Professional Home Health Care Agency, Inc.
4934 South Laurel Road · London, KY 40744 · (606) 864-0724 · Fax (606) 864-5256

CITATIONS OF DEFICIENCIES

2221 JACKSBORO PIKE
SUITE A-9
LAFOLLETTE, TENNESSEE 37766
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1829 SOUTH MAIN
CORBIN, KY 40701
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1957 SOUTH US HWY 25E
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141 PROSPEROUS PLACE
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KRS 13A.030 Duties of subcommittee

(2) The subcommittee may make a determination:

(a) That an effective administrative regulation or an administrative regulation filed with the Commission is deficient because it:

7. Appears to impose an unreasonable burden on government or small business, or both;

11. Appears to be deficient in any other manner
- Regulation has been a moving target – Lack of Due Process
- Policy centered – Not Patient Centered

KRS 216B.010 Legislative findings and purposes.

1. The General Assembly finds that the licensure of health facilities and health services is a means to insure that the citizens of this Commonwealth will have safe, adequate, and efficient medical care; that the proliferation of unnecessary health-care facilities, health services, and major medical equipment results in costly duplication and underuse of such facilities, services, and equipment; and that such proliferation increases the cost of quality health care within the Commonwealth. Therefore, it is the purpose of this chapter to fully authorize and empower the Cabinet for Health and Family Services to perform any certificate-of-need function and other statutory functions necessary to improve the quality and increase access to health-care facilities, services, and providers, and to create a cost-efficient health-care delivery system for the citizens of the Commonwealth.

PROLIFERATION=Rapid increase in numbers, large number of something

KRS 13A.250 Consideration of costs to local and state government and

regulated entities -- Fiscal note. (Effective until March 15, 2024) (1) An administrative body that promulgates an administrative regulation shall consider the cost that the administrative regulation may cause state or local government and regulated entities to incur.

2 (C) The second part of the cost analysis shall include the projected cost or cost savings to the regulated entities affected by the administrative regulation.

Page 9, (5) of fiscal report. Pursuant to **KRS 13A.010 (13),** The new administrative Regulation is not expected to have a major economic impact on related entities.

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Kentucky State Health Plan

Violates SHP definition of Expansion

To expand a "Home Health Service" means to add to the applicant's existing service area, a Kentucky County or Counties that are contiguous to the applicant's existing service area if the expansion does not involve the establishment of a parent home health agency or sub-unit as defined by Medicare.

Special Legislation in violation of the Kentucky Constitution.

a. This special legislation only benefits hospitals and nursing homes, to the detriment of small businesses and health departments.

<u>902 KAR 20:081 3 (3) & (9)</u>

b. (3) 3 Home health services shall be available to the total population regardless of age, sex, and ethnic background. (NOT JUST DISCHARGED PATIENTS)
c. (9) Planning. Each agency shall develop and annually review a long-range plan which includes:
   a. Assessment of needs for services in the service area of agency (No geographic boundaries);
   b. Identification of agency's role in meeting those needs;
   c. Staff expansion for a two (2) year period;
   d. Establishment of goals and objectives; and
   e. Coordination of volunteer services, community education, and community development activities if these services are provided by the agency.

(How can they assess the service when they are only seeing discharged patients with no geographic boundaries)

<u>Task Force Memorandum</u> – See Attached
Recommendation – The task force recommends that further study may provide additional information to guide statutory and regulatory changes in Kentucky's certificate of need program.

<u>Ascendient study</u> (commissioned by Baptist Health) to retain CON – See Attached.

DEFICIENCY RATIONALE 900 KAR 6:075 Section 2 (3) (h) (5) (i)

Conflict with Existing Statutes - KRS 13A.30 (2) (a)(2)

1. **Contravention 902 KAR 20:081 3 (3) & (9)**
   a. (3) 3 Home health services shall be available to the total population regardless of age, sex, and ethnic background. **(NOT JUST DISCHARGED PATIENTS)**
   b. (9) Planning. Each agency shall develop and annually review a long-range plan which includes:
      a. Assessment of needs for services in the service area of agency (**No geographic boundaries**);
      b. Identification of agency's role in meeting those needs;
      c. Staff expansion for a two (2) year period;
      d. Establishment of goals and objectives; and
      e. Coordination of volunteer services, community education, and community development activities if these services are provided by the agency.

   (How can they assess the service when they are only seeing discharged patients)

2. **Contravention KRS 216B.010**
   a. The General Assembly finds that the licensure of health facilities and health services is a means to insure that the citizens of this Commonwealth will have safe, adequate, and efficient medical care; that the proliferation of unnecessary health-care facilities, health services, and major medical equipment results in costly duplication and underuse of such facilities, services, and equipment; and that such proliferation increases the cost of quality health care within the Commonwealth. Therefore, it is the purpose of this chapter to fully authorize and empower the Cabinet for Health and Family Services to perform any certificate-of-need function and other statutory functions necessary to improve the quality and increase access to health-care facilities, services, and providers, and to create a cost-efficient health-care delivery system for the citizens of the Commonwealth.
   b. To our knowledge, no data/analysis has been provided by the Cabinet to support this need. In fact, the data provided by the OIG's needs analysis purports the opposite result.

