WHEN HOSPITALS MERGE:

Updating State Oversight to Protect Access to Care

MERGERWATCH
PROTECTING PATIENTS' RIGHTS WHEN HOSPITALS MERGE

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ACKNOWLEDGEMENTS

This report was made possible with generous funding support from the following foundations and donors: Alki Fund of the Rockefeller Family Fund, the Ford Foundation, the Robert Sterling Clark Foundation and Katharine S. Villers.

The authors wish to thank former MergerWatch Advocacy Coordinator Sheila Reynertson for recognizing the need for this research and getting the project started.
Special thanks go the following people for their suggestions on improving the report: Jessica Curtis and Michele Craig.

The authors also wish to thank Ali Harris for his assistance with the state grading system as well as former MergerWatch interns Chelsea Ebin, Sarina Singh, and Ciara Johnson for their research and editing support.

An abbreviated version of this report appeared in the March 2016 issue of the American Medical Association Journal of Ethics. Available at: http://journalofethics.ama-assn.org/2016/03/pfor3-1603.html

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EXECUTIVE SUMMARY

PHOTO MONTAGE: BRUCIE ROSCH

The hospital landscape in America is changing rapidly.

Hospitals are consolidating at increased rates, creating large scale regional and national health care systems that own and operate dozens of hospitals in multiple states. These systems wield considerable financial and political power, enabling them to grow even larger through the acquisition of remaining independent, stand-alone hospitals in this country. Evidence of this trend can be found in the steadily increasing number of hospital mergers and acquisitions over the last five years. Hospital transactions grew from 66 in 2010 to 95 in 2014 and 112 in 2015.[1,2] Industry analysts predict this activity will continue to stay strong in 2016.[3]

1. Ellen J. Hirst, "Hospital mergers continued to create larger systems in 2014," http://www.chicagotribune.com/business/ct-hospital-mergers-0211-biz-20150210-story.html, (February 10, 2015).
2. "Hospital Merger and Acquisition Activity Up Sharply in 2015, According to Kaufman Hall Analysis," http://www.kaufmanhall.com/about/news/hospital-merger-and-acquisition-activity-up-sharply-in-2015-according-to-kaufman-hall-analysis, (accessed January 22, 2016).
3. Beth Kutscher, "Healthcare merger and acquisition activity likely to stay strong in 2016," http://www.modernhealthcare.com/article/20160101/MAGAZINE/301029931/healthcare-merger-and-acquisition-activity-likely-to-stay-strong-in, (January 1, 2016).

Further evidence of consolidation in the hospital industry can be found in new data analysis from MergerWatch showing that the number of short-term acute-care hospitals dropped from 4,017 in 2001 to 3,779 in 2016. An important contributor to the decline in overall hospital numbers has been the closure of more than 60 rural hospitals across 20 states since 2010.[4] This trend is likely to continue because of financial factors, including the failure of 19 states to expand their Medicaid programs, leaving large numbers of patients still without insurance to pay for hospital visits. Additionally, there is a shift towards outpatient care, which is causing hospitals to shrink the number of available beds.[5] Hospital consolidation is often accompanied by promises of financial stability, lower costs and improved services, but studies have shown those promises may go unfulfilled.[6]

Over the same 15-year period, there was steady growth in the size of the nation's 25 largest health systems, which went from controlling 916 hospitals to 1,189 hospitals. As a result, the proportion of all acute care hospitals that are part of these 25 large health systems has jumped from 23 percent to 33 percent. At the same time, the Affordable Care Act ("ACA") has spurred the creation of new forms of health industry partnerships, such as Accountable Care Organizations (ACOs) and other entities that bring together hospitals, insurers, outpatient clinics, physician practices, pharmacies and community-based organizations.

WHO IS WATCHING OUT FOR THE NEEDS OF HEALTH CARE CONSUMERS?

Who is watching out for the needs of health care consumers as the hospitals and health systems on which they rely are consolidating and integrating in new ways, or even closing? A new national study by the MergerWatch Project has concluded that at the state level, there is largely inadequate oversight to protect consumers' access to needed health care services in their own communities in this new era of health industry consolidation.[7] MergerWatch staff studied state oversight of hospital transactions through

4. Ayla Ellison, "The rural hospital closure crisis: 15 key findings and trends," http://www.beckershospitalreview.com/finance/the-rural-hospital-closure-crisis-15-key-findings-and-trends.html, (February 11, 2016).
5. Melanie Evans, "Hospitals face closures as 'a new day in healthcare' dawns," http://www.modernhealthcare.com/article/20150221/MAGAZINE/302219988, (February 21, 2015).
6. Julie Creswell and Reed Abelson, "New Laws and Rising Costs Create a Surge of Supersizing Hospitals," http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html, (August 12, 2013).
7. There is also federal-level regulation of hospital consolidation from an anti-trust standpoint through the Federal Trade Commission. That regulatory structure was not the focus of this study.

so-called Certificate of Need (CON)[8] laws to determine ways in which these regulatory mechanisms could be used by consumers to maintain access to the full spectrum of health care, including reproductive health services.[9] We analyzed the state statutes, regulations and Certificate of Need websites to determine the requirements in each state.

The study found that state hospital oversight programs as they exist today are insufficient to address the current market conditions. In fact, in some states there is no CON mechanism overseeing hospital transactions at all. Even in states that have more robust CON oversight, the programs were designed for an earlier era of hospital expansion in order to prevent expensive duplication of services, and so they are not suitable to address the impact on consumers of the current wave of hospital downsizing and consolidation.

IN FACT, IN SOME STATES THERE IS NO CON MECHANISM OVERSEEING HOSPITAL TRANSACTIONS AT ALL.

Moreover, hospitals are merging using arrangements other than full-asset sales, instead structuring deals as joint ventures, strategic partnerships or affiliations.[10] While these arrangements are becoming more common and have implications for the provision of care, they often do not require CON review to move forward. Additionally, many states do not require CON review when a hospital closes or reduces a type of service, another common occurrence today. Another emerging issue is the creation of coordinated care networks such as Accountable Care Organizations (ACOs) and other entities comprised of multiple hospitals and other providers. These entities are created to ensure care is coordinated and to focus on shared savings, but CON was not designed to regulate these entities or other similar networks that include many types of providers and can have an impact on access to care.

8. In some states, Certificate of Need goes by a different name, but for ease of discussion, we will use the term "Certificate of Need" to refer to these programs.
9. Certificate of Need review, which is the focus of this report, is one type of state level oversight of hospital transactions. The appendix includes summaries of other types of state and federal hospital merger oversight, including anti-trust review and state Attorney General oversight of non-profit hospital charitable assets and conversions of non-profit hospitals to for-profit entitites.
10. Helen Adamopoulos, "4 Transaction Models for Community Hospitals," Becker's Hospital Review, http://www.beckershospitalreview.com/hospital-transactions-and-valuation/4-transaction-models-for-community-hospitals.html, (January 31, 2014).

IT CAN BE DIFFICULT FOR CONSUMERS TO GET ADEQUATE INFORMATION ABOUT THE TRANSACTIONS THEIR HOSPITALS ARE PROPOSING.

MergerWatch's research also found that many existing CON programs are not very consumer friendly. It can be difficult for consumers to get adequate information about the transactions their hospitals are proposing or the regulatory process that will review and potentially approve these proposals. In many states, the consumer voice is not sought or considered in the CON decision making process, even though consumers' access to health care in their own communities can be negatively affected by hospital consolidations.

