	27	131			
County Home			103			103			
Total Carroll County	**11,941**	**478**	**103**	**191**	**72**	**366**	**112**	**23.43%**	**31**

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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds County	Licensed Beds NH	Licensed Beds ECU	Licensed Beds TOTAL	He-Hea 904.03 Unmet. Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
Cheshire County:									
Alstead						-			
Chesterfield						-			
Dublin						-			
Fitzwilliam						-			
Gilsum						-			
Harrisville						-			
Hinsdale						-			
Jaffrey						-			
Keene				83		83			
Marlborough				216		216			
Marlow						-			
Nelson						-			
Richmond						-			
Rindge						-			
Roxbury						-			
Stoddard						-			
Sullivan						-			
Surry						-			
Swanzey						-			
Troy						-			
Walpole						-			
Westmoreland						-			
Winchester						-			
County Home			150	72		72			
Total Cheshire County	**13,279**	**531**	**150**	**371**	**-**	150 **521**	**10**	**1.88%**	**39**

STATE OF NEW HAMPSHIRE
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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds				He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
			County	NH	ECU	TOTAL			
Coos County:									
Berlin				80		80			
Carroll						-			
Clarksville						-			
Colebrook						-			
Columbia						-			
Dalton						-			
Dummer						-			
Errol						-			
Gorham						-			
Jefferson						-			
Lancaster				86		86			
Milan						-			
Northumberland						-			
Pittsburg						-			
Randolph						-			
Shelburne						-			
Stark						-			
Stewartstown						-			
Stratford						-			
Whitefield				57		57			
County Home			197		-	197			
Total Coos County	**7,238**	**290**	**197**	**223**	**-**	**420**	**(130)**	**-44.83%**	**58**

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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	County	Licensed Beds NH	ECU	TOTAL	He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
Grafton County:									
Alexandria						-			
Ashland						-			
Bath						-			
Benton						-			
Bethlehem						-			
Bridgewater						-			
Bristol						-			
Campton						-			
Canaan						-			
Dorchester						-			
Easton						-			
Ellsworth						-			
Enfield						-			
Franconia				72		72			
Grafton						-			
Groton						-			
Hanover				100		100			
Haverhill						-			
Hebron						-			
Holderness						-			
Landaff						-			
Lebanon				110	50	160			
Lincoln						-			
Lisbon						-			
Littleton						-			
Lyman						-			
Lyme						-			
Monroe						-			

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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds County	NH	ECU	TOTAL	He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
Orange						-			
Orford						-			
Piermont						-			
Plymouth						-			
Rumney						-			
Sugar Hill						-			
Thornton						-			
Warren						-			
Waterville Valley						-			
Wentworth						-			
Woodstock						-			
County Home			135			135			
Total Grafton County	**16,673**	**667**	**135**	**282**	**50**	**467**	**200**	**29.99%**	**28**

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DIVISION OF PUBLIC HEALTH SERVICES
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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	County	Licensed Beds NH	ECU	TOTAL	He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
Hillsborough County:									
Amherst						-			
Antrim						-			
Bedford				399		399			
Bennington						-			
Brookline						-			
Deering						-			
Francestown						-			
Goffstown				35		35			
Greenfield						-			
Greenville						-			
Hancock						-			
Hillsborough				33		33			
Hollis						-			
Hudson				101		101			
Litchfield						-			
Lyndeborough						-			
Manchester				765		765			
Mason						-			
Merrimack						-			
Milford				134		134			
Mont Vernon						-			
Nashua				390		390			
New Boston						-			
New Ipswich						-			
Pelham						-			
Peterborough				99		99			
Sharon						-			
Temple						-			

STATE OF NEW HAMPSHIRE
DIVISION OF PUBLIC HEALTH SERVICES
HEALTH SERVICES PLANNING AND REVIEW
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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds County	NH	ECU	TOTAL	He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
Weare						-			
Wilton						-			
Windsor						-			
County Home			300			300			
Total Hillsborough Co.	**57,946**	**2,318**	**300**	**1,956**	**-**	**2,256**	**62**	**2.67%**	**39**

STATE OF NEW HAMPSHIRE
DIVISION OF PUBLIC HEALTH SERVICES
HEALTH SERVICES PLANNING AND REVIEW
ESTIMATED 2015 BED NEED FOR A DELINEATION OF TEN COUNTIES
BASIS: 40 BEDS/1000 POP. AGED 65+ (PER HE-HEA-904 AND RSA 151-C:4, III(b))

Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds County	Licensed Beds NH	Licensed Beds ECU	Licensed Beds TOTAL	He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
Merrimack County:									
Allenstown						-			
Andover						-			
Boscawen						-			
Bow						-			
Bradford						-			
Canterbury						-			
Chichester						-			
Concord				409		409			
Danbury						-			
Dunbarton						-			
Epsom				108		108			
Franklin				115		115			
Henniker						-			
Hill						-			
Hooksett						-			
Hopkinton						-			
Loudon						-			
Newbury						-			
New London					58	58			
Northfield						-			
Pembroke						-			
Pittsfield						-			
Salisbury						-			
Sutton						-			
Warner						-			
Webster						-			
Wilmot						-			
County Home			290			290			
Total Merrimack Co.	**24,468**	**979**	**290**	**632**	**58**	**980**	**(1)**	**-0.10%**	**40**

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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	County	Licensed Beds NH	ECU	TOTAL	He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
Rockingham County:									
Atkinson						-			
Auburn						-			
Brentwood						-			
Candia						-			
Chester						-			
Danville						-			
Deerfield						-			
Derry				174		174			
East Kingston						-			
Epping						-			
Exeter				81		81			
Fremont				50		50			
Greenland						-			
Hampstead						-			
Hampton				117		117			
Hampton Falls						-			
Kensington						-			
Kingston						-			
Londonderry						-			
New Castle						-			
Newfields						-			
Newington						-			
Newmarket						-			
Newton						-			
North Hampton						-			
Northwood						-			
Nottingham						-			
Plaistow						-			

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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds				He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
			County	NH	ECU	TOTAL			
Portsmouth				327		327			
Raymond						-			
Rye				66		66			
Salem				110		110			
Sandown						-			
Seabrook						-			
South Hampton						-			
Stratham						-			
Windham				32		32			
County Home			268			268			
Total Rockingham Co.	**47,649**	**1,906**	**268**	**957**	**-**	**1,225**	**681**	**35.73%**	**26**

