Reform of CON Law in Tennessee - 2021

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The Tennessee General Assembly enacted legislation in 2021 to update and reform the certificate of need ("CON") process. The legislative effort to change Tennessee CON law began in the General Assembly's 2020 session. With considerable input from various provider groups and other stakeholders, the General Assembly arrived at final legislative proposal that was enacted as 2021 Pub. Ch. 557. The slides that follow summarize this enactment. Except as indicated in the following summary, the changes enacted by 2021 Pub. Ch. 557 are effective October 1, 2021.

Items Excluded From CON Coverage

- Addition of beds to existing hospitals and redistribution of beds to existing categories in hospitals (acute, rehabilitation and long-term care)
  - [Note: This provision is effective June 2, 2021]
- Mental health hospitals or the initiation of psychiatric services
- Initiation of MRI or PET services in counties with a population of 175,000 or more (except CON still required for MRI in larger counties if more than five patients 14 years or younger will be served annually)
- Home health agencies limited to either (1) the federal EEIOCPA program, (2) to patients under 18
- Relocation of the principal office within the service area of an existing home health agency or hospice

Items Excluded From CON Coverage

- Hospice or residential hospice for patients under the care of certain research institutions
- Increase in beds by nursing homes tri-annually by the lesser of 10 beds or 10% of existing beds
- Any service or institution in economically distressed counties without a hospital as of January 1, 2021 (Clay, Grundy and Lake)
- Reopening of a closed hospital in a rural county with a population under 49,000 that is a Tier 2, 3 or 4 enhancement county
  - Hospital must have been closed within the last 15 years
  - CON application must be submitted within 12 months after the facility becomes licensed

Items Excluded From CON Coverage

- Nonresidential substitution-based treatment center for opiate addiction center located on the campus of a mental health hospital (licensed under title 33)
- Relocation of existing health care institutions and services if the executive director finds (1) that 75% of the patients to be served in the new location are reasonably expected to reside in the same ZIP codes as served at the existing location, and (2) the relocation will not reduce access to consumers

What's Still Covered

- Establishment of a designated healthcare institution:
  - **Hospitals (except mental health)**
  - **Ambulatory Surgical Treatment Center**
  - **Outpatient Diagnostic Center**
  - **Nursing Home**
  - **Home Health Agency (subject to exceptions)**
  - **Hospice Agency (subject to exceptions)**
  - **Residential Hospice (subject to exceptions)**
  - **Intellectual Disability Institutional Habilitation Facility**
  - **Rehabilitation Facility**
  - **Nonresidential substitution-based treatment center for opiate addiction (unless on the campus of mental health hospital)**

What's Still Covered

- Initiation of designated services:
  - **MRI in counties under 175,000**
  - **MRI in all counties if more than five pediatric patients (14 years or younger) will be served annually**
  - **PET in counties under 175,000**
  - **Linear Accelerator (regardless of county size)**
  - **Burn unit**
  - **NICU unit**
  - **Open heart surgery**
  - **Organ transplantation**
  - **Cardiac catheterization**

What's Still Covered

- Increasing the number of MRIs for an existing provider in counties with a population under 175,000
- Redistributing hospital beds to acute, rehabilitation or long-term care categories
- Relocations of existing health care institutions and covered services (unless exempted by the Executive Director)
- Increase in beds for an existing nursing homes in excess of tri-annual increase of the lesser of 10 or 10%
- Establishing a satellite ED or satellite inpatient facility

Changes in the CON Process

- Criteria for institutions and services covered by CON will be developed by the HSDA rather the Division of Health Planning
  - Developed by the HSDA through rulemaking
  - Each criterion evaluated and updated at least every 5 years
  - HSDA also authorized to conduct annual needs assessment
- Health planning fees will increase; filing fees will be reduced significantly
- CON application review process is reduced and streamlined; most applications will be considered within about 60 days of the date the application is filed

Changes in the CON Process

- Information in a CON application will be independently verified by the HSDA staff. Departments of Health and Mental Health are required to provide data upon request. Departments, in their discretion, may also submit reports and testify on CON applications
- Providers who wish to appear in opposition to a CON application must (1) be located within a 35-mile radius of the site of the CON applicant and (2) file written opposition at least 15 days in advance of the hearing specifying why the application fails to meet one or more of the statutory criteria
- A home health agency or hospice wishing to oppose a CON application must serve at least one of the counties proposed in CON application

Changes in the CON Process

- Economic feasibility and contribution to the orderly development of healthcare have been eliminated from the statutory criteria applicable to all projects. The 3 statutory criteria are now:
  - **Need (current law)**
  - **The project will meet appropriate quality standards (current law)**
  - **Effects attributed to competition or duplication will be positive for consumers (new)**
- If there is an appeal, the losing party is required to pay costs incurred by the prevailing party including attorney's fees

Other Administrative and Process Changes

- "Use it or lose it" provision added to the law. If an activity authorized by CON is not provided for a continuous period of 1 year from the date the CON was originally implemented, the CON is void with respect to the dormant service
  - Applicable to each county for which a home health agency or hospice is authorized
  - Not applicable to health care institutions or beds
  - The HSDA may issue a temporary exemption for good cause and if there is a plan to resume the activity
- New provisions establishing a process for Agency review of actions delegated to the Executive Director (e.g., CON extensions and modifications)
- The Executive Director is required to provide an annual report to the Chairs of the Senate and House health committees that includes a comparison or payer mix and uncompensated care projected by CON holders with what has occurred

Other Administrative and Process Changes

- The Executive Director is required to submit to the Chairs of the Senate and House health committees by January 1, 2023, a plan to consolidate the powers and duties of the HSDA and the Board for Licensing Health Care Facilities
- Providers of the following services are required to submit annual reports to the HSDA by July 30 regarding utilization by payment source and ZIP code origins of patients served:
  - **Cardiac catheterization**
  - **Open heart surgery**
  - **Organ transplantation**
  - **Burn unit**
  - **NICU**
  - **Home health**
  - **Hospice**
- Note bill language says first report is due 9/30/2021, but the HSDA has announced that the first report will not be due until September of 2022.