3. **Contravention KRS 13A.010 (13)**
   a. (13) "Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars ($500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies;

b. Includes: (No analysis completed, deficiency in the statement of consideration, no explanation given to comments from regulated entities)

    i. Cabinet adding staff and processes to facilitate oversight
    ii. A new process for licensing would have to be created. Currently, there is no differentiation available, either an entity is licensed to operate in a given county, proposed language would allow open access for hospital's discharged patients. E.g. a Knox county citizen that receives inpatient medical care in Fayette County, could be serviced by that same hospital entity for home health in Knox County – NO GEOGRAPHIC BOUNDARIES FOR HOSPITALS ONLY
    iii. Loss of revenue in aggregate to small businesses and health departments - STATEWIDE
    iv. Loss of Staff, additional recruitment costs for small businesses and health departments – STATEWIDE. KHA has noted that their own vacancy rate is currently 15%, without adding additional services.

4. **Special Legislation in violation of the Kentucky Constitution.**

    a. This special legislation only benefits hospitals and nursing homes, to the detriment of small businesses and health departments.

Unreasonable burden on small business and deficient in other manners - KRS 13A.30 (2) (a) (7 & 11)

5. The broad Proposed language amounts to The Cabinet allowing Hospitals and Nursing Homes to **monopolize** this healthcare segment with no oversight.

    a. This language relinquishes the management and oversight of home health care for hospitalized patients to the hospitals themselves, effectively deeming them a quasi-governmental agency, as statutes and regulations dictate that management and oversight is to be performed by the Cabinet. Further, the language does not impose a duty on the hospitals to provide transparency but gives them arbitrary choice as to where to place patients.

    b. Silo/Cherry picking
        i. Low-complexity cases
        ii. Yield profitability
        iii. New revenue stream for Nursing Homes

    c. The cost/personnel needed (whether it be formal or non-sub) will create the same amount of expense.

    d. No Established Guidelines for complaint/resolution (to include reimbursement to injured party) to protect small businesses and health Departments.

i. Does the Cabinet have the current resources? Upon information and belief, this could very well be an additional expense not addressed in the original proposal.

6. Unfortunately, the public hearing on this matter was canceled and never rescheduled.

7. We respectfully submit that the responses to regulated entities were vague and incomplete, and therefore deficient. Specifically, the following rationale submitted via the Regulatory Impact Analysis, Fiscal Note, and statement of Consideration is severely lacking supporting data. (specific examples have been cited)

a. Regulatory Impact Analysis (2) (b)

"2 (b) The necessity of the amendment to this administrative regulation:
This amendment is being proposed pursuant to KRS 216B.095(3)(f), which permits the cabinet to grant nonsubstantive review status to a certificate of need application in accordance with circumstances prescribed by the cabinet via administrative regulation. These changes were requested by providers to allow them to add needed health care services more quickly and efficiently in response to their patient's changing needs. This amendment is needed to expand access to health services throughout the state, including in rural areas, to enhance immediate access to resources."

b. Regulatory Impact Analysis (5) (a & b)

"(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:
(a) Initially:
There are no additional costs to the Office of Inspector General for implementation of this amendment.
(b) On a continuing basis:
There are no additional costs to the Office of Inspector General for implementation of this amendment on a continuing basis."

c. Fiscal Note (4)

"(4) Estimate the effect of this administrative regulation on the expenditures and cost savings of regulated entities for the first full year the administrative regulation is to be in effect.
(a) How much cost savings will this administrative regulation generate for the regulated entities for the first year?
This administrative regulation will not generate cost savings for regulated entities during the first year.

(b) How much cost savings will this administrative regulation generate for the regulated entities for subsequent years?
This administrative regulation will not generate cost savings for regulated entities during subsequent years.
(c) How much will it cost the regulated entities for the first year?
This administrative regulation imposes no additional costs on regulated entities.
(d) How much will it cost the regulated entities for subsequent years?
This administrative regulation imposes no additional costs on regulated entities during subsequent years."

d. Fiscal Note (5)

"(5) Explain whether this administrative regulation will have a major economic impact, as defined below.
"Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars ($500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies. [KRS 13A.010(13)] This administrative regulation is not expected to have a major economic impact on the regulated entities."

***** During the comment period, Whitley County Health Department stated that they alone will lose $1.1 million dollars annually. Bear in mind, this one provider in one of the 120 counties.**

8. No data supports this change

a. Refer to the State Home Health Need Survey
    i. A need methodology is included in the State Health Plan and incorporated by reference. It also recognizes that a small numerical need number can be addressed by existing agencies adding additional staff.
b. Refer to targeted Needs analysis
    i. 61 of the 120 Kentucky Counties have a net need of 0 or less
    ii. Only 20 of the remaining 59 counties qualify for the CON application.
    iii. In those 20 counties, only 3 currently do not have Hospital based Home Health
        1. Edmundson County
        2. Owen County
        3. Green County
        4. If hospital-based home health is the solution, why are there 17 counties (that have this service available), still have a huge need.
c. No Nursing Home has ever applied in the state of Kentucky for a CON to provide home health services.