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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds County	Licensed Beds NH	Licensed Beds ECU	Licensed Beds TOTAL	He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
Strafford County:									
Barrington						-			
Dover				196		196			
Durham						-			
Farmington						-			
Lee						-			
Madbury						-			
Middleton						-			
Milton						-			
New Durham						-			
Rochester				187		187			
Rollinsford						-			
Somersworth						-			
Strafford						-			
County Home			215			215			
Total Strafford County	**17,364**	**695**	**215**	**383**	**-**	**598**	**97**	**13.96%**	**34**

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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds				He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
			County	NH	ECU	TOTAL			
Sullivan County:									
Acworth						-			
Charlestown						-			
Claremont				68		68			
Cornish						-			
Croydon						-			
Goshen						-			
Grantham						-			
Langdon						-			
Lempster						-			
Newport				53		53			
Plainfield						-			
Springfield						-			
Sunapee						-			
Unity						-			
Washington						-			
County Home			156			156			
Total Sullivan County	**8,703**	**348**	**156**	**121**	**-**	**277**	**71**	**20.40%**	**32**
State Totals	217,313	8,694	1,908	5,418	180	7,506	1,188	13.66%	34.54

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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds				He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
			County	NH	ECU	TOTAL			
Summary by County:									
Belknap County							86	17.84%	32.86
Carroll County							112	23.43%	30.65
Cheshire County							10	1.88%	39.23
Coos County							(130)	-44.83%	58.03
Grafton County							200	29.99%	28.01
Hillsborough County							62	2.67%	38.93
Merrimack County							(1)	-0.10%	40.05
Rockingham County							681	35.73%	25.71
Strafford County							97	13.96%	34.44
Sullivan County							71	20.40%	31.83
State Total							1,188	13.66%	34.54

NH = Nursing Home
ECU = Extended Care Unit in Hospital

CCRCs and surrendered beds are not included in the calculation.

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Town	2015 Estimated Population Age 65+	He-Hea 904.01 Bed Need (40/1000)	Licensed Beds				He-Hea 904.03 Unmet Need	Degree of Unmet Need	Projected Licensed Beds/1000 Age 65+
			County	NH	ECU	TOTAL			

NOTES:

1. Alice Peck Day ECU (in Grafton County) redesignated its 50 beds per RSA 151-C:6, IV. Still included in the bed inventory.
2. Mark Wentworth Home (in Rockingham County) redesignated its 69 beds per RSA 151-C:6, IV. Still included in the bed inventory.
3. Transitional Care of Wolfeboro (Huggins Hospital ECU) (in Carroll County) redesignated its 27 beds per RSA 151-C:6, IV. Still included in the bed inventory.
4. Rockingham County Nursing Home redesignated 42 beds per RSA 151-C:6, IV. Still included in the bed inventory.
5. Webster at Rye (Rockingham County) purchased 19 beds from Eventide Home in 2008. Subsequently sold 4 beds to Warde Health Center. Five beds not yet licensed; remaining 10 beds are licensed.
6. Warde Health Center (Rockingham County) purchased 4 beds from Webster at Rye. Beds not yet licensed but are included in the bed inventory.
7. Easter Seals (Hillsborough County) holds 21 beds purchased from The Gale Home which are unassigned/unused. These beds are included in the inventory.
8. Golden View Health Center (Belknap County) redesignated 16 beds per RSA 151-C:6, IV. Still included in the bed inventory. Ten additional beds approved for redesignation but not yet redesignated.

SOURCES:

County Population Projections, 2013
Obtained from the New Hampshire Office of Energy and Planning

"Health Facilities Licensed Under RSA 151" - 12/4/14
Prepared by the DHHS Bureau of Health Facilities Administration

COMPILED BY:

Health Services Planning and Review

MERCATUS ON POLICY

Three Prescriptions for States to Improve Health Care

Matthew Mitchell, Anna Mills, and Dana Williams

January 2015

MERCATUS CENTER
George Mason University

Well before the advent of the Affordable Care Act (ACA), the US health care system lacked many of the basic elements of consumer choice, price transparency, and efficiency enjoyed by consumers in other industries. The ACA, unfortunately, did not change this.

Most health care transactions take place without any reference to prices. Indeed, a large share of hospitals cannot even tell patients the price of a standard procedure.[1] The market is hamstrung by a third-party-payer model that divorces the consumer from choice. Moreover, it is limited by a patchwork of constraints that favor risk-averse insiders over innovative disruptors who might transform the system to the consumers' benefit.[2] The result is a system that lacks the sort of dynamic competition that permits other industries to discover innovative ways to improve quality, reduce prices, and enhance the user experience.[3]

In this paper we discuss three ways that states can benefit patients by making their health care markets more competitive: they can abolish certificate-of-need laws, liberalize scope-of-practice regulations, and remove barriers to telemedicine.

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CERTIFICATE-OF-NEED LAWS

A certificate-of-need (CON) law requires anyone wanting to open or expand a health care facility to first obtain approval from a regulator by proving that the community "needs" the new or expanded service. As shown in figure 1, 35 states and the District of Columbia currently have CON laws.[4] Though they vary from state to state, these laws cover everything from the construction of new hospitals to the purchase of new equipment. North Carolina's CON law, for example, "prohibits health care providers from acquiring, replacing, or adding to their

facilities and equipment, except in specified circumstances, without the prior approval of the Department of Health and Human Services."[5]

As is often the case with health care policy, CON laws were devised as a means to overcome the unintended consequences of other government policies. Because Medicare and Medicaid reimburse providers on a fee-for-service basis, it was thought that these laws would prevent health care providers from ordering unnecessary and duplicative procedures.[6] By this same logic, Congress enacted legislation in 1975 conditioning federal funds on the enactment of CON laws.[7] Every state but Louisiana responded to the incentive and enacted a CON statute. Early studies, however, found that these laws failed to control costs.[8] So Congress reversed course, repealing the federal incentive in 1986.[9] Since then 14 states have repealed their CON laws.[10]

Providers were quick to realize that CON laws, which were ostensibly enacted to restrain costs, also restrained competition. In 1968, the American Hospital Association began campaigning for state enactment of CON laws.[11] This is consistent with the public choice theory of regulation, which predicts that producers will favor—and often obtain—regulations that shield them from competition.[12] During the CON approval process, incumbent providers are often invited to testify against their would-be competitors, and in many cases regulators have an explicit mandate to guard the profits of these incumbents.[13] The approval process can be long and expensive. In Virginia, for example, Dr. Mark Monteferrante spent five years and $175,000 navigating the CON process to add a second MRI machine in his office.[14]

Today, CON laws are often defended as a means to promote care for the needy. Advocates argue that states offer providers this monopoly protection on the condition that the providers use some of their above-normal profits to supply care to those in need. Recent research, however, suggests that CON laws do not work this way.[15] Thomas Stratmann and Jacob Russ examine data from 50 states and the District of Columbia and find that, while CON laws are associated with fewer hospital beds, MRI services, CT scanners, and colonoscopies, they do not correlate with any greater access to care among the needy.