The MergerWatch review of all CON laws sought to evaluate the effectiveness of state government oversight of hospital transactions and the level of patient protections. The review analyzed all CON statutes and regulations in effect as of April 2016.[11] The review produced findings about each state that has a CON program, including:

- **Which types of proposed hospital transactions** require CON review?
- **Which designated agency** reviews CON applications in the state?
- **What are the criteria for review** under CON in the state?
- **In what way is the public notified** when the state is conducting a CON review?
- **How does the state allow the public to participate** in the CON process?
- **Does the state have mechanisms in place** for post-approval review and enforcement of any conditions imposed?

11. This study did not analyze how these policies are implemented in practice. As a result, local advocates may find that their personal experiences with state oversight of hospital transactions has differed from what the policies appear to require on paper.

KEY FINDINGS

Currently, 35 states and the District of Columbia have a Certificate of Need Program and California has a similar process of review through the Office of the Attorney General. MergerWatch has developed a grading system based on whether a state's hospital oversight program includes key elements, such as when CON review is required, what are the review standards and whether there is effective engagement of affected consumers. Under this grading system, **ONLY SIX STATES receive either an A or A- for their hospital oversight processes.** The study found room for improvement in all of the top-rated states. Many states fall in the middle of our rankings, with 12 states and Washington, D.C., receiving a grade of **B** or **B-** and eight states receiving a grade of **C**. But five states received a **D** and 20 states received an **F** because they either have no CON, have an extremely limited review that does not apply to hospitals or a have CON program that is largely ineffective. The grades assigned to each state can be found on page 24. A more detailed summary of each state's hospital merger oversight mechanisms can be found at www.WhenHospitalsMerge.com

6 STATES

CA	NJ
CT	RI
IL	TN

The analysis found that only a limited number of states have the CON policies that are most important for maintaining access to services in a merger:

- **Only 10 states require CON review** when a hospital is going to close or if a service would be discontinued.
- **Only eight states require CON review** for an affiliation that is less formal than a sale, purchase or lease.
- **Just nine states require consumer representation** on the CON reviewing body.
- **Only six states require a separate public hearing** for each CON application.

ONLY 10 STATES REQUIRE CON REVIEW WHEN A HOSPITAL IS GOING TO CLOSE OR IF A SERVICE WOULD BE DISCONTINUED.

MODEL POLICIES

Based on this national research, and our analysis of trends in hospital consolidation, MergerWatch is proposing a set of model Certificate of Need policies that we believe should be included in all state programs to ensure that there is government oversight when hospitals are proposing to consolidate, downsize or close. With these policies in place, a potential loss of service in a community can be properly analyzed by government regulators and affected consumers will be able to participate in the process. With so much hospital consolidation occurring, strong CON programs are desperately needed to ensure that communities do not lose timely, affordable access to a comprehensive range of health services.

MERGERWATCH IS PROPOSING A SET OF MODEL CERTIFICATE OF NEED POLICIES THAT WE BELIEVE SHOULD BE INCLUDED IN ALL STATE PROGRAMS.

Our proposed model policies (listed on page 26 of this report) would allow for state oversight of a wider range of proposed hospital transactions, such as affiliations, and in circumstances when control of a hospital board is to be shifted to another entity, such as a health system. Review would be required for proposed hospital closings and when services would be discontinued at one or more of the partnering hospitals. We also propose that CON review boards be required to include consumers and consumer advocates, and have limits on the number of members who are hospital industry insiders. Under our model policies, CON review would include an examination of community health needs, as documented in an existing or new needs assessment or state health planning document, and an assessment of how services meeting those needs would be affected by the proposed transaction. We also propose much more transparency to the public about the review process and any transactions being reviewed, as well engagement of affected consumers through such mechanisms as public hearings or submission of written comments. These changes to state hospital oversight would do much to ensure that community access to care is not harmed as rapid consolidation continues.

THE BACKGROUND:

HOSPITAL CONSOLIDATION IS THE NEW NORMAL

Starting in the late 1990s, the rate of hospital consolidations began growing as it became harder for independent hospitals to stay afloat without the support of larger systems. Hospital mergers were also motivated by the desire for greater local market share to increase hospital bargaining power with insurance companies.[12] More recently, hospitals have cited the Affordable Care Act (ACA) as encouraging consolidations by promoting value-based health care that looks to provide better quality care in a more cost effective way.[13] Hospitals have repeatedly stated that their goals in consolidating are to create more efficiency, better quality of care and increased cost savings for patients. Yet, one recent study shows that costs are higher in areas with less hospital competition.[14] Another recent study shows that increases in consolidation activity within a state can lead to higher prices in other markets within that state.[15] Instead of savings for consumers, hospital mergers often lead to increased hospital prices and higher costs for patients and employers that provide health insurance.[16,17] Because of the financial benefits for hospitals, the move towards hospital consolidation will likely continue, despite the potentially negative results for health care consumers.

12. Robert Town and William Vogt, "How has hospital consolidation affected the price and quality of hospital care?" Research Synthesis Report No. 9, (February 2006).
13. Creswell and Abelson, 2013
14. Zack Cooper, Stuart Craig, Martin Gaynor and John Van Reenan, "The Price Ain't Right: Hospital Prices and Health Spending on the Privately Insured" (December 2015) available at: www.healthcarepricingproject.org
15. Leemore Dafny, Kate Ho and Robin S. Le, *The Price Effects of Cross-Market Hospital Mergers* http://www.kellogg.northwestern.edu/docs/faculty/dafny/price-effects-of-cross-market-hospital-mergers.pdf, (March 18, 2016)
16. David M. Cutler and Fiona S. Morton, "Hospitals, Market Share, and Consolidation" 310 JAMA 1964, (2013).
17. Ibid.

Those financially struggling community-based hospitals that do not join systems are continuing to downsize or close.[18] More than half the rural hospitals considered vulnerable to closure in the coming years are located in communities with the greatest health disparities that "can least afford to lose access to care," one study states.[19] The result of these combined industry trends can leave consumers with reduced choices for where to obtain hospital based medical services and the potential to have to travel long distances to receive care.

NEONATAL INTENSIVE CARE UNITS, EMERGENCY DEPARTMENTS, PEDIATRICS AND OBSTETRICS UNITS ARE ESPECIALLY AT RISK OF CLOSURE.

The impact of health industry consolidation on local access to needed services can be significant. For example, mergers of religiously-sponsored hospitals with secular (non-religious) community hospitals can impose religious restrictions on the merged entity, causing a loss of community access to key reproductive health services, as well as some end-of-life choices and some types of LGBT care.[20] In other cases, non-profit hospitals are being acquired by for-profit systems that introduce a bottom-line orientation that could lead to closure or downsizing of non-profitable service lines.[21] Neonatal intensive care units, emergency departments,[22] pediatrics and obstetrics units are especially at risk of closure from these changes.[23, 24] For instance, in Philadelphia, PA, 13 of the 19 obstetrics units in the city were closed between 1997 and 2012.[25] In the majority of states, Certificate of Need oversight is not required when hospitals or hospital units close and because of this, it is difficult for health care consumers to voice their concerns about the changes to available care.

