House Select Committee on the Certificate of Need Process

My name is Dennis Coffey. I am the Chief Financial Officer for Dosher Memorial Hospital in Southport. Dosher is a Critical Access Hospital that has served the needs of Southeast Brunswick County for over 80 years. First, let me say that I am supportive of the CON law and believe it is necessary to avoid unnecessary duplication of services and "skimming of profitable services" that financially harm community hospitals. It is far too difficult in today's environment to cover the cost of those patients without the ability to pay who use community hospitals as their primary source of healthcare. I do believe there are many opportunities to improve the process and reduce the administrative burden on healthcare providers.

These issues are fresh on my mind, as our Hospital filed on November 15th the document I have with me tonight. You can see that this I quite a large amount of paper for a project that will renovate patient rooms that were built in the 70's, do not meet ADA requirements for toilet facilities, and do not have a sprinkler system. We have incurred costs of over $100,000 just to file this application. And this does not count the staff time expended to gather the data required to fulfill the requirements. Many of the documents requested could be avoided if the facility making the request is Joint Commission Accredited. Copies of policies required for accreditation should not be needed.

I would offer the following suggestions for improving the process:

- The current $2,000,000 limit is too low. This has not changed in far too many years.

- There needs to be an expansion of the categories of what can be expedited. $5 million is a good start, but replacement / modernization project limits could move up to a higher level, maybe $15 million and save everyone time and money.

- Appeals process is too long and costly; should be shortened; penalties for frivolous appeals should be higher and more enforceable. There should be particular focus on appeals by competing entities so that appeals are not filed merely to slow down a competitor.

- Small hospitals are penalized by current target occupancy tiers. Critical Access Hospital's (CAH) target occupancy should not be same as 99 bed hospital. Daily fluctuations in census have a much greater impact on smaller facilities. Five patients in a CAH would be 20% of the licensed bed capacity, vs. 5% of the 99 bed hospital. CAH should have lower target, no more than 50%.

- Failure to recognize dual role of beds for observation/inpatient acute care is not realistic. CON methodologies and state plan need to keep up with reality of way small hospitals are operated. Observation patients occupy the same beds as patients counted in current methodologies. Using these patients in the census count would reflect the reality of using the same beds, which is far more cost effective than building and staffing a separate unit. This would hold true up for most hospitals with less than 100 beds.