HARM TO SMALL BUSINESSES AND HEALTH DEPARTMENTS

1. The CON law is critical to supporting a more level playing field among providers, especially those serving more vulnerable communities in making sure that the services needed are available.

2. The current structure allows for diversity and competition in providing that care.

3. KHA hired an expert in August 2023 that confirmed the benefits of a CON (see attached).

4. The broad, proposed language will erode the revenue and infrastructure of small businesses and health departments until the end result will be annihilation.

In conclusion, there are multiple deficiencies in this proposal. There is substantial due diligence still needed.

2022 Home Health Need

County	2022 Home Health Need by Age Cohorts						TOTAL	Avg. '20-'21 Patients Served	Net Need
	0-14	15-44	45-64	65-74	75-84	85+			
Adair	1	18	110	151	163	111	555	940	(384)
Allen	2	19	123	159	174	93	570	561	10
Anderson	2	23	150	170	175	113	633	894	(261)
Ballard	1	7	45	66	76	55	250	235	15
Barren	4	42	257	327	361	263	1,253	1,361	(108)
Bath	1	12	75	92	95	67	342	451	(109)
Bell	2	21	138	193	209	140	704	1,225	(520)
Boone	13	139	793	873	863	549	3,230	2,681	550
Bourbon	2	18	119	158	182	142	620	528	92
Boyd	4	44	280	393	440	309	1,470	1,534	(63)
Boyle	2	31	167	233	272	230	934	1,037	(103)
Bracken	1	8	51	66	62	36	223	248	(24)
Breathitt	1	12	86	111	101	55	367	312	55
Breckinridge	2	18	123	176	179	106	603	587	16
Bullitt	6	82	512	602	633	353	2,188	1,618	571
Butler	1	11	72	97	107	67	355	361	(6)
Caldwell	1	11	71	106	117	95	401	379	22
Calloway	3	43	186	264	301	205	1,002	983	19
Campbell	7	97	523	683	640	484	2,434	1,884	550
Carlisle	0	4	27	37	48	37	154	151	3
Carroll	1	10	60	72	72	55	271	298	(27)
Carter	2	24	153	212	240	144	775	815	(40)
Casey	1	14	90	131	150	97	483	655	(172)
Christian	8	88	265	359	422	333	1,475	1,803	(327)
Clark	3	35	220	281	302	207	1,047	927	120
Clay	2	21	120	139	134	75	491	761	(269)
Clinton	1	8	55	75	88	46	273	655	(382)
Crittenden	1	8	52	75	90	52	278	201	77
Cumberland	1	5	36	55	61	39	196	383	(187)
Daviess	9	101	564	741	791	617	2,824	2,755	69
Edmonson	1	11	75	105	119	75	386	257	129
Elliott	0	7	43	60	70	47	227	137	90
Estill	1	13	88	113	128	58	401	447	(46)
Fayette	27	389	1,634	2,001	1,971	1,445	7,467	6,273	1,194
Fleming	1	14	88	116	126	66	413	404	9
Floyd	3	32	210	295	291	164	994	855	139
Franklin	4	51	300	406	415	277	1,452	1,016	436
Fulton	0	6	35	57	61	36	196	313	(116)
Gallatin	1	7	54	59	54	23	197	124	73
Garrard	1	15	110	137	138	95	496	535	(38)
Grant	2	25	141	154	165	81	569	619	(50)
Graves	3	33	204	282	313	218	1,053	1,231	(178)
Grayson	2	25	152	206	214	114	713	1,031	(317)
Green	1	31	208	308	354	241	1,143	615	528

Yellow: An Established Home Health Agency can Expand to this County.
Green: New Home Health Agency can be Established in this County.