As Table 1 demonstrates, the number of short-term acute care hospitals in the United States has been dropping since 2001, when MergerWatch began tracking trends in hospital ownership. Overall, there was a loss of more than 200 hospitals during the 15-year period 2001 to 2016. Analysis of trends by ownership type found that for-profit (or proprietary) hospitals were the only growing sector, while all other categories of ownership declined. However, separate analysis

18. Evans, 2015
19. Ellison, 2016
20. Lois Uttley, Sheila Reynertson, Lorraine Kenny and Louise Melling, Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care, http://www.mergerwatch.org/storage/pdf-files/Growth-of-Catholic-Hospitals-2013.pdf, (2013).
21. Jill R. Horwitz, "Making Profits and Providing Care; Comparing Nonprofit, For-Profit and Government Hospitals" Health Affairs, 24, no. 3 (2005).
22. Jason Silverstien, "The Decline of Emergency Care," http://www.theatlantic.com/health/archive/2013/04/the-decline-of-emergency-care/275306/ , (April 26, 2013).
23. Gregory A. Freeman, "Value-based Care is Ripping Into Health System Profits," http://www.healthleadersmedia.com/finance/value-based-care-ripping-health-system-profits?page=0%2C2#, (March 10, 2016).
24. Michelle Andrews, "More Rural Hospitals Are Closing Their Maternity Units," http://www.npr.org/sections/health-shots/2016/02/24/467848568/more-rural-hospitals-are-closing-their-maternity-units, (February 24, 2016).
25. Scott A. Lorch, Sindhu K. Srinivas, Corinne Ahlberg, and Dylan S. Small, The impact of obstetric unit closures on maternal and infant pregnancy outcomes, Health Services Research, 48(2 0 1), 10.1111/j.1475–6773.2012.01455.x, http://doi.org/10.1111/j.1475-6773.2012.01455.x, (2013).

of Catholic-owned, affiliated or identified hospitals shows that this segment also continues to grow,[26] as MergerWatch first noted in a 2013 report. Both for-profit/non-profit hospital consolidation and Catholic/secular hospital mergers pose special challenges for affected consumers, clinicians and communities, as well as for state hospital oversight.[27]

TABLE 1: **Number and Ownership Type of Short-Term Acute Care Hospitals**

HOSPITAL OWNERSHIP	2001 HOSPITALS	2001 % OF HOSPITALS	2011 HOSPITALS	2011 % OF HOSPITALS	2016 HOSPITALS	2016 % OF HOSPITALS	CHANGE 2001 TO 2016
Church Non-Profit	577	14.4%	528	13.9%	508	13.4%	-12%
Secular Non-Profit	1,937	48.2%	1,713	45.2%	1,723	45.6%	-11%
Public	843	21.0%	581	15.3%	556	14.7%	-34%
For-Profit	660	16.4%	964	25.5%	992	26.3%	+50%
TOTAL	4,017		3,786		3,779		-6%

Meanwhile, hospital consolidation has been helping grow the size and influence of the largest 25 health systems in the United States. By January of 2016, these systems controlled 1,189 of the acute care hospitals in the United States – nearly one third of all acute care hospitals – according to MergerWatch research. (See Table 2 on p. 13) These 25 systems accounted for more than 10 million patient discharges.[28] The size of these top 25 systems is also reflected in their combined patient charges, which amount to more than $890 billion in the most recent year for which data was available. (See Table 3 on p. 14) Of the top 10 systems, eight are from the fastest-growing hospital sectors: four are for-profit (Hospital Corporation of America, Community Health Systems, Tenet Healthcare and LifePoint Health) and four are Catholic sponsored or identified (Ascension Health, Catholic Health Initiatives, Trinity Health and Dignity Health).

26. MergerWatch data analysts and staff identified those hospitals that are either part of Catholic health systems, or are affiliated with Catholic hospitals and adhering to Catholic health restrictions, or are historically Catholic and continue to follow Catholic restrictions, even after a change of ownership to a secular system. See our separate report on the continued growth of Catholic hospitals and health systems at www.MergerWatch.org
27. The 2013 report from MergerWatch and the ACLU, *Miscarriage of Medicine*, flagged special issues of concern for women's health services when hospital services are restricted by the Ethical and Religious Directives for Catholic Health Services.
28. Data analysis from hospital cost reports submitted to the federal government and compiled in the Definitive Healthcare database. Systems and hospitals data is from 2016. Beds and discharges data are from the most recent cost report submitted by these hospitals, most of which date to 2015 or 2014.

TABLE 2: **Largest Hospital Systems in the U.S. in 2016**
Ranked by total staffed acute care beds*

RANK		SYSTEM SPONSORSHIP	TOTAL STAFFED BEDS	NUMBER OF HOSPITALS	TOTAL PATIENT DISCHARGES
1	**Hospital Corporation of America** (HCA)	For-Profit	35,245	173	1,662,836
2	**Community Health Systems** (CHS)	For-Profit	23,982	186	914,691
3	**Tenet Healthcare**	For-Profit	17,605	86	766,753
4	**Ascension Health**	Catholic	16,825	90	786,358
5	**Catholic Health Initiatives** (CHI)	Catholic	14,555	84	692,498
6	**Trinity Health** (FKA: CHE Trinity Health)	Catholic	13,506	60	663,792
7	**Kaiser Permanente Health Foundation**	Secular Non-Profit	8,566	34	410,115
8	**LifePoint Health** (FKA: LifePoint Hospitals)	For-Profit	7,365	64	260,352
9	**Dignity Health** (FKA Catholic Healthcare West)	Catholic	7,311	37	356,590
10	**New York Presbyterian Healthcare System**	Secular Non-Profit	5,932	25	310,411
11	**Prime Healthcare Services**	For-Profit	5,742	40	231,492
12	**Adventist Health System**	Church/ Non-Catholic	5,553	29	280,923
13	**Providence Health & Services**	Catholic	5,385	23	275,904
14	**Universal Health Services**	For-Profit	5,344	30	266,150
15	**Banner Health**	Secular Non-Profit	4,949	21	252,549
16	**Carolinas HealthCare System**	Secular Non-Profit	4,626	23	224,044
17	**Northwell Health** (AKA: North Shore Long Island Jewish Health System / North Shore LIJ)	Secular Non-Profit	4,463	18	256,361
18	**University Of Pittsburgh Medical Center** (UPMC)	Secular Non-Profit	4,246	18	194,343
19	**Sutter Health**	Secular Non-Profit	3,828	27	173,620
20	**Baylor Scott & White Health**	Church/ Non-Catholic	3,727	29	173,636
21	**Advocate NorthShore Health Partners**	Church/ Non-Catholic	3,671	14	197,557
22	**SSM Health** (FKA: SSM Health Care)	Catholic	3,411	19	154,230
23	**CHRISTUS Health**	Catholic	3,367	23	135,918
24	**Texas Health Resources**	Secular Non-Profit	3,258	19	155,251
25	**Mercy Health** (FKA Catholic Health Partners)	Catholic	3,075	17	161,558
		TOTAL	**215,537**	**1,189**	**10,152,310**

*Number of hospitals as of January 2016. Bed counts from latest cost report filed with CMS (typically from 2014 or 2015)

