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IS THE COMMUNITY HEALTH NEEDS ASSESSMENT REPLACING THE CERTIFICATE OF NEED?

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ABSTRACT

The purpose of this paper is to question the need for Certificates of Need at the state level. At the Federal level the Affordable Care Act requires hospitals must justify their community impact through a Community Health Needs Assessment (IRS Form 990 Schedule H) in order to retain their tax-exempt status. Not-for-profit hospitals will save money, time and personnel resources if the CON is combined with the CHNA and all states accept this change, no longer requiring the CON.

I. INTRODUCTION

The healthcare industry continues to face increasing regulatory oversight. The Affordable Care Act (P.L. 1110148, 124 Stat. 199) imposes significant filing and reporting requirements for tax-exempt hospitals, heavily focusing on documenting the organization's impact on the community (Internal Revenue Service, 2009). More specifically, the Congressional mandates of the Affordable Care Act require hospitals to do a community health needs assessment (CHNA). According to the American Hospital Association's 2013 edition of *Hospital Statistics*, over 58 percent of all community hospitals are not-for-profit (American Hospital Association, 2013). Therefore, these regulatory changes have the potential to impact a wide assortment of healthcare providers.

While this new Federal law attempts to address the types and levels of activities that provide benefit to the community, the regulatory environment at the state level appears to be at a crossroads. More specifically, state certificate of need (CON) regulatory oversight is declining. This paper seeks to question whether new Federal regulations focusing on community health needs assessments may be catalysts to end certificate of need laws, and whether CON laws are sustainable in today's economic environment.

The purpose of this paper is to discuss the community health needs assessment regulations and the current status of CON legislation. Some in the healthcare industry argue that the community health needs assessment rules can be used to replace CON laws. We will attempt to address this argument by fully discussing the development of CON and the current trends at the state level. We argue the underlying purposes of both CHNA and CON regulations are cost containment and the provision of quality care.

II. CERTIFICATE OF NEEDS REGULATIONS

According to Smith and Forgione (2009) " CON legislation began as an effort to build hospitals in needy areas, while at the same time control health care costs by requiring states to review capital expenditures exceeding certain dollar amount thresholds" (pg. 35). The Hill-Burton Act of 1946 was the catalyst to spur hospital construction and promote charity care to wide areas of the country. Many argue the Hill-Burton Act created a 'community service obligation', where hospitals were expected to provide services to individuals within the hospital's surrounding community (Smith & Forgione, 2009; Havighurst, 1973). According to McGinley (1995), Congress had three goals when enacting CON legislation as follows:

- Restrain skyrocketing healthcare cost
- Prevent the unnecessary duplication of health resources
- Achieve equal access to quality healthcare at a reasonable cost

The intersection of aligning public need with healthcare services through government regulation is common. For example, Section 1122 of the Social Security Act required review of healthcare capital expenditures, in order to justify alignment with states' health plans (U.S.C; McGinley 1995). Furthermore, Health Systems Agencies (HSAs) were often created at the state level to assess the needs of the area served by hospitals (U.S. Congress, Congressional Budget Office, 1982). The National Health Planning and Resource Development Act of 1974, and its related amendments focused on providing quality care to the underserved and emphasized a coordination of services among institutions (Smith & Forgione, 2009).

Despite its creation at the Federal level, states began legislating hospital construction in the 1960s. For example, New York implemented the Metcalf-McCloskey Act of 1964, in order to determine the exact needs of the community prior to hospital construction (Metcalf-McCloskey Act of 1964). Four other states also developed CON laws in the late 1960s (Maryland, Rhode Island, California and Connecticut). Under CON, hospitals were required to justify any expansions through identifying actual demand (Cordato, 2005). The overall goal of CON was to 'control costs by preventing duplication of services' (Smith & Forgione, 2009).

Smith and Forgione (2009) provide an overview of the legislative history of CON laws. Congress repealed legislation mandating state CON laws in 1987, so it was left up to individual states to either continue or adjust specific CON regulations. Since then, fourteen states have completely repealed their CON mandates. As seen in Table 1, many of the states with existing CON laws are reducing the number of regulated services. The American Health Planning Association supports the continued use of CON regulations, believing that CON programs promote competition while keeping costs low. The AHPA also argues CON laws have a valuable impact on quality of care and are a valuable resource for policy makers because they distribute programs to underserved areas (American Health Planning Association, 2011).

Table 1
CON Regulated Services by State

State	Number of Regulated Services 2008*	Number of Regulated Services 2011 **	% Change
Alabama	24	20	-17%
Alaska	28	19	-32%
Arkansas	8	6	-25%
Connecticut	28	17	-39%
Delaware	9	8	-11%
District of Columbia	24	28	17%
Florida	12	11	-8%
Georgia	26	17	-35%
Hawaii	26	27	4%
Illinois	19	15	-21%
Iowa	8	9	13%
Kentucky	21	18	-14%
Louisiana	2	3	50%
Maine	25	24	-4%
Maryland	20	16	-20%
Massachusetts	18	14	-22%
Michigan	20	18	-10%
Mississippi	19	18	-5%
Missouri	17	14	-18%
Montana	7	7	0%
Nebraska	2	2	0%
Nevada	10	4	-60%
New Hampshire	16	13	-19%
New Jersey	13	12	-8%
New York	27	18	-33%
North Carolina	28	25	-11%
Ohio	2	1	-50%
Oklahoma	7	4	-43%
Oregon	1	4	300%
Rhode Island	20	20	0%
South Carolina	21	20	-5%
Tennessee	22	20	-9%
Vermont	26	30	15%
Virginia	22	19	-14%
Washington	16	17	6%
West Virginia	27	21	-22%
Wisconsin	4	3	-25%