One of the first steps a state can take to make its health care market more competitive—that is, more responsive to the needs of practitioners and consumers—is to repeal its CON law.

SCOPE-OF-PRACTICE LAWS

Scope-of-practice laws are state-specific mandates that determine what tasks nurses, nurse practitioners, physicians' assistants, and other health care providers may undertake in the course of caring for patients.[16] As shown in figure 2, scope-of-practice regulations vary in stringency across states. New Mexico and Vermont, for example, are among the 18 states that allow nurse practitioners (NPs) to operate fully autonomous practices, meaning that they may be primary care providers and may diagnose, treat, and independently prescribe

FIGURE 1: CERTIFICATE-OF-NEED (CON) REGULATION IN THE UNITED STATES

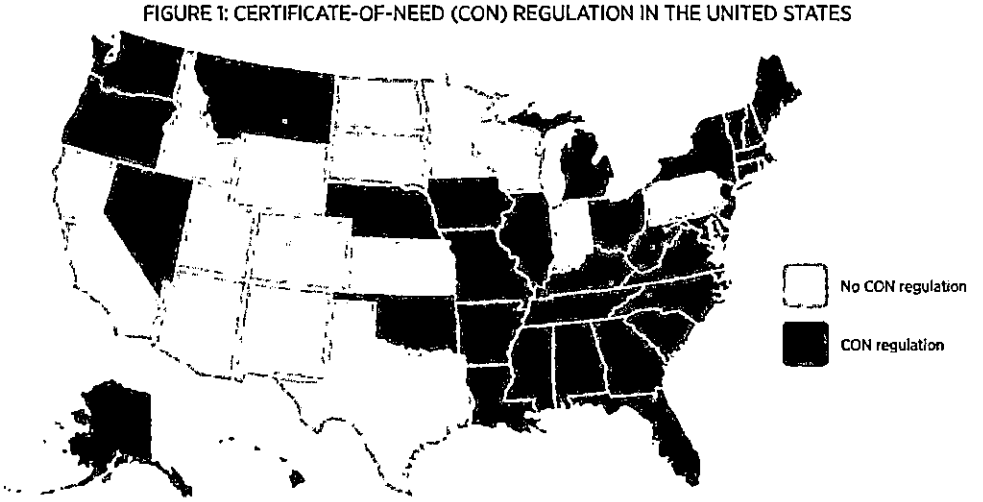
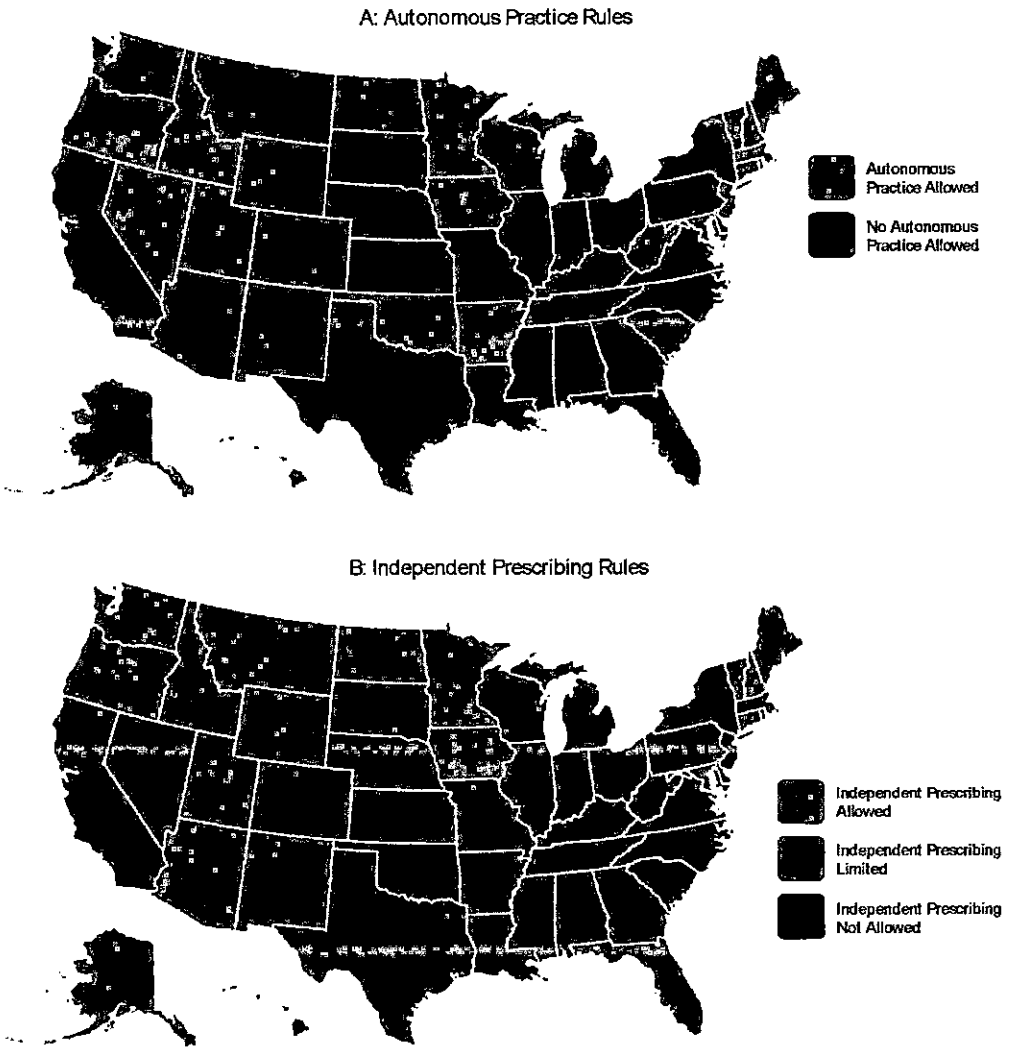