TABLE 3: **Patient Charges for the 25 Largest Health Systems in the U.S.***

RANK		TOTAL PATIENT CHARGES*	TOTAL MEDICAID CHARGES*	TOTAL MEDICARE CHARGES*	MEDICAID & MEDICARE AS % OF TOTAL CHARGES*
1	**Hospital Corporation of America** (HCA)	$187,133,746,838	$27,454,353,497	$55,484,246,745	44.3%
2	**Community Health Systems** (CHS)	$98,530,866,437	$14,243,568,545	$34,321,559,699	49.3%
3	**Tenet Healthcare**	$75,001,675,757	$15,503,143,444	$19,956,161,938	47.3%
4	**Ascension Health**	$53,563,346,559	$6,287,714,770	$17,016,330,441	43.5%
5	**Catholic Health Initiatives** (CHI)	$58,094,763,152	$8,045,958,174	$18,490,367,293	45.7%
6	**Trinity Health** (FKA: CHE Trinity Health)	$45,420,136,472	$6,489,837,920	$14,251,498,084	45.7%
7	**Kaiser Permanente Health Foundation**	N/A	N/A	N/A	N/A
8	**LifePoint Health** (FKA: LifePoint Hospitals)	$18,773,225,792	$3,060,202,146	$6,398,509,329	50.4%
9	**Dignity Health** (FKA Catholic Healthcare West)	$39,667,082,271	$9,328,513,388	$12,061,754,220	53.9%
10	**New York Presbyterian Healthcare System**	$27,002,310,172	$5,777,542,445	$7,822,148,826	50.4%
11	**Prime Healthcare Services**	$18,238,759,317	$3,142,536,921	$6,170,717,039	51.1%
12	**Adventist Health System**	$25,111,669,303	$3,359,173,506	$7,557,063,969	43.5%
13	**Providence Health & Services**	$23,842,492,651	$4,385,189,117	$7,432,093,385	49.6%
14	**Universal Health Services**	$24,412,529,640	$5,115,170,379	$6,617,693,916	48.1%
15	**Banner Health**	$20,857,112,239	$4,678,603,551	$5,363,100,871	48.1%
16	**Carolinas HealthCare System**	$19,008,783,043	$2,926,756,189	$5,545,381,842	44.6%
17	**Northwell Health** (AKA: North Shore Long Island Jewish Health System / North Shore LIJ)	$22,945,827,074	$4,566,277,591	$5,970,315,127	45.9%
18	**University Of Pittsburgh Medical Center** (UPMC)	$24,963,329,608	$2,950,519,706	$4,791,507,951	31.0%
19	**Sutter Health**	$28,915,631,244	$4,815,992,352	$6,540,411,859	39.3%
20	**Baylor Scott & White Health**	$15,673,751,082	$1,077,333,920	$4,913,246,632	38.2%
21	**Advocate NorthShore Health Partners**	$17,200,565,876	$2,544,721,272	$6,123,634,505	50.4%
22	**SSM Health** (FKA: SSM Health Care)	$11,356,166,831	$2,848,261,154	$3,611,086,296	56.9%
23	**CHRISTUS Health**	$11,928,928,994	$1,248,888,004	$3,483,294,281	39.7%
24	**Texas Health Resources**	$11,127,050,078	$1,169,533,320	$3,237,218,937	39.6%
25	**Mercy Health** (FKA Catholic Health Partners)	$11,693,649,057	$2,348,874,347	$3,382,577,735	49.0%
	TOTAL / AVERAGE	**$890,463,399,487**	**$143,368,665,658**	**$266,541,920,920**	**46.0%**

*Charges reflect most recent cost report filed with CMS (typically from 2014 or 2015)

CERTIFICATE OF NEED PROGRAMS:
A NATIONAL SURVEY

History of Certificate of Need programs

In most states, the existing system of hospital oversight is called a Certificate of Need (CON) program. CON programs started to appear in the 1960s and 1970s, when hospitals were being built thanks to grants from the 1946 Hill Burton Act, and in response to the need created by the enactment of the Medicare and Medicaid programs in 1965.[29] States recognized there should be a demonstration of need in the community before a new hospital was erected or established, in order to prevent overbuilding, duplication of services or unnecessary purchase of expensive medical equipment.[30] As more and more states adopted CON programs, the federal government enacted the Health Planning Resources Development Act in 1974, which provided federal funds to implement programs that required states to approve any major hospital developments or purchases of costly equipment, based on needs assessments and regional health planning. Certificate of Need (CON) programs were implemented in all 50 states.

Some states terminated their CON programs in the 1980s and 1990s after the federal government repealed the Health Planning Resources Development Act and removed funding support for the programs.[31]

29. Pamela C. Smith and Dana A. Forgione, "The Development of Certificate of Need Legislation," *Journal of Healthcare Finance*, Vol. 36, No. 2, (Winter 2009).
30. Ibid.
31. Ibid.

35 STATES & DC

AL	LA	NY
AK	ME	NV
AR	MA	OH
CT	MD	OK
DC	MI	OR
DE	MO	RI
FL	MS	SC
GA	MT	TN
HI	NC	VA
IL	NE	VT
IA	NH	WA
KY	NJ	WV

TODAY, 35 STATES AND WASHINGTON, D.C., still have CON programs.[32] However, these remaining regulatory systems were created long before the current trend of hospital industry consolidation and hospital closures, so most are not useful to respond to current market conditions. Certificate of Need Programs have the potential to be used effectively to ensure community access to health care services is maintained during a hospital consolidation, but most of the laws need to be updated and strengthened.

Which types of hospital transactions require Certificate of Need review?

Despite the overwhelming impact on a community when a hospital closes, most states do not require CON review in such cases. This is despite the fact that in the current health care climate, hospitals are opening at a slower pace than they are closing and consolidating, especially in rural areas.[33] In addition to the 60 rural hospitals that have closed since 2010, 673 more rural hospitals are at risk of closure, according to a new report.[34] Since one of the original goals for CON programs was to reduce unnecessary duplication of health care facilities, in the beginning all CON programs required review of a proposed new health care facility to determine if there was a need for it in the community.[35] Almost all of the states with CON (32) require a review when a new health care facility or health care service is being established.[36]

10 STATES

IA	KY
NY	HI
NJ	CT
TN	IL
MD	RI

BY CONTRAST, ONLY 10 STATES require a CON when health care services or facilities are being discontinued. Hospitals routinely close as the result of transactions between two or more hospitals. Often a service offered at both hospitals will be removed from one facility so that it is offered at just one hospital, or an entire facility will close or be transformed into a different type of facility (such as one concentrating on substance abuse treatment or outpatient treatment). In the case of religious/secular hospital mergers, reproductive health services that were once offered at the secular hospital could be completely discontinued with no notice given to the affected communities and no action required to ensure the services are provided elsewhere in the community.

32. For detailed information on each state and links to each state's laws go to www.WhenHospitalsMerge.org
33. Jayne O'Donnell and Laura Ungar, *Rural Hospitals in Critical Condition*, USA Today, http://www.usatoday.com/story/news/nation/2014/11/12/rural-hospital-closings-federal-reimbursement-medicaid-aca/18532471/ , (November 12, 2014).
34. Ellison, 2016
35. Smith and Forgione, 2009
36. Richard Cauchi, *Certificate of Need: State Health Laws and Programs*, National Conference of State Legislatures http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx., (July 2014).

THE REVIEW PROCESS CAN PROVIDE AN OPPORTUNITY FOR CONSUMERS TO VOICE CONCERNS.