* National Conference of State Legislatures; Smith & Forgione 2009
** AHPA. 2011 http://www.ahpanet.org/matrix_copn.html

Critics of CON regulations argue, despite its original intentions, the laws have failed to control healthcare costs. Empirical research has shown various effects of CON regulations on hospital costs, often finding the programs did not significantly influence hospital expenditures (Conover & Sloan, 1998; Lanning, Morrisey, & Ohsfeldt, 2009; Mendelson & Arnold, 1993). More recent research supports the critics of CON laws. For example, Rivers *et al*. (2007, page 241) empirically determine CON's "policy initiative had not achieved its stated objectives" based on a

significant increase in hospital cost per adjusted admission (Rivers, Fottler & Younis, 2007). Lanning, Morrisey, & Ohsfeldt (2009) find hospital pricing actually increased under CON laws due to restraining competition (Lanning, Morrisey, & Ohsfeldt, 2009). Mendelson & Arnold (1993). also document the ineffectiveness of CON legislation in states where the program was abolished, citing an actual decrease in spending when the legislation was eliminated. These empirical findings appear to warrant support for deregulation on CON laws (Rivers, Fottler & Younis, 2007; Campbell & Fournier, 2003).

It is evident that the intent of CON regulations was to ensure quality healthcare is provided to those in need. Despite the repeal of CON regulations at the Federal level, states continue to seek ways to ensure healthcare is provided to those served. The continued focus on providing care to the needy at the Federal level is evident through the enactment of the Affordable Care Act. More specifically, requiring community health needs assessments is one of the major aspects of the law that focusing on serving a common good.

III. COMMUNITY HEALTH NEEDS ASSESMENT

The overarching themes of 'providing for the community' and 'serving a common good' are consistent for legislators when developing laws for nonprofit hospitals. Since the concept of tax-exempt status for organizations providing charitable benefit to the community came into law, lawmakers and practitioners continue to struggle with not only how to define charity care but how much charity care is necessary to maintain federal tax-exemption. As a result, tax-exempt hospitals face continuous scrutiny on the level of charity care provided, in order to justify their tax-exempt status. Regulatory oversight of community benefits within the nonprofit healthcare sector is vast – including the 2006 Internal Revenue Service (IRS) Hospital Compliance Project and the Affordable Care Act of 2010 (Internal Revenue Service, 2009). The IRS Hospital Compliance Project focused on how tax-exempt hospitals provide for the community. The provision of community benefits necessary for tax-exempt status culminated with the ACA's mandate for community health needs assessments.

Newly created Internal Revenue Code (IRC) § 501(r) mandates hospitals, in order to remain tax-exempt, must justify their community impact. CHNAs are disclosed as part of the IRS Form 990, Schedule H. CHNAs were created through IRC §501(r)(3)(B), mandating the CHNAs account for the health needs of the community served by the hospital. These provisions are not clearly defined in the tax law, but can be viewed as a process for identifying an opportunity for improvement in health care service (Griffith, 2011; Smith & Noe, 2012). Hospitals must conduct a community health needs assessment at least once every three taxable years, and must adopt an implementation strategy to meet the community health needs identified through the assessment. When developing such a strategy, the hospital must take into consideration input from individuals who represent the broad interests of its service area, especially those with specialized knowledge in the health field.

The definition of the community served by the hospital is flexible, allowing a hospital to focus on target demographics, such as women or children, or geographic area, as long as it does not exclude populations medically underserved, low-income persons, minority groups, or others with chronic disease needs. The hospital must also show how it considered the opinions of surveyed individuals who represent the broad interests of their community. This documentation should describe when and how the organization met with these individuals, such as a public meeting or individual interview, make note of any person with specialized knowledge or expertise, and the role of individuals considered leaders or representative of the community (Campbell, Smith & Hostetler, 2013).

Griffith 2011 argues CHNAs are a process for identifying opportunity for improvement in any are of health care services that would provide a benefit to the community. This may include improving access, controlling costs, or maintaining or improving the quality of healthcare services. He argues that reporting on community needs is related to the foundation of CON laws. Specifically, he states:

> "Although state certificate of need laws often require an advance demonstration of need, those requirements tend to be limited to the specific facility, equipment or service for which the certificate of need is sought. The development of community health standards on which the certificate of need rules are based, however, are intended to take into account projections of community need and changes in population and demographics." Griffith (2011), page 6.

Smith and Noe (2012), document the required components of a CHNA, including descriptions of the community served by the facility, and which community health needs have been identified as a priority. The institution is also required to disclose any health care needs that are not being addressed, and why those needs are not being addressed.

IV. CONCLUSION

CHNAs by their very nature demographically identify underserved population groups in the community served by a hospital; therefore, it is highly likely that the certificate of need will identify the same underserved population groups, which is one of the goals of the CON laws. Duplicating conclusions drawn from the data gathered for the CHNA and the CON is inevitable therefore negating one purpose of the CON (to prevent the unnecessary duplication of health services). Two additional drawbacks of states requiring a CON while the IRS requires a CHNA are the increased cost of having to provide both a CON and a CHNA without the equivalent increase in quality of care or access to care for the community served by the hospital.

In conclusion, it appears that not-for-profit hospitals already burdened by the demands of increasing regulatory oversight with the passage of the Affordable Care Act would benefit from not having to also submit a CON when requesting state funding to enable the hospital to more adequately serve the community.

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