FIGURE 2: NURSE PRACTITIONER SCOPE-OF-PRACTICE



drugs.[17] Other states, such as Virginia and North Carolina, only permit restricted practices, allowing NPs to be primary care providers but only under physician supervision.[18] By restraining the supply of medical services, scope-of-practice laws have contributed to the shortage in primary care givers, a problem which is particularly acute in rural areas.[19]

The variability in scope-of-practice laws from state to state allows researchers to estimate the effects of these regulations. One recent study analyzes how these regulations affect wages, employment, costs, and the quality of certain types of medical services.[20] The authors find that more stringent regulations limit the hours worked by NPs and that restricting NPs' ability to write a prescription increases the cost of a well-child medical exam by about $16 (or 16 percent). Furthermore, the authors find that these regulations seem to have no discernable effect on outcomes such as infant mortality or malpractice premiums.[21] The authors *do* find that scope-of-practice laws reduce NP wages while boosting physician wages.[22] On balance, it seems that these regulations privilege certain providers under the guise of consumer protection.[23]

By allowing non-physician providers greater autonomy of practice, states could dramatically reduce the cost of care for their residents and increase access to care,

especially for low-income families. If all states allowed NPs to practice autonomously without physician oversight, the total cost savings is estimated to be about $810 million.[24]

TELEMEDICINE

Telemedicine, or telehealth, is the remote diagnosis, treatment, and monitoring of patients by means of telecommunications technology. This form of delivery, which utilizes both current and developing mobile medical technologies, promises patients greater access, improved quality, and enhanced efficiency of care. Indeed, it may be the sort of disruptive technology that has ushered in dramatically lower costs in industries such as retail and air travel but has so far eluded the health care industry.[25]

Consider in-person dermatological consultations. The typical patient waits 29 days for an appointment.[26] And on average these visits cost Medicare around $88.[27] New smartphone and computer applications, however, permit patients to snap high-definition pictures of worrisome moles or bothersome rashes and within 24 hours they can get a diagnosis for $40 (or less if covered under a health network membership).[28]

This technology allows doctors to fill idle time by serving patients thousands of miles away. It can also allow patients in underserved (often rural) communities to access some of the best medical professionals in the country. Doctors and nurse practitioners could diagnose minor illnesses and treat patients with the help of already available mobile-compatible stethoscopes, otoscopes, thermometers, blood pressure monitors, and eye exam diagnostic tools.[29]

There are a number of mobile-compatible devices that either are on the market or are currently under FDA review that can run disposable diagnostic tests for strep A, Influenza A and B, adenovirus, and RSV using only saliva or a prick of the finger; devices that can test urine for preeclampsia, gestational diabetes, kidney failure, and urinary tract infections; and even ingestible biomedical sensors that can monitor medication adherence.[30] Many of these devices are expensive now but experience shows that when patients internalize real prices, entrepreneurs find ways to lower prices. The price of a home drug test in 2015, for example, is one-sixth the price it was in 2003.[31] One can imagine a world in which it is common for families to purchase basic mobile medical kits for under $100 (or when they subscribe to a mobile diagnostic service).

Despite its promise, a number of policies stand in the way of this technology's adoption. As shown in figure 3, 41 states and the District of Columbia have laws requiring doctors to perform in-person examinations before they may write prescriptions.[32] Other states bar doctors from even making a diagnosis without seeing the patient in the office.[33] And others discriminate against out-of-state providers.[34]

Policymakers should recognize that technological innovation has outpaced these 20th-century regulations and scrap those restrictions that stand in the way of competitive, quality telemedicine.

They should also acknowledge that differing scope-of-practice regulations make it difficult for caregivers to

FIGURE 3: STATES WITH PHYSICAL EXAM LAWS

operate in more than one state. These disparate regulations might be reconciled (and ideally eased) through an interstate compact similar to the driver's license agreement, which would allow medical professionals to see patients in all participating states after going through a single licensure process.

CONCLUSION

The goals of health policy are not in contention. Nearly everyone would like to see a system in which patients enjoy access to efficient, innovative, low-cost, and high-quality care. With federal health care policy hopelessly mired in politics, states have an opportunity to make their health care markets significantly more competitive by repealing CON laws, easing scope-of-practice restrictions, and removing the barriers to telemedicine. A more competitive market is not simply a ticket to lower prices. Dynamic competition permits providers to be more nimble and innovative—better able to adjust to changing needs and to incorporate innovative technologies that improve lives.[35]

NOTES

1. "Only 16% of a randomly selected group of U.S. hospitals were able to provide a complete bundled price, though an additional 47% of hospitals could provide a complete price when hospitals and health care providers were contacted separately. Obtaining pricing information was difficult and frequently required multiple conversations with numerous staff members." Jaime A. Rosenthal, "Availability of Consumer Prices from U.S. Hospitals for a Common Surgical Procedure," Medical Bene_ts 30, no. 11 (June 15, 2013): 10–11.