2022 Home Health Need

County	2022 Home Health Need by Age Cohorts 0-14	15-44	45-64	65-74	75-84	85+	TOTAL	Avg. '20-'21 Patients Served	Net Need
Greenup	3	31	208	308	354	241	1,145	1,301	(156)
Hancock	1	8	53	66	77	45	250	195	55
Hardin	11	116	613	711	719	496	2,665	3,143	(478)
Harlan	1	18	109	157	176	116	578	651	(73)
Harrison	2	17	114	142	145	102	522	447	76
Hart	2	18	115	140	143	90	508	629	(121)
Henderson	4	42	254	350	365	250	1,264	1,254	10
Henry	1	14	94	124	122	71	427	544	(117)
Hickman	0	4	27	42	56	47	177	192	(15)
Hopkins	4	30	257	358	379	253	1,281	1,444	(162)
Jackson	1	12	79	104	102	51	348	376	(28)
Jefferson	68	813	4,282	5,630	5,567	4,333	20,693	20,760	(66)
Jessamine	5	54	305	366	367	305	1,402	1,211	191
Johnson	2	21	134	181	192	104	633	434	199
Kenton	15	177	935	1,146	1,067	740	4,080	3,460	621
Knott	1	12	86	121	120	69	409	238	171
Knox	3	29	168	210	254	151	815	945	(130)
Larue	1	14	88	111	118	83	417	360	57
Laurel	5	61	368	454	472	283	1,643	1,583	60
Lawrence	1	15	97	131	126	68	438	455	(17)
Lee	0	7	46	59	52	28	194	114	80
Leslie	1	9	64	84	84	55	298	277	21
Letcher	2	18	126	189	183	98	616	585	31
Lewis	1	12	79	106	109	71	378	375	3
Lincoln	2	21	143	187	208	136	696	892	(195)
Livingston	1	7	56	81	94	54	293	293	(0)
Logan	2	25	156	207	240	157	788	799	(11)
Lyon	0	8	55	93	103	68	328	239	89
Madison	7	111	482	577	585	388	2,150	1,897	254
Magoffin	1	10	71	94	91	50	317	216	101
Marion	2	18	114	140	144	121	539	489	50
Marshall	2	14	190	281	327	211	1,025	1,114	(89)
Martin	1	12	62	85	77	58	295	216	79
Mason	1	15	99	137	138	83	474	519	(45)
McCracken	5	63	379	558	622	494	2,121	1,990	132
McCreary	1	17	93	114	126	62	413	495	(82)
McLean	1	8	53	73	85	56	276	314	(38)
Meade	2	30	184	205	195	112	729	594	136
Menifee	0	5	41	56	57	35	195	229	(33)
Mercer	2	20	141	180	196	122	661	721	(60)
Metcalfe	1	9	60	81	94	62	307	350	(43)
Monroe	1	10	68	89	105	52	325	581	(256)
Montgomery	3	19	134	150	165	104	575	1,068	(493)
Morgan	1	9	84	106	97	67	363	244	120
Muhlenberg	2	29	176	241	282	187	918	919	(1)

Yellow: An Established Home Health Agency can Expand to this County.
Green: New Home Health Agency can be Established in this County.

2022 Home Health Need

County	2022 Home Health Need by Age Cohorts						TOTAL	Avg. '20-'21 Patients Served	Net Need
	0-14	15-44	45-64	65-74	75-84	85+			
Nelson	4	45	276	352	330	208	1,216	1,429	(213)
Nicholas	1	7	46	54	56	36	199	207	(7)
Ohio	2	22	134	179	196	129	662	653	9
Oldham	6	69	419	422	414	242	1,571	1,167	404
Owen	1	10	70	97	95	52	324	186	138
Owsley	0	3	23	32	36	25	120	87	34
Pendleton	1	6	92	109	103	68	380	345	35
Perry	2	26	169	222	209	122	750	540	211
Pike	5	52	350	489	486	308	1,690	1,426	264
Powell	1	13	76	96	90	45	322	404	(82)
Pulaski	5	60	389	525	573	324	1,876	2,078	(201)
Robertson	0	2	14	18	24	21	78	50	29
Rockcastle	1	14	101	128	139	78	462	449	13
Rowan	2	31	115	146	167	105	566	655	(89)
Russell	2	15	109	153	160	117	556	655	(99)
Scott	6	64	331	341	311	178	1,231	1,107	124
Shelby	5	49	296	348	346	124	1,167	1,201	(34)
Simpson	2	19	115	142	151	88	517	538	(21)
Spencer	2	18	135	142	120	71	488	554	(65)
Taylor	2	26	136	193	219	145	722	1,193	(471)
Todd	1	11	68	83	91	62	315	309	6
Trigg	1	11	87	135	154	83	470	520	(49)
Trimble	1	7	54	66	70	40	238	223	16
Union	1	15	75	110	94	62	358	371	(13)
Warren	11	165	668	776	789	555	2,964	3,179	(215)
Washington	1	11	73	91	101	79	355	344	11
Wayne	1	17	115	174	201	119	628	590	38
Webster	1	12	74	100	100	70	357	366	(9)
Whitley	4	37	189	239	270	160	898	916	(18)
Wolfe	1	6	39	54	58	33	191	163	28
Woodford	2	24	161	234	236	146	803	726	77
State Totals	381	4,514	25,404	32,675	33,739	22,839	119,551	118,831	721

Statewide Rates					
0-14	15-44	45-64	65-74	75-84	85+
0.45	2.60	22.10	68.68	137.80	266.92

* Numbers shown are rounded to the nearest whole number, while formulas within the cells are calculated with the unrounded number. This may make it appear that a Net Need number is off by one.

** Net Need has been adjusted to reflect CON approval to Establish (-250) or Expand (-125) Home Health Services in a county if the approved agency did not serve patients in the approved county as reported in the latest publication of the Kentucky Annual Home Health

61 KY Counties w/ Net Need ≤ 0

Yellow: An Established Home Health Agency can Expand to this County.
Green: New Home Health Agency can be Established in this County.