Even in these states that require review when a service is discontinued, the "service" being eliminated is often not defined to include reproductive health services. For example, if contraceptive counseling and sterilization procedures will now be prohibited due to the introduction of religious restrictions at a formerly secular hospital, the facility still may not need to apply for a CON, as long as the obstetrics and gynecology department will remain. This is because the regulation may consider "loss of services" to mean loss of a department or a number of beds, rather than defining it narrowly to include specific types of procedures.

When state approval is required to close a hospital or end certain services, the review process can provide an opportunity for consumers to voice concerns and for regulators to assess and address the potential impact on community access to care. A case that emerged in Rhode Island in early 2016 presented an example of this process at work. Memorial Hospital in Pawtucket, RI, which in 2013 became part of the Care New England health system, proposed to close its obstetrics unit, and send pregnant women to other nearby Care New England hospitals. The state Department of Health was required to issue a "reversal" of Certificate of Need and held three public hearings in the Pawtucket area, during which local women and midwives voiced concerns about loss of the hospital's "mother-friendly" birthing center. Although the DOH ultimately approved the shut-down, citing the hospital's "unsustainable" financial situation, it imposed several "patient-focused conditions." For example, Care New England was required to submit a plan to "replicate Memorial Hospital's unique alternative birthing experience" at another of the system's hospitals and ensure low-income women would have transportation to this alternative location.[37]

24 STATES

AL	ME	NV
AK	MA	OH
AR	MD	OK
CT	MI	OR
DE	MO	RI
FL	MS	SC
GA	MT	TN
HI	NC	VA

CURRENTLY, 24 STATES require Certificate of Need review when a hospital is sold or a health system purchases another hospital or health facility. In the past, it was quite common for hospitals to engage in full asset purchases of other health facilities, or to acquire majority stakes in other hospitals. However, the current trend in hospital transactions is towards looser affiliations between hospitals, such as joint ventures, joint operating agreements and strategic partnerships.[38] **ONLY EIGHT STATES AND D.C. require CON review (and in California, Attorney General review) for these types of arrangements between hospitals, despite the consequences they may have for the provision of services.**

8 STATES & DC

CA	MS
CT	NJ
DC	NY
IL	RI
ME	

37. RIDOH Issues Decision on Memorial Hospital Obstetrics Proposal With Patient-Focused Conditions http://www.ri.gov/press/view/27654
38. Adamopoulos, 2014

RECENT EXAMPLES OF RELIGIOUS/ SECULAR PARTNERSHIPS HAVE BEEN STRUCTURED SO AS TO "FLY UNDER THE RADAR" OF CON REVIEW.

There have been recent examples of religious/secular partnerships that have been structured so as to "fly under the radar" of CON review, with the result that reproductive health services have been discontinued without any government oversight or public notice. For instance, Washington is a state that requires CON review for hospitals involved in a "sale, purchase or lease" but not for looser affiliation agreements.[39] In recent years, a number of transactions between secular and Catholic hospitals in Washington have been structured as affiliations that have not required CON review. For example, the Franciscan Health System, which is part of the national Catholic Health Initiatives system, entered into an affiliation agreement with Harrison Medical Center, the only full-service hospital on Kitsap Peninsula. This affiliation was not a "sale, purchase or lease" and therefore did not require CON review, but the affiliation agreement had real-life consequences for the Kitsap Peninsula community, since it prevented Harrison Medical Center from performing elective abortions or providing aid-in-dying services that are otherwise legal in the state. The closest health facility where residents could go to receive those services was an hour-long ferry ride away in Seattle.[40, 41]

Which designated agency conducts Certificate of Need review in a state?

Our review found that each state CON program has a different set of guidelines that are used to determine who reviews a CON application -- whether it is a state agency, a designated review board or a planning commission. Consumer access to needed health services is directly affected by hospital consolidations, yet **ONLY EIGHT CON PROGRAMS (seven states and D.C.) actually require consumers to be represented on the board or commission that conducts the review process.** Requiring consumer representation on these boards or commissions could ensure that decision-makers hear from people who are actually affected by the potential hospital affiliations, instead of only from government employees or health industry insiders. In most instances, members of a CON board or commission are appointed either because of their expertise in the health industry, or because of they hold a political office. Consumers and their advocates often can contribute a deeper understanding of the health needs of the community.

7 STATES & DC

AL	IL
DE	NJ
DC	NY
HI	TN

39. In 2013 the WA DOH promulgated a new rule that would require CON review for a "transfer of control" but after the WA Hospital Association sued saying the WA DOH did not have the authority to change the rule, the Supreme Court of WA struck it down.
40. *Request for Department of Health to Decline to Issue Determination of Non-Reviewability Regarding Proposed Affiliation of Franciscan Health System and Harrison Medical Center*, American Civil Liberties Union of Washington, https://aclu-wa.org/sites/default/files/attachments/2013-07-16--Letter%20to%20DOH%20re%20Harrison-Franciscan.pdf, (July 16, 2013).
41. Uttley, Reynertson, Kenny, and Melling, 2013

15 STATES & DC

AK	MA
CT	MS
DC	MT
FL	NE
GA	SC
KY	VA
LA	WA
ME	WV

FIFTEEN STATES AND D.C. conduct CON review through staff members employed at the state's Department of Health or another administrative agency that handles CON. In these states, the staff will perform the review and an appointed commissioner will sign off on the final decision. A reviewing body comprised only of agency staff can potentially ensure isolation from political influence, but it may also lack specific industry expertise or the consumer viewpoint that an appointed board may bring.

Regulations can determine who must be represented on CON review boards. There are 14 states with regulations that articulate guidelines for the Governor to follow in making appointments to the board. Those guidelines include criteria such as which industries/fields the representatives should come from. For instance, in Delaware, the Governor must appoint one person from each of the following: the Delaware Health Care Commission, the state Department of Health, a labor union, the health insurance industry, a health care administrator, a physician, someone from a long-term care organization, a representative from a provider group other than a hospital or nursing home, and a health care purchaser (an employer for example). There also must be four representatives from the general public.

What are the criteria for review under CON in the state?

Reviewing entities are required to follow statutory and regulatory guidelines that outline the criteria for reviewing CON applications. While a demonstration of need in the community for a new facility or piece of equipment makes sense in the original context of CON,[42] there are other review guidelines that are crucial in the current health care landscape. For example, **17 STATES AND D.C. do require a reviewing entity to consider whether the facility will be accessible to medically-underserved populations and whether there are similar health services available in the same geographic area.** Such requirements could be invoked by mobilized consumers to ensure that access to reproductive health services is not diminished, or that potential closing of an emergency department does not leave vulnerable patients with unreasonable travel distances to the next facility. Similarly, 23 states require that the proposed project applying for a CON must be compatible with existing state health policies. Thus, a project that results in loss of services to a community or geographic region could be found to directly violate state health policies.

17 STATES & DC

AK	IL	NJ
CA	IA	RI
CT	MS	SC
DC	MT	VT
FL	NC	WA
GA	NH	WV

42. Cauchi, 2014

AN ASSESSMENT SHOULD IDENTIFY ANY POTENTIAL BARRIERS TO CARE THAT WOULD BE CREATED.