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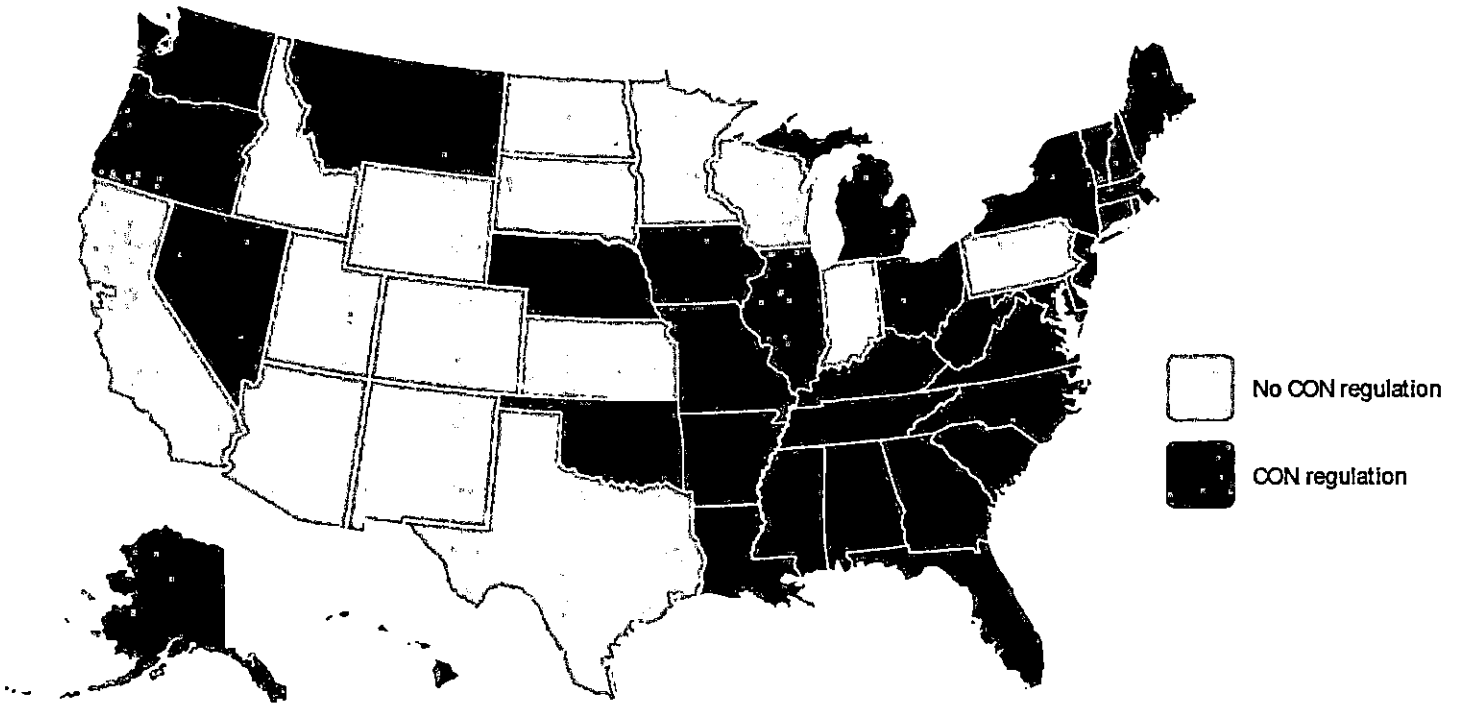
#4

FIGURE 1 CERTIFICATE-OF-NEED (CON) REGULATION IN THE UNITED STATES



Source: Matthew Mitchell and Christopher Koopman, "40 Years of Certificate-of-Need Laws across America," Mercatus Center at George Mason University, October 14, 2014, http://mercatus.org/publication/40-years-certificate-need-laws-across-america.

Produced for Matthew Mitchell, Anna Mills, and Dana Williams, "Three Prescriptions for a Better Health Care System" (Mercatus on Policy, Mercatus Center at George Mason University, Arlington, VA, January 2015), http://mercatus.org/publication/three-prescriptions-states-improve-health-care

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#5

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HB 389-FN
Testimony of John Prochilo
Chief Executive Officer
Northeast Rehabilitation Hospital Network
January 29, 2015

Good morning Mr. Chairman and members of the Committee. My name is John Prochilo and I am the Chief Executive Officer of Northeast Rehabilitation Hospital Network. Northeast Rehabilitation Hospital Network is opposed to repealing the existing Certificate of Need moratorium on nursing home and rehabilitation beds for the reasons set forth below:

Background

Northeast Rehabilitation Hospital Network consists of 3 inpatient rehab hospitals in Salem, Nashua and Portsmouth, and a new rehabilitation hospital unit that is about to open within the Elliot Hospital in Manchester. We also own and operate a number of outpatient physical rehabilitation clinics. We employ over 1,000 people and have been operating in New Hampshire for 30 years. We treat patients who have neurologic, orthopedic, and other types of illness and injuries that cause a decline in physical function. We treat patients who have had a stroke, traumatic brain injury, amputations, multiple trauma and other types of conditions causing disability. These patients need short-term intensive rehabilitation services, which rehab hospitals and units like Northeast Rehab provide.

Rational control of the number of inpatient rehabilitation beds in the State is important for the following reasons:

In 2002, Medicare sought to hold facilities accountable to its 75% Rule. 75% of the patients admitted to an inpatient rehab hospital had to fall within 13 diagnostic categories.

In short order, Medicare realized that the majority of the existing inpatient rehab hospitals could not comply with the 75% rule because there were not enough qualifying patients within those 13 diagnostic categories for facilities to comply with the rule. Medicare had to relax its standard permanently and established a 60% compliance threshold. Since the inception of the 60% rule, the number of rehabilitation beds in the nation has declined.

If the moratorium on the development of new inpatient rehab beds in New Hampshire were to be lifted, all of the existing inpatient rehab hospitals and units, including Northeast Rehab, would have great difficulty in complying with Medicare's 60% rule. As my colleagues have testified, these Federal criteria are becoming more restrictive.

In 1995 this General Court placed a moratorium on the development of new rehab hospital and

nursing home beds as an initiative to avoid inefficient use of existing inventory and to hold costs down.

There is tremendous competition among specialty rehabilitation hospitals for very specialized and expensive staff (physical therapists, occupational therapists, speech language pathologists and rehabilitation physicians) that specifically have hospital level inpatient rehabilitation training.

Northeast Rehab successfully opened a new facility in Portsmouth by cross utilizing specialized staff from its existing locations to supplement the requirements of our new facility. This has resulted in the most efficient use of limited resources with a concerted effort not to "raid" staff from existing rehab providers, which would have caused quality of care concerns among other rehab hospitals and facilities along with keeping the cost of staffing with specialized resources stable.

If the moratorium is lifted, the newly established rehab facilities and units will increase the competition for qualified staff resulting in a "salary arms war" with one facility trying to outbid the others for staff.

Inpatient specialty rehab hospitals are expensive to build and staff. The existing inventory of inpatient rehab hospital and unit beds within the State are not fully occupied. If the moratorium is lifted, the results will be several rehab hospitals and units with minimum occupancy, inadequate staff and high levels of inefficiency with the potential economic failure of some.