ADD	County	Total Admissions	Hospital Based HHA Admits	Hospital Based HHA Admit %	Non Hospital Based HHA Admits	Non Hospital Based HHA Admit %	Included in Hospital Based HHA Admits
1	MCCRACKEN	2054	1998	97%	56	3%	Baptist Health Home Care Louisville, Mercy Health - Home Care **(NET NEED 132)**
4	EDMONSON	245	0	0%	245	100%	N/A **(NET NEED 129)**
5	MEADE	483	191	40%	292	60%	Baptist Health Home Care Breckinridge, VNA Health At Home (Louisville) **(NET NEED 136)**
6	BULLITT	1204	808	67%	396	33%	Baptist Health Home Care Louisville, Norton Home Health, VNA Health At Home Louisville **(NET NEED 571)**
6	OLDHAM	1146	565	49%	581	51%	Baptist Health Home Care Louisville, Norton Home Health, VNA Health At Home Louisville **(NET NEED 404)**
7	BOONE	2642	1287	49%	1355	51%	St Elizabeth Home Care **(NET NEED 550)**
7	CAMPBELL	1947	889	46%	1058	54%	St Elizabeth Home Care **(NET NEED 550)**
7	KENTON	3260	1706	52%	1554	48%	St Elizabeth Home Care **(NET NEED 621)**
7	OWEN	171	0	0%	171	100%	N/A **(NET NEED 138)**
11	FLOYD	815	438	54%	377	46%	Highlands ARH Home Health **(NET NEED 139)**
11	JOHNSON	384	116	30%	268	70%	Highlands ARH Home Health, Three Rivers Home Care **(NET NEED 199)**
11	PIKE	1387	515	37%	872	63%	ARH Pike County HHA **(NET NEED 264)**
12	KNOTT	184	184	100%	0	0%	Hazard ARH HHA, Whitesburg ARH HHA **(NET NEED 171)**
12	PERRY	465	465	100%	0	0%	Hazard ARH HHA, Mary Breckinridger ARH HHA **(NET NEED 211)**
14	GREEN	501	0	0%	501	100%	N/A **(NET NEED 528)**
15	FAYETTE	5969	2179	37%	3790	63%	Baptist Health Home Care Lexington, VNA Health At Home (Lexington) **(NET NEED 1194)**
15	FRANKLIN	857	236	28%	621	72%	Baptist Health Home Care Lexington, VNA Health At Home (Lexington) **(NET NEED 436)**
15	JESSAMINE	1107	432	39%	675	61%	Baptist Health Home Care Lexington, VNA Health At Home (Lexington) **(NET NEED 191)**
15	MADISON	1731	642	37%	1089	63%	Baptist Health Home Care Lexington, VNA Health At Home (Lexington) **(NET NEED 254)**
15	SCOTT	1012	229	23%	783	77%	Baptist Health Home Care Lexington, VNA Health At Home (Lexington) **(NET NEED 124)**

New Home Health Agency Can be Established in this County (green)
An Established Home Health Agency Can Expand to this County (orange)

Information From "2022 Home Health Need by Age Cohorts"

MEMORANDUM

To: Robert Stivers, President of the Senate
David Osborne, Speaker of the House
Members of the Legislative Research Commission

From: Senator Donald Douglas, Co-Chair
Representative Russell Webber, Co-Chair

Subject: Findings and Recommendations of the Certificate of Need Task Force

Date: December 14, 2023

In a memorandum dated April 26, 2023, the Legislative Research Commission (LRC) established the Certificate of Need Task Force and directed it to:

1. Review Kentucky's certificate of need program, including the state health plan and related statutes.
2. Review the need for maintaining or modifying certificate of need for each health service currently covered.
3. Submit findings and recommendations regarding certificate of need to the LRC for referral to appropriate committee of jurisdiction.

The April 26, 2023, memorandum references 2023 RS SCR 165 and 2023 RS HCR 85.

The ten-member task force began meeting in June 2023 and convened seven times during the 2023 Interim. The task force heard testimony from several individual stakeholders and agencies and received numerous written public comments.

In accordance with the April 26, 2023, memorandum, the task force submits the following finding and recommendation to LRC for consideration and referral to the appropriate committee or committees. The recommendation is based on the testimony and information provided to the task force during the 2023 Interim. The finding does not include independent research by LRC staff. This memorandum serves as the final work product of the task force.

Finding:
There are two general positions on Kentucky's existing certificate of need requirements.

- One position is that certificate of need laws limit competition by protecting incumbent providers and creating a burdensome approval process for establishing new or expanding health services and facilities, and that there is little evidence that certificate of need laws control costs, improve quality, or ensure access to healthcare.
- A second position is that healthcare service delivery does not operate in a free market, thus certificate of need laws are necessary to control costs, improve quality, and ensure

access to healthcare for all people in all geographic areas. The existing certificate of need program may be improved with modifications for some healthcare facilities and services.

Recommendation:
The task force recommends that further study may provide additional information to guide statutory and regulatory changes in Kentucky's certificate of need program.

Testimony:
A summary of the testimony provided to the task force during the 2023 Interim is below. Task force meetings may be viewed on LRC YouTube Live and task force materials, including written public comments submitted at the request of the task force co-chairs, are available on the LRC website.