As the name Certificate of Need suggests, virtually all states require a showing that the project would fill a need and 23 states require that the proposed project under review be compatible with state health planning goals or policies. To be most useful, however, this requirement should be fulfilled with the preparation of an independent, comprehensive needs assessment analyzing the health needs of the affected community, with a focus on low-income populations. Such an assessment should identify any potential barriers to care that would be created as a result of the proposed transaction, such as lack of transportation to alternative providers of care that would be discontinued. Alternatively, reviewers might consult an existing state health planning document, if it identifies health needs of the affected hospital service area.

How is the public notified and engaged in Certificate of Need review?

Are state CON websites transparent and user-friendly?

Our review found that although every state's CON program has provisions giving an appearance of engaging the public, the actual extent to which consumer views are sought and considered varies widely, and is often quite limited. In order for members of the public to be engaged in the CON process, they need to be informed that CON review is going to occur in the first place. Every state with a CON program has a website, or a section of a website belonging to a state agency (such as a Department of Health), where the public can go to learn more information about the CON process, but these websites vary greatly in their user-friendliness and the amount of information provided.

THE ACTUAL EXTENT TO WHICH CONSUMER VIEWS ARE SOUGHT AND CONSIDERED VARIES WIDELY.

If consumers are going to participate in the Certificate of Need review process, they will need to be able to find information about each application easily and in a timely manner, with the information being written in an easily understandable tone and in multiple languages. Many of the current state Certificate of Need websites do not even post applications or information about the process. The ones that do post such CON information often do not explain the applications in easy to understand ways.

CONSUMERS MAY DISCOVER THAT CON STATUTES ARE NOT SUMMARIZED OR EXPLAINED IN PLAIN ENGLISH.

Most of the CON websites include links to the relevant statutes and regulations concerning the CON process, a summary of the CON program and information about public hearings for CON applications. Many CON websites also post notifications when a new application is under review. However, in order for consumers to see such notification, they would first have to find the state's CON website, which isn't always an easy process. Sometimes "Google" will lead to it, but often it does not.

For example, if consumers in Connecticut, a state with robust CON laws, wanted to learn about the CON process there, they might use a search engine to look for "Connecticut Certificate of Need," which would bring them to a website that simply has links to the statutes discussing CON. It is important for the state to require notification of the public about a pending transaction by other means, because if consumers did not know to search for the term "Certificate of Need," they might not find the relevant website. A search of "Connecticut Hospital Merger" brings up a list of articles about hospitals that have merged or will merge, but not a link to the state's CON website. Once consumers do find a state CON website, they may discover that CON statutes are not summarized or explained in plain English and can only be found in their full text form, which is challenging for an average person to read. The Connecticut CON website does explain the rule that a public hearing may be held and includes a link that says "Certificate of Need Status Report,"[43] which is where an individual can find information about current CON applications and scheduled public hearings.

How is the public informed about a proposed hospital transaction?

A total of 21 CON programs require the public to be notified by a means other than the CON website. Of these, **17 (16 STATES AND DC) REQUIRE publication of notice about a new CON application in a newspaper.** Unfortunately, many of these notices may be published in the legal notices section of a newspaper, which are not widely read by the general public. Florida and Maryland inform the public through their state's administrative register, which is a state's official notification mechanism of rulemaking activity and is usually only accessible to those who know where to find it. Hawaii and Nevada require the public to be informed, but do not specify how.

16
STATES & DC

AL	IL	RI
AK	ME	SC
CT	MO	TN
DC	MS	VT
DE	MT	WV
GA	OR	

43. *Public Hearing Notices & Reports*, State of Connecticut Department of Public Health, http://www.ct.gov/dph/cwp/view.asp?a=3902&q=276950, (March 28, 2016).

ONLY SIX STATES REQUIRE A SEPARATE PUBLIC HEARING FOR EACH CON APPLICATION.

The MergerWatch review did not find any examples of requirements for potentially more effective notification of affected consumers, such as through issuance of press releases to local newspapers, notification of local officials, postings in local libraries or through use of social media.

Can consumers testify at public hearings?

Only six states require a separate public hearing to specifically address each pending CON application (Alaska, California, Hawaii, Iowa, New Jersey and Virginia). **THERE ARE 22 PROGRAMS (21 STATES AND D.C.) that will only hold a public hearing upon request, with varying requirements as to who has the standing to make such a request.** In eight states, the public can participate in the CON process only by attending a regularly-scheduled review board meeting that may contain multiple agenda items in addition to the CON application, and may or may not have a public comment opportunity.

21
STATES & DC

CT	MD	NJ
DE	ME	OR
DC	MI	RI
FL	MO	SC
GA	MS	WA
IL	MT	WV
KY	NC	
MA	NH	

Can consumers submit written testimony?

19
STATES

AK	MD	SC
AL	MO	TN
CA	MT	VA
GA	NC	VT
IL	NJ	WA
ME	NY	
MA	RI	

ONLY 19 CON PROGRAMS allow people to submit written testimony spelling out their concerns with the proposed transaction. Of those states that allow written testimony to be submitted, only four have laws requiring that written comments must be considered by the official CON reviewing body: Alaska, Alabama, Maryland and Vermont. The rest of the programs are not required to make the written comments part of the record.

Is there post-approval review and enforcement of terms?

25 STATES

AK	MD	OR
DE	MI	RI
FL	MO	TN
GA	MT	VT
HI	NC	VA
IL	NE	WA
IA	NH	WV
LA	NJ	
ME	NY	

Most CON programs have some form of post-approval review and enforcement process in order to ensure that CON holders are complying with the terms agreed to when they were granted a CON. Once a CON is issued, **25 STATE CON PROGRAMS require the state to monitor a CON holder's progress.** In most of these programs, progress is measured by requiring the CON holder to submit periodic updates to the state. In some programs, the CON authority is supposed to check on the progress of the project after a specified amount of time. While most states set conditions for the hospital to follow when their CON is approved, only 23 states have provisions allowing a CON to be revoked if the terms are not followed: Alaska, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Louisiana, Maryland, Michigan, Missouri, North Carolina, Nebraska, New Hampshire, New Jersey, New York, Oregon, Rhode Island, Tennessee, Vermont, Virginia, Washington and West Virginia. Some programs will also allow an extension on the CON if that is needed to comply with the conditions attached to approval. The scope of this review did not allow independent assessment of whether CON approvals are ever revoked if the terms are not met.

ONLY 23 STATES HAVE PROVISIONS ALLOWING A CON TO BE REVOKED IF THE TERMS ARE NOT FOLLOWED.

State grades

In the following two pages, we present the overall grade we have given each state's CON program (if there is one), as well as grades on key policies within state CON review that we believe are important to protect community access to essential services. These include when CON review is required, who performs the review, and how the public can participate in the process.

You can click on the name of the state in the chart or go to www.WhenHospitalsMerge.org where we have posted more detailed information about each state. Our grading methodology gave extra weight to certain aspects of a CON program. See page 30 for more details.