In an effort to keep these expensive failing facilities afloat, there is a danger that quality of care concerns would arise due to cost cutting initiatives. Also, Northeast Rehab and other inpatient rehab hospitals and units like it need to have a predictable and stable economic environment- one in which we can assure bankers, HUD and other lending agencies that we have a stable future in order for us to continually invest in our staff, in technology and in the upkeep of our facilities.

For these reasons, Northeast Rehab is opposed to repealing the Certificate of Need moratorium.

Thank you for the opportunity for allowing me to present this testimony.

#6

Health, Human Services and Elderly Affairs Committee
Testimony of Catherine Devaney
Chief Executive Officer
HealthSouth Rehabilitation Hospital of Concord
Re: HB 389-FN
January 29, 2015

My name is Catherine Devaney. I am the Chief Executive Officer of HealthSouth Rehabilitation Hospital of Concord. We are a 50-bed Rehabilitation Hospital that opened in 1992. We employ approximately 176 people, and in 2014 we provided inpatient rehabilitation to over nine-hundred inpatients.

I am here today to ask you to oppose HB 389 which proposes to lift the current moratorium on nursing home and rehabilitation beds effective June 30, 2015.

Currently there are 322 licensed rehabilitation beds in free-standing rehabilitation hospitals and rehabilitation units within acute care hospitals in the state. This is 162 more than our current bed need formula indicates is needed. The bed need formula used in New Hampshire is sound and consistent with many other states. This was most recently reviewed and reaffirmed in 2012. While there are is an unmet need of 9 beds in the northern region, our hospital in Concord routinely receives referrals for patients in the northern portions of the state for specialty hospital-level rehabilitation care.

Our length of stay is 13 days, and nearly 75% of our patients return directly back to their community. Inpatient rehabilitation is a specialty service requiring equipment and levels of medical, therapy, and rehabilitation nursing care not easily found. Patients in rehabilitation hospital settings must receive three hours of physical, occupational, or speech therapy a day. They must have oversight by a physician with experience in rehabilitation and require 24-hours a day of rehabilitation nursing care.

The Centers for Medicare and Medicaid (CMS) also requires rehabilitation hospitals and units to ensure that at least 60% of their admissions or discharges are in 13 diagnostic categories considered by CMS to be traditional rehabilitation diagnoses. This rule is also known as the CMS-13 or the 60% Rule. These 13 diagnostic categories include: stroke, brain injury, spinal cord injury, amputation, and neurological disorders, among others. They do not include some diagnostic groups very common today such as cardiac and pulmonary conditions, cancer, orthopedic injuries, or joint replacements. The origin of this rule goes back to 1984 with the formulation of DRGs and unfortunately the diagnostic categories considered "rehabilitation" has not been updated to reflect significant changes in the types of chronic, debilitating conditions more commonly seen today in medical surgical hospitals.

Effective October 2015, CMS is further limiting these 13 diagnostic categories by removing a large number of ICD 9 codes that were previously included in these categories. Examples of these include upper extremity amputations, rheumatoid

arthritis, and some additional orthopedic conditions among many others. This could reduce occupancy rates in existing rehabilitation hospitals and units as fewer patients will fall into the 60% "compliant" category.

Given that the current total number of rehabilitation beds in the state exceeds a solid bed need methodology, the need to maintain specialized equipment and staffing levels far different than other types of facilities, and the pending federal rule that could reduce occupancy in rehabilitation hospitals and units this is not the time to lift a moratorium on these types of beds. I respectfully request that you maintain the moratorium on these beds at this time to ensure the survival of the existing rehabilitation providers in the state.

MERCATUS CENTER
George Mason University
Bridging the gap between academic ideas and real-world problems

RESEARCH SUMMARY

DO CERTIFICATE-OF-NEED LAWS INCREASE INDIGENT CARE?

Originally introduced to the United States in 1964 by New York, certificate-of-need (CON) regulations seek to contain health care costs by limiting overinvestment in facilities and equipment. CON regulations require a medical provider, such as a hospital, nursing home, or ambulatory surgical center, to demonstrate a clear public need before providing a new service or facility. An intended result of this government restriction on the marketplace is that providers will use the profits gained from decreased competition to subsidize care for indigent people by covering losses on services that cannot be paid for by the patient or by government.

In a new empirical study of CON regulation and indigent care, economists Thomas Stratmann and Jacob W. Russ find no evidence that CON regulations increase indigent care, but they do find evidence that the regulations limit the provision of medical services. Consequently, the price of medical care is likely higher under CON regulations, while the poorest Americans see no increase in the availability of care.

DATA AND EMPIRICAL STRATEGY

The study uses state-level measures of indigent care and compiles a comprehensive database on state CON regulations from three sources:

- The Healthcare Cost Report Information System provides the direct measure of indigent care: uncompensated care. For example, the number of beds from reporting hospitals is used to standardize uncompensated care on a per-bed basis.
- Two American Hospital Association sources (*Hospital Statistics 2013* and Health Forum's Medicaid statistics) provide an indirect measure of indigent care by looking at the ratios of Medicaid patient days to total patient days and Medicaid admissions to total patient discharges.

For more information, contact
Kyle Precourt, 703-993-8196, kprecourt@mercatus.gmu.edu
Mercatus Center at George Mason University
3434 Washington Boulevard, 4th Floor, Arlington, VA 22201

- CON regulation data come from the American Health Planning Association's annual survey of state CON programs. From this data, the authors have compiled the most comprehensive dataset on CON regulations to date.

The study uses several empirical strategies when analyzing the data:

- It takes into account the fact that although a state may have a CON regulation agency, the agency may or may not regulate a particular service or type of equipment—states have different approaches to CON regulation.
- It controls for demographic information from the Census Bureau, as well as unemployment-rate data and real income, by indexing each year to inflation using 2011 as a base year.
- It uses the percentage of adults with diabetes as an additional control variable to capture poor health outcomes that may not be captured by other control variables.

RESULTS

If state CON regulations grant medical providers market power, there should be evidence of hospital capacity restrictions such as fewer hospital beds. Capacity restrictions would allow providers to raise prices, giving them excess profits to spend on indigent care. However, without market power, providers are unlikely to have additional money to spend on indigent care, though such spending may be mandated in some CON regulations.