Representatives from National Conference of State Legislatures (NCSL) presented an overview of certificate of need laws in other states.

Certificate of need laws require proposals for healthcare services and facilities to demonstrate to state regulators that there is an unmet need in the geographical area for the proposed service or facility. The intent of certificate of need laws is to control healthcare costs by avoiding unnecessary expansion or duplicative services and ensure access to services in all geographic areas. Several states are reforming or repealing their certificate of need laws.

There is great variation in the healthcare services and facilities that are required to meet certificate of need requirements among the 35 states that have certificate of need laws. For example, according to NCSL, all 35 states include nursing facilities while 14 include home health agencies, 4 include freestanding birthing centers, and 2 include ambulance services.

Representatives from the Office of Inspector General (OIG) presented an overview of Kentucky's certificate of need program.

The certificate of need program was enacted by the Kentucky General Assembly in 1980. KRS Chapter 216B authorizes the Cabinet for Health and Family Services to perform any certificate of need function to improve quality, increase access, create cost efficiency of healthcare facilities and services for the citizens of the Commonwealth.

The definitions and the review criteria for evaluating certificate of need applications are established in KRS 216B.040 and include consistency with the state health plan. The state health plan contains the specific requirements for each healthcare facility and service included. The state health plan is incorporated by reference in 900 KAR 5:020, updated at least annually by the cabinet, and subject to a period for public comments.

The OIG oversees the certificate of need application process and applications are reviewed by administrative hearing officers in accordance with KRS Chapter 13B.

There are two types of reviews of a proposal for a certificate of need under KRS Chapter 216B. A formal review of a proposal requires that the applicant bear the burden of demonstrating the

proposed healthcare service or facility is needed and is consistent with the state health plan. A nonsubstantive review presumes the need for the healthcare service or facility proposed unless that need is rebutted by clear and convincing evidence by an affected party.

Select healthcare facilities and services are exempt from any certificate of need requirement under KRS 216B.020.

Betsy Johnson, president and executive director of Kentucky Association of Health Care Facilities and Tim Veno, president of LeadingAge Kentucky testified that a certificate of need is important for nursing facilities because they do not operate in a free market system. Nursing facilities do not set the price of care or the services they provide. Most residents in Kentucky's nursing facilities are covered by government payors such as Medicare or Medicaid.

Evan Reinhardt, executive director of the Kentucky Home Care Association, testified that home health agencies do not operate in a free market because the rates for most individuals are set by the Medicare or Medicaid. Certificate of need serves as a formal and detailed vetting process for agencies ensuring that agencies are accountable and fraud and abuse is minimized.

David Cook, chief executive officer of Hosparus, testified that a certificate of need for hospice care helps to keep costs low by maintaining a high standard of quality and integrity. A lower quality of hospice care is found in states when the certificate of need laws are removed.

Liz Fowler, Chief Executive Officer, Bluegrass Care Navigators, discussed how certificate of need laws help prevent fraud, abuse, and profiteering in hospice care.

Nancy Galvagni, president of the Kentucky Hospital Association, discussed the context and importance of certificate of need for healthcare access and safety. Medicaid's and Medicare's lack of federal payments to fully pay for the coverage of treatments result in cost shifting by hospitals. Certificate of need laws ensure continuity of care. The removal of the certificate of need laws would result in hospital closures, particularly in rural areas. She presented proposals for reform related to the application and appeals process, flexibility in the use of hospital beds, retention of formal reviews for certain hospital services including diagnostic and therapeutic equipment and procedures, and specific criteria in the state health plan for free-standing birthing centers.

Melissa Fausz, state government affairs director for Americans for Prosperity, testified that there has been more capital investment in healthcare in states that have removed certificate of need. A review of research papers on certificate of need laws showed neutral to negative effects of certificate of need laws on healthcare services. States without certificate of need laws have more hospital beds per capita, including in rural areas, and patient care costs are lower. There are challenges to hospital financial viability but certificate of need laws are not the answer.

Dr. John Garen, professor emeritus of economics at the Bluegrass Institute, University of Kentucky, discussed the harm of anticompetitive certificate of need laws on healthcare services and facilities and evidence that removal of Kentucky's certificate of need laws would have

positive effects on healthcare. Studies have found no clear pattern of greater access to healthcare in the underserved in states with certificate of need.

Sarah Giolando, senior vice president and chief strategy officer, St. Elizabeth Healthcare, testified that certificate of need ensures access to healthcare services and facilities. Kentucky has more hospitals per 100,000 population and over 1.5 times the number of physicians per 1,000 square miles than states with no certificate of need laws. Certificate of need protects rural healthcare access. Two federal courts have cited ensuring access in upholding Kentucky's certificate of need laws.

Mark Guilfoyle, partner at DBL Law, discussed the benefits of access to healthcare provided by certificate of need including lower healthcare costs to payors. He expressed support for the modernization of Kentucky's certificate of need laws and noted St. Elizabeth Healthcare's support for certificate of need applications filed by other providers. The repeal of certificate of need would result in health providers cherry-picking private pay patients from safety net hospitals threatening the survival of providers of Medicare, Medicaid, and indigent care.