State grades

STATE Click on the name of a state to get more details on our website: www.WhenHospitalsMerge.org	OVERALL GRADE	CRITERIA FOR TRIGGERING REVIEW	ORGANIZATIONAL STRUCTURE OF REVIEW BOARD & TRANSPARENCY	REVIEW STANDARDS	ACCOUNTABILITY AND PUBLIC ENGAGEMENT	COMMUNICATION WITH THE PUBLIC	POST-APPROVAL REVIEW AND ENFORCEMENT
Alabama	C+	F	A	C	B	B	B
Alaska	B	F	C	A	A	A	A
Arizona	F	No CON	No CON	No CON	No CON	No CON	No CON
Arkansas	F	No CON	No CON	No CON	No CON	No CON	No CON
California*	A-	C	C	A	A	A	A
Colorado	F	No CON	No CON	No CON	No CON	No CON	No CON
Connecticut	A	A	C	A	C	A	B
DC	B+	C	A	B	B	A	A
Delaware	C	F	A	C	C	B	B
Florida	C+	F	C	B	C	A	B
Georgia	C	F	C	A	B	B	A
Hawaii	B	C	A	C	B	B	A
Idaho	F	No CON	No CON	No CON	No CON	No CON	No CON
Illinois	A	A	A	A	B	A	B
Indiana	F	No CON	No CON	No CON	No CON	No CON	No CON
Iowa	B-	F	B	A	B	B	A
Kansas	F	No CON	No CON	No CON	No CON	No CON	No CON
Kentucky	D	C	C	F	C	B	B
Louisiana	F	F	C	F	F	C	B
Maine	B	C	C	C	B	A	A
Maryland	B-	F	B	C	B	B	A
Massachusetts	B-	F	A	F	B	B	B
Michigan	C+	F	B	B	B	B	B
Minnesota	F	No CON	No CON	No CON	No CON	No CON	No CON
Mississippi	B	B	C	A	C	B	A

*ranking based on Attorney General review of Hospital Mergers

State grades, continued

STATE Click on the name of a state to get more details on our website: www.WhenHospitalsMerge.org	OVERALL GRADE	CRITERIA FOR TRIGGERING REVIEW	ORGANIZATIONAL STRUCTURE OF REVIEW BOARD & TRANSPARENCY	REVIEW STANDARDS	ACCOUNTABILITY AND PUBLIC ENGAGEMENT	COMMUNICATION WITH THE PUBLIC	POST-APPROVAL REVIEW AND ENFORCEMENT
Missouri	C-	F	B	F	B	A	B
Montana	B-	F	C	A	B	A	F
Nebraska	F	F	C	F	F	C	B
Nevada	F	No CON	No CON	No CON	No CON	No CON	No CON
New Hampshire	D+	F	B	B	C	B	B
New Jersey	A	A	A	A	A	C	B
New Mexico	F	No CON	No CON	No CON	No CON	No CON	No CON
New York	B	C	A-	C	B	B	F
North Carolina	B-	F	B	B	B	B	B
North Dakota	F	No CON	No CON	No CON	No CON	No CON	No CON
Ohio	F	No CON	No CON	No CON	No CON	No CON	No CON
Oklahoma	F	No CON	No CON	No CON	No CON	No CON	No CON
Oregon	D-	F	B	F	C	B	A
Pennsylvania	F	No CON	No CON	No CON	No CON	No CON	No CON
Rhode Island	A-	A	B	C	B	B	A
South Carolina	D	F	C	B	B	B	B
South Dakota	F	No CON	No CON	No CON	No CON	No CON	No CON
Tennessee	A-	B	A	C	B	A	A
Texas	F	No CON	No CON	No CON	No CON	No CON	No CON
Utah	F	No CON	No CON	No CON	No CON	No CON	No CON
Vermont	B-	F	B	B	B	A	A
Virginia	B	C	C	C	A	B	A
Washington	C-	F	C	B	B	B	A
West Virginia	D	F	C	B	C	B	A
Wisconsin	F	No CON	No CON	No CON	No CON	No CON	No CON
Wyoming	F	No CON	No CON	No CON	No CON	No CON	No CON

MODEL POLICIES AND ACTION STEPS

Model Certificate of Need policies for the new era of hospital consolidation

Current Certificate of Need policies vary widely across the states, but they share a need to be updated to reflect the shifting realities of the health care landscape. As the hospital industry continues to move towards more consolidation, and there are an increasing number of rural hospital closings, it is important to ensure that state oversight policies like Certificate of Need can be utilized to protect access to care. Patient access to care will only be protected if consumers can meaningfully participate in the Certificate of Need review process by being fully informed and having the ability to provide testimony about the potential impact on their communities.

1. Criteria for triggering CON:

- Ideally, a CON would be required any time a hospital is involved in a sale, purchase, lease, affiliation or transfer of board control.
- It would also be required when the proposed transaction would result in a loss of services, with services defined to include reproductive health services such as tubal ligations, abortions, and contraceptive counseling.

2. Organizational structure of review board and transparency:

- The board reviewing the CON application should be composed based on set criteria in the CON statute (or regulations) to encourage diversity and safeguard against political pressure.
- The review board should be required to include members of the community and consumer advocates, as well as health experts from various fields.
- No more than 50% of the members should be representatives of institutional health care providers because of their tendency to vote for each other's projects and move each other forward.

3. Review standards:

- The standards for reviewing a CON should be publicly available and established by regulation/statute.
- The review should include a comprehensive, independently performed health needs assessment that analyzes health needs of the community (defined broadly), the availability of services in the community, transportation and other access needs and a comprehensive assessment of the impact of the proposed change on the availability and access to key services. Alternatively, if an existing state health planning document identifies the health needs of the affected hospital service area, it can be used in the review process.

4. Communications with the public:

- To ensure that the CON process is transparent and consumers can have the opportunity to meaningfully engage in review of proposed changes to the hospitals in their community, the Department of Health (or similarly situated department handling CON in the state) should provide adequate information to the public, focusing on anyone likely to be impacted by the transaction. Information should be in multiple languages, culturally sensitive, and easy to access in multiple platforms.
- There should an easily navigable website with all relevant CON documents available for download. There should be summaries of each proposed transaction including the above required impact statements written in plain English and other languages spoken in the community. All information

about regulations, meetings and details about submitting comments should be available on this website in an easy to find, easy to read format.

- All such information should also be submitted to at least one local newspaper for publication, posted in local health centers and distributed to local officials who can disseminate the information to their constituencies.

5. Accountability and public engagement

- Most vital to a more robust CON process is the way it facilitates and relies on meaningful public engagement. There should be an opportunity for affected members of the public, and their representatives, to obtain key CON documents submitted by the applicants and to submit written comments on CON applications.
- In addition, for hospital CON applications, there should be a requirement that public hearings should be held at the location of the proposed transaction, (as opposed to only in the state capital) upon request by affected consumers.
- There should be time allotted for testimony from consumers and advocates.

6. Post approval review and enforcement

- In addition to hearings and comments during the approval process, a robust CON process will include the ability for the public to request a post-approval review, or a have the ability to appeal any decision made on the CON.
- There needs to be an enforcement mechanism in place whereby the Department of Health or another regulatory body must perform a review of the CON conditions at one year, two year and five year intervals to ensure requirements are being carried out.

Action steps for advocates

There are many ways to get involved to protect access to health care when hospitals merge. Advocates can learn about their state's Certificate of Need policies, employ them to the maximum extent possible when cases arise and document the impact of gaps in their state's policies in order to push for stronger state oversight of proposed hospital transactions.