Hospital Capacity

CON regulations do correlate with fewer hospital beds and with other measures of restricted capacity.

- On average, there are 362 hospital beds per 100,000 people in the United States.
- The presence of a state CON regulation program is associated with 99 fewer hospital beds per 100,000 people. Not every state regulates acute hospital beds, however. In states that do, there are on average about 131 fewer beds per 100,000 people.
- On average, there are 4.7 fewer hospital beds per 100,000 people for each additional service a state regulates.
- CON regulations reduce the number of hospitals with MRI machines by one to two hospitals per 500,000 people. States that regulate MRI machines have, on average, 2.5 fewer hospitals with MRI machines.

Indigent Care

Uncompensated care is given by a medical provider when the patient is unable to pay the provider. For 2007–2011, the average annual level of uncompensated care in the United States was about $100,000 per hospital bed.

- A CON regulation that requires charitable care by the provider does not statistically correlate with an increase in uncompensated care.

- Medicaid patients may have higher patient costs and lower reimbursement rates. There is little evidence of CON regulations providing a cross-subsidy for Medicaid patients.
- An increase in uncompensated care may not represent a true increase in indigent care. If regulators focus on uncompensated care to measure the provision of medical services to indigent people, they may incentivize hospitals to provide unnecessary, billable services to the same number of patients, increasing costs but not the level of care for indigent people.

CONCLUSION

- CON regulations that regulate certain medical services in a state do not seem to help finance a subsidy to the medically indigent. The data collected does not allow a conclusion about whether the lack of cross-subsidization is due to an insufficient increase in hospital profits or a state's failure to enforce indigent care provisions.
- CON regulations are effective at restricting the supply of regulated medical services, and this does not correlate with an increase in the level of indigent care.
- With services such as the number of beds and MRI machines restricted statewide, prices are likely higher for most patients, without the desired increase in indigent care.

Voting Sheets

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 389-FN

BILL TITLE: **repealing the certificate of need moratorium.**

DATE: February 17, 2015

LOB ROOM: 205

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep. Thomas Sherman

Seconded by Rep. Barbara French

Vote: 9-5 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: NO

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Bill Nelson

Rep. Bill Nelson, Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 389-FN

BILL TITLE: **repealing the certificate of need moratorium.**

DATE: 2/17/15

LOB ROOM: 205

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, (ITL), Retained (Please circle one.)

Moved by Rep. Sherman

Seconded by Rep. French

Vote: (Please attach record of roll call vote.) YEAS 9 NAYS 5

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.) NO

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Bill Nelson, Clerk

Bill Nelson

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

1/8/2015 1:44:45 PM
Roll Call Committee Registers Report

2015 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: HB 389-FN Title: Repealing the certificate of need moratorium

PH Date: 1/9/15 Exec Session Date: 2/17/15

Motion: ITL Amendment #:

MEMBER	YEAS	NAYS
Kotowski, Frank R., Chairman		✓
LeBrun, Donald L., V Chairman		✓
Emerson, Susan	✓	
McMahon, Charles E.	—	
Martel, Andre A.	—	
Nelson, Bill G., Clerk		✓
Schmidt, Stephen J.		✓
Stepanek, Stephen B.	—	
Guthrie, Joseph A.	—	
Ward, Joanne A.		✓
Donovan, Daniel A	—	
Fothergill, John	✓	
MacKay, James R.	—	
French, Barbara C	✓	
Deloge, Helen M.	—	
Sherman, Thomas M.	✓	
Ticehurst, Susan J.	✓	
Weber, Lucy M.	✓	
Freitas, Mary C.	✓	
Gordon, Pamela S.	✓	
Snow, Kendall A.	✓	
TOTAL VOTE:	9	5

Committee Report

REGULAR CALENDAR

March 4, 2015

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Majority of the Committee on HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS to which was referred HB389-FN,

AN ACT repealing the certificate of need moratorium.

Having considered the same, report the same with the following Resolution: RESOLVED, That it is INEXPEDIENT TO LEGISLATE.

Rep. Thomas M. Sherman

FOR THE MAJORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MAJORITY
COMMITTEE REPORT

Committee:	**HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS**
Bill Number:	**HB389-FN**
Title:	**repealing the certificate of need moratorium.**
Date:	**February 18, 2015**
Consent Calendar:	**NO**
Recommendation:	**INEXPEDIENT TO LEGISLATE**

STATEMENT OF INTENT

This bill carves out the nursing home, skilled nursing facility, intermediate care facility and rehabilitation facility industry for a moratorium on the certificate of need statute restrictions. The majority of the committee, while divided on whether the CON process should be allowed to sunset in 2016 as planned, were united in their opposition to exceptional carve outs from the CON process without clear benefit to the citizens of New Hampshire and with testimony to the resulting significant negative impact to current providers.

Vote 9-5

Rep. Thomas M. Sherman
FOR THE MAJORITY

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

HB389-FN, repealing the certificate of need moratorium. **INEXPEDIENT TO LEGISLATE.** Rep. Thomas M. Sherman for the **Majority** of HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS. This bill carves out the nursing home, skilled nursing facility, intermediate care facility and rehabilitation facility industry for a moratorium on the certificate of need statute restrictions. The majority of the committee, while divided on whether the CON process should be allowed to sunset in 2016 as planned, were united in their opposition to exceptional carve outs from the CON process without clear benefit to the citizens of New Hampshire and with testimony to the resulting significant negative impact to current providers. **Vote 9-5.**

Original: House Clerk
Cc: Committee Bill File

HB 389-FN repealing the certificate of need moratorium.

This bill carves out the nursing home, skilled nursing facility, intermediate care facility and rehabilitation facility industry for a moratorium on the certificate of need statute restrictions. The majority of the committee, while divided on whether the CON process should be allowed to sunset in 2016 as planned, were united in their opposition to exceptional carve outs from the CON process without clear benefit to the citizens of New Hampshire and with testimony to the resulting significant negative impact to current providers.

Rep. Thomas Sherman
For the Majority
9-5 –ITL - RC

OK
G.R.F

COMMITTEE REPORT

COMMITTEE: Health, Human Services & Elderly Affairs

BILL NUMBER: HB 389-FN

TITLE: Repealing the certificate of need moratorium.