Mary Kathryn DeLodder with the Kentucky Birth Coalition, testified that there is a demand for freestanding birthing centers as a delivery option, but the burden of the certificate of need requirement has made it impossible to establish them. She discussed the 2012 denial for a freestanding birth center certificate of need application.

Victoria Burslem, MSN, faculty at the Frontier Nursing University, discussed the birth center feasibility study she developed for the university and recent birth center litigation.

Senator Shelley Funke Frommeyer discussed the need for birthing centers. There are maternity care deserts.

Jaimie Cavanaugh, attorney at the Institute for Justice, testified that certificate of need laws do not prevent rural hospital closures and that there is a lack of evidence that hospitals rely on cost-shifting. She said that certificate of need laws increase healthcare costs and that there are negative consequences of artificially limiting the supply of healthcare. Patients in states with certificate of need laws wait longer and drive farther for healthcare. States with certificate of need laws have fewer hospitals, fewer hospital beds, fewer psychiatric care facilities, fewer dialysis clinics, and fewer medical imaging devices.

Matthew D. Mitchell, Ph.D., senior research fellow and certificate of need coordinator for the Knee Center for the Study of Occupational Regulation, West Virginia University, discussed the anticompetitive features of certificate of need laws and the literature that examines how certificate of need limits healthcare spending, access to care, quality of care, and healthcare for underserved populations.

Representative Marianne Proctor testified that the goals of certificate of need laws are not attained. There are federal groups that support the repeal of certificate of need and several states have repealed their certificate of need laws. She discussed the negative impacts of certificate of

need laws on establishing rural and urban hospitals even though there is a need for more healthcare facilities.

Dr. Mark Schroer testified that repealing certificate of need laws would create greater competition among healthcare providers, allow more data driven health policy, and help address the need for better healthcare in rural areas.

Carol Dwyer, RN, discussed her employment experience as a registered nurse working in hospitals and her personal experiences as a caregiver to her husband and mother and having to deal with multiple hospitals because of certificate of need laws that limit healthcare options.

Russ Ranallo, the chief financial officer of Owensboro Health, discussed the 2007 Pennsylvania Health Care Cost Containment Council study that found negative effects on healthcare after a repeal of certificate of need laws.

Dr. Aaron Crum, the chief marketing officer of Pikeville Regional Medical Center discussed the safeguards provided by the certificate of need laws for maternity care and the need for freestanding birthing centers to meet the same standards required of hospitals for delivery.

Dr. Allana Oak, the director of family medicine at the University of Kentucky, College of Medicine, Northern Kentucky Campus, discussed her difficult experiences with out-of-hospital delivery patients, and recommended that certificate of need be required for freestanding birthing centers.

Jeffrey A. Singer a senior fellow with the Cato Institute, discussed research on problems created by certificate of need laws including, a lack of competition in health systems, inability to respond to public health emergencies, higher costs for care, and limited options for healthcare services.

Laura D'Agostino, attorney with the Pacific Legal Foundation, discussed research that shows that there is less access to healthcare services in states with certificate of need laws, including the closure of rural hospitals. A possible reform would repeal the veto power over certificate of need applications for competing healthcare services.

Deborah Hayes, president and chief executive officer of the Christ Hospital Health Network, testified on the costs and resources involved in attempting to establish new healthcare services and facilities under the certificate of need process.

Retain Certificate of Need

KHA and Kentucky hospitals strongly support retaining the Certificate of Need (CON) program. The CON law is critical to supporting a more level playing field among providers, especially those serving more vulnerable communities. Kentucky is one of 35 states (including the District of Columbia) that maintain a CON program. This year, a national CON expert[1] produced a comprehensive research and impact analysis for KHA, which found that Kentucky's CON program provides substantial benefits and is delivering value for Kentuckians. The analysis compared states with varying degrees of CON regulation to states without CON. The report found that CON states outperform no-CON states in access to, and prices of, health care services.

Kentucky outperforms no-CON states by any number of measures:

- **ACCESS IS STRONG: Kentucky provides better access to most health care services than no-CON states.**
  - Kentucky has more hospitals per 100,000 population, as well as twice the number of hospitals and 1.5 times the number of physicians per 1,000 square miles than no-CON states. Kentucky's access to Medicare-certified ambulatory surgery centers (ASCs) per 1,000 square miles is similar to no-CON states and is higher when both ASC and hospital density are combined.
- **COSTS ARE LOW: Kentucky has lower prices and costs than no-CON states.**
  - Kentucky has the **tenth lowest price (net payment) per inpatient discharge in the U.S. and is nearly $1,000 less than the median of no-CON states**; $6,561 per discharge compared to $7,474 in states with no CON laws. (Kentucky's low-cost position is consistent with other national reports.[2])
- **VALUE IS HIGH: Kentucky hospitals provide better value than no-CON states, considering Kentucky serves a more vulnerable population that uses more services. Kentucky hospitals serve a more vulnerable population than most any other state.**
  - Kentucky's population is older, poorer (Kentucky ranks fifth highest in poverty) and less healthy (life expectancy is 5th lowest in the U.S. and three years lower than the median of no-CON states), with the 9th highest rate of Medicaid inpatients in the U.S.
  - Despite these factors, Kentucky's total per capita health care costs ($10,257) are similar to the national median ($10,212).
  - Kentucky's total per capita costs are also less than other nearby states with no CON laws (IN, OH) and Kentucky's price (net payment) per inpatient discharge is lower as well.