Here are some recommended action steps for state consumer health advocates:

1. **Get to know the Certificate of Need policies in your state.** Start with the information on each state that you can find in this report and get more detail by going to our website, www.WhenHospitalsMerge.org
2. **Review our Model Policies and the CON policies** in neighboring or comparable states to see how your state stacks up.
3. **Engage allies in your state who care about health care access** and start a discussion about whether your state's hospital oversight is strong enough to protect community access to care when hospitals merge. Identify those policies that are weak or missing, and need to be strengthened.
4. **Identify key health policy makers in your state** and push them to analyze the impact of hospital consolidation on consumers in your state.
5. **Advocate for changes to your state's Certificate of Need laws** to create a more robust system of oversight over hospital consolidation. Is there a hospital merger right now in your community that needs your attention? Contact us for help in identifying aspects of your state's existing hospital oversight laws that you could employ to protect community access to care. Reach us at www.MergerWatch.org

Follow us on **Facebook** and **Twitter** to keep up with the latest developments.

APPENDIX

Methodology

Methodology of research and grading

The MergerWatch Project conducted a review of the laws in each state that regulate proposed hospital transactions, such as mergers, acquisitions and closings. These laws are generally referred to as Certificate of Need (CON) programs, although the name may be different in some states (such as Determination of Need in Massachusetts). We developed a list of key policies within these CON laws that are essential to ensuring that the potential impact of a transaction on community access to care is considered, and that affected consumers are engaged in the review process. Examples of such policies include broad definitions of the types of transactions requiring review (to include affiliations and other looser forms of partnerships), notification of communities that would be affected by a proposed hospital consolidation, and engagement of consumers through such means as public hearings or submission of written comments.

We then evaluated whether these key policies were present in each state's CON program and assigned a point grade from 4 to 0, depending on whether the policy was robust, weak or non-existent. Those policies that we determined to be especially important to achieving an effective hospital oversight system were given extra weight in our grading system. The grades given to each state were assigned based on the weighted score.

MergerWatch recognizes that some states conduct oversight of proposed hospital transactions under laws other than Certificate of Need, a few of which our outlined in the report. California is the only state without a Certificate of Need program that we included in our grading system because its Attorney General Review process so closely mirrors CON. By narrowing our focus to Certificate of Need, we were able to compare a specific type of program among different states.

Methodology of data analysis

Tables 1, 2 and 3 in this report were prepared by consultant Patricia HasBrouck, MBA, using hospital data acquired from Definitive Healthcare – a health care informatics company whose products include an online database of hospital descriptive, utilization and financial information. The data are updated on a daily basis as information becomes available related to new cost report filings, hospital mergers and acquisitions and other data modifications.

The hospitals included in our analysis are short-term acute-care hospitals that provide a full range of services. Not included are psychiatric, long-term care, rehabilitation, critical access, pediatric, federal and developmental disability facilities. Only hospitals present in the Definitive Healthcare database in January 2016 were included. Bed counts and patient charges information for each hospital come from the most recently-available Medicare Cost Report that is filed annually by every hospital. For most of the hospitals included in this study, the cost report dates to 2014 or 2015.

Our tables reflect the four basic sponsorship types of community hospitals in the United States, as defined by the Center for Medicare and Medicaid Services (CMS): governmental (such as those operated by a municipality), proprietary or for-profit, and two categories of voluntary non-profits: church and other. For purposes of this report and its audience, the term public is used to describe governmental hospitals, for-profit to describe proprietary, and secular non-profit for those hospitals that are not religiously-sponsored.

Other state level review of hospital transactions

CON-like review in California

In California, where there is no Certificate of Need program, the Attorney General is required to review transactions when a non-profit proposes to "sell, transfer, lease, exchange, option, convey, or otherwise dispose of a material amount of assets, or transfer control of assets or operations to another non-profit or for-profit corporation."[44] The Attorney General may consider any factor that is relevant when reviewing the transaction, including: whether the terms and conditions of the transaction are fair and reasonable with no private inurement and consistent with the non-profit purpose; the effects of the transaction on the public; the impact on health care; any significant effects on the availability or accessibility of health care services to the affected community; and whether the transaction is in the public interest.[45] The guidelines for review also specifically state that the Attorney General shall not consent to an agreement whether the seller restricts the type or level of medical services that may be provided at the health facility that is the subject of the agreement.[46]

Information about the review process in California can be found very easily on the Attorney General's website.[47] That information includes, but is not limited to, notices of nonprofit hospital transactions that are being reviewed, the relevant state statutes and regulations about the review process, and an archive of previous transactions that were reviewed by the Attorney General.[48] For this review process, the Attorney General is required to hold a public meeting and public notice of the meeting must be given in a newspaper of general circulation, and if an interested party would like to provide comments on the proposed agreement, then they may submit written or electronic mail to the Deputy Attorney General.[49]

Attorney General review of charitable assets

In most states, even those that do not have Certificate of Need programs, state Attorneys General have the authority to review and regulate hospital mergers and other types of non-profit hospital transactions, due to their long standing authority over charitable assets. When a non-profit is created, the state has an interest in ensuring that the organization is carrying out the charitable

44. Cal Corp. Code § 5914(a)(1)(A) (West 2014).
45. Cal Corp. Code § 5917 (West 2014).
46. Cal Corp. Code § 5917.5 (West 2014).
47. *Nonprofit Hospital Transaction Notices*, The California Department of Justice Office of the Attorney General http://oag.ca.gov/charities/nonprofithosp, (2014).
48. Ibid.
49. Cal Corp. Code § 5916 (2014).

mission for which it was initially created. State Attorneys General are charged with representing the public in ensuring that the charitable mission is carried out in at least some capacity.[50] For example, if a secular non-profit hospital merges with a religious hospital and now may have to abide by religious restrictions to care, it can be argued that the charitable mission has shifted and therefore will require Attorney General review. Additionally, Attorneys General can review hospital conversions, meaning a transaction where a non-profit corporation converts to a for-profit corporation, for a similar reason. When a non-profit hospital becomes for profit, due to being purchased by a for-profit entity or for another reason, that is also a mission change that must be analyzed by the Attorney General.[51]

Anti-trust review by state Attorneys General and FTC or Justice Department

Mergers, sales and acquisitions of hospitals can be scrutinized at the federal level (and in many cases at the state level by the Attorney General as well) by the Department of Justice and the Federal Trade Commission, due to the possibility of antitrust or anti-competition issues.[52] In anti-trust cases, the FTC and the Department of Justice look at whether the proposed merger will have anti-competitive effects and lead to higher prices in a specific market. Their analysis includes determining what the relevant geographic market is, whether the merging entities were previously in competition with each other, and whether there are other hospitals in the geographic location that will provide enough competition to keep prices down.[53] Analysts also say that there is less likely to be an anti-trust challenge to the merger if it promotes a benefit in the community, whereas a loss of access to services could be seen as a violation of anti-trust law.

50. PA Butler, *State Policy Issues in Hospital Conversions*, 16 Health Affairs no. 2. 69, 70, (1997).
51. 13 Kan. J.L. & Pub. Pol'y 357 2003-2004
52. *Statements of Antitrust Enforcement Policy in Health Care*, U.S. Department of Justice and the Federal Trade Commission, https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf, (August 1996).
53. Kathleen Roney, "An Overview of Recent Challenges to Hospital Transactions: Is the FTC Really More Aggressive?," http://www.beckershospitalreview.com/hospital-transactions-and-valuation/an-overview-of-recent-challenges-to-hospital-transactions-is-the-ftc-really-more-aggressive.html, (May 01, 2012).