DATE: 2/17/15 CONSENT CALENDAR: YES ☐ NO ☒

☐ OUGHT TO PASS

☐ OUGHT TO PASS W/ AMENDMENT

☒ INEXPEDIENT TO LEGISLATE

☐ INTERIM STUDY (Available only 2nd year of biennium)

Amendment No. _____

STATEMENT OF INTENT:

This bill carves out the nursing home, skilled nursing facility, intermediate care facility and rehabilitation facility industry for a moratorium on the Certificate of Need statute restrictions. The majority of the Committee, while divided on whether the CON process should be allowed to sunset in 2016 as planned, were united in their opposition to exceptional carve outs from the CON process without clear benefit to the citizens of New Hampshire and with testimony to the resulting significant negative impact to current providers. MK

COMMITTEE VOTE: 9-5

RESPECTFULLY SUBMITTED,

- Copy to Committee Bill File
- Use Another Report for Minority Report

Rep. _____
For the Committee

Rev. 02/01/07 - Yellow

REGULAR CALENDAR

March 4, 2015

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Minority of the Committee on HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS to which was referred HB389-FN,

AN ACT repealing the certificate of need moratorium.

Having considered the same, and being unable to agree with the Majority, report with the recommendation that the bill OUGHT TO PASS.

Rep. Stephen J. Schmidt

FOR THE MINORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MINORITY
COMMITTEE REPORT

Committee:	**HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS**
Bill Number:	**HB389-FN**
Title:	**repealing the certificate of need moratorium.**
Date:	**February 18, 2015**
Consent Calendar:	**NO**
Recommendation:	**OUGHT TO PASS**

STATEMENT OF INTENT

The minority believes that the existing moratorium of new certificates of need for nursing home, skilled nursing facilities, intermediate care facilities or rehabilitation facilities through the period of June 30, 2016 is not in the best interest of New Hampshire. This bill simply ends the moratorium one year early on June 30, 2015, which will allow the consideration of new certificates of need to be issued upon review of the "Certificate of Need Board".

Rep. Stephen J. Schmidt
FOR THE MINORITY

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

HB389-FN, repealing the certificate of need moratorium. **OUGHT TO PASS.**

Rep. Stephen J. Schmidt for the **Minority** of HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS. The minority believes that the existing moratorium of new certificates of need for nursing home, skilled nursing facilities, intermediate care facilities or rehabilitation facilities through the period of June 30, 2016 is not in the best interest of New Hampshire. This bill simply ends the moratorium one year early on June 30, 2015, which will allow the consideration of new certificates of need to be issued upon review of the "Certificate of Need Board".

Original: House Clerk
Cc: Committee Bill File

HB 389-FN repealing the certificate of need moratorium.

The minority believes that the existing moratorium of new certificates of need for nursing home, skilled nursing facilities, intermediate care facilities or rehabilitation facilities through the period of June 30, 2016 is not in the best interest of New Hampshire. This bill simply ends the moratorium one year early on June 30, 2015, which will allow the consideration of new certificates of need to be issued upon review of the "Certificate of Need Board".

Rep. Stephen Schmidt
For the Minority
8-6 OTP RC

OK
SRK

MINORITY REPORT

COMMITTEE: H, HS & EA

BILL NUMBER: 389-FN

TITLE: Repealing the CERTIFICATE of need MORATORIUM

DATE: 2-17-2015 **CONSENT CALENDAR:** YES ☐ NO ☒

☒ **OUGHT TO PASS**

☐ **OUGHT TO PASS W/ AMENDMENT**

☐ **INEXPEDIENT TO LEGISLATE**

Amendment No. _____

☐ **INTERIM STUDY** (Available only 2nd year of biennium)

STATEMENT OF INTENT:

The minority believes that the existing moratorium of new certificates of need for nursing homes, skilled nursing facilities, intermediate care facilities or rehabilitation facilities through the period of June 30, 2016 is not in the best interest of New Hampshire. This bill simply ends the moratorium one year early, on June 30, 2015 which will allow the consideration of new certificates of need to be issued upon ~~reviewing~~ review of the "Certificate of Need Board".

COMMITTEE VOTE: 8 YAY 6 NAY

RESPECTFULLY SUBMITTED,

• Copy to Committee Bill File

Rep. Stephen Shurtleff
For the Minority

Rev. 02/01/07 - Blue

Johnston, Judith

From: Larivee, Kathy
Sent: Wednesday, February 25, 2015 10:10 AM
To: Johnston, Judith
Subject: HB389-FN-Majority.doc
Importance: High

Updated report. The speaker has eliminate the minority report.

REGULAR CALENDAR

March 4, 2015

HOUSE OF REPRESENTATIVES
REPORT OF COMMITTEE

The Committee on HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS to which was referred HB389-FN,

AN ACT repealing the certificate of need moratorium. Having considered the same, report the same with the following Resolution: RESOLVED, That it is INEXPEDIENT TO LEGISLATE.

Rep. Thomas M. Sherman
FOR THE COMMITTEE

COMMITTEE REPORT

Committee:	**HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS**
Bill Number:	**HB389-FN**
Title:	**repealing the certificate of need moratorium.**
Date:	**February 18, 2015**
Consent Calendar:	**NO**
Recommendation:	**INEXPEDIENT TO LEGISLATE**

STATEMENT OF INTENT

This bill carves out the nursing home, skilled nursing facility, intermediate care facility and rehabilitation facility industry for a moratorium on the certificate of need statute restrictions. The majority of the committee, while divided on whether the CON process should be allowed to sunset in 2016 as planned, were united in their opposition to exceptional carve outs from the CON process without clear benefit to the citizens of New Hampshire and with testimony to the resulting significant negative impact to current providers.

Vote 9-5

Rep. Thomas M. Sherman
FOR THE COMMITTEE

REGULAR CALENDAR

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

HB389-FN, repealing the certificate of need moratorium. **INEXPEDIENT TO LEGISLATE.** Rep. Thomas M. Sherman for HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS. This bill carves out the nursing home, skilled nursing facility, intermediate care facility and rehabilitation facility industry for a moratorium on the certificate of need statute restrictions. The majority of the committee, while divided on whether the CON process should be allowed to sunset in 2016 as planned, were united in their opposition to exceptional carve outs from the CON process without clear benefit to the citizens of New Hampshire and with testimony to the resulting significant negative impact to current providers. **Vote 9-5.**