	KENTUCKY	INDIANA	OHIO
Total Per Capita	**$10,257**	**$10,517**	**$10,478**
Net Inpatient Price/Discharge	**$6,561**	**$7,847**	**$7,005**

CON REPEAL would likely cause hospitals to close, costs to rise and access to worsen, particularly in rural communities.

An analysis of states that have fully or partially repealed CON suggests that doing so would be another nail in the coffin for rural communities:

- Kentucky is one of the most rural states in the U.S. and a disproportionate share of hospital closures over the last decade have been small, rural facilities. The study identified **at least eleven hospitals vulnerable to closure. Each of the facilities is the sole provider in their community**, and their closure would end access to hospital and emergency room services.

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[1] Ascendient, CON Analysis and Impact Study, August 2023
[2] Kentucky ranks twelfth lowest of 50 states in hospital price in a 2022 RAND National Hospital Price Transparency Report

CON Repeal would likely cause hospitals to close - continued

- Closure would eliminate jobs, which provide economic benefit, and require thousands of patients, who are typically older, poorer and more dependent on public assistance, to travel further for hospital and emergency care.
- These most vulnerable citizens will be disproportionately affected by service reductions, hospital closures, and the "urbanization" of health care – the tendency for health care services to be expanded in affluent and suburban areas at the expense of a loss of access in rural communities.
- Kentucky's hospitals employ over 74,000 people, of which more than 24,000 are in rural hospitals. Hospitals pay $4.7 billion in wages, of which $1.5 billion are to rural hospital employees.
- Closure of the eleven most vulnerable hospitals would mean the loss of 3,200 jobs with $214 million in wages and more than 500 patients **each day** would have to find hospital care elsewhere.
- The experience in Georgia, Ohio, and Pennsylvania – where CON has been partially or fully repealed – indicates Kentucky can expect to see as many as 120 ASCs developed at the expense of struggling rural hospitals.
- Of the 9 Georgia hospitals reported as closed since 2018, 7 were adjacent to counties – often more than one county – with multiple new single-specialty ASCs developed after they were no longer covered by CON.
- If Kentucky were to mirror the no-CON state statistics, the state would **lose 10 hospitals, Kentuckians (and their payors) would pay $450 million more per year for inpatient services, and per capita costs would increase at a rate of 19% above the national growth rate.**

There are inherent features of the U.S. health care system that limit competition:

- HEALTH CARE IS NOT A FREE MARKET – 70 to 80 percent of Kentucky hospital patients, on average, are covered by Medicare or Medicaid (or both), where government sets payment rates that are below actual cost, requiring cross subsidization for hospitals to maintain essential services. Kentucky has the seventh highest percentage of inpatient discharges attributable to Medicare and Medicaid patients, and a higher percentage than all no-CON states.
- **Federal EMTALA laws require hospitals to treat all patients, regardless of ability to pay, and society sees health care as a right.**
- **Insurance companies limit choice through narrow networks and coverage limitations.**

Kentucky's CON program has been modernized over the last several years such that primary care and most outpatient services are now exempt from CON.[3]

KHA supports retaining CON for new beds, ambulatory surgery centers, expensive technology, where sufficient volume is needed for good outcomes (as recommended by national guidelines), and freestanding birthing centers. KHA will oppose legislation fully or partially repealing CON.

	Kentucky	No-CON States
Hospitals per 100,000 Population	2.24	1.99
Hospital Density (# per 1,000 square miles)	2.56	1.30
Medicare-Certified ASC Density (# per 1000 square miles)	0.94	1.2
Physician Density (# per 1,000 square miles)	246.08	148.9
Net Price/Inpatient Discharge (CMI/WI Adjusted)	$ 6,561	$ 7,474
% Population Age 65+	17%	16.7%
Median Household Income	$ 55,573	$ 67,044
Life Expectancy	73.5	76.9
State Health Score	-0.76	0.03
% Inpatient Discharges Medicaid	25.1%	21.4%
% Inpatient Discharges Medicare/Medicaid	71.3%	65.4%

[3] CON no longer covers ambulatory care clinics, most mobile health services, most diagnostic imaging equipment, community mental health centers, primary care centers, rehabilitation agencies, retail-based health clinics, residential crisis stabilization units, residential freestanding substance use disorder facilities with 16 or less beds, residential hospice facilities, rural health clinics, special health clinics, relocation of acute care beds among hospitals under common ownership in the area development district and redistribution of existing licensed beds among service lines in an acute care hospital.