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Background

As of July 1, 2019, the Florida legislature removed statewide certificate of need (CON) regulations for general hospitals, categorized as "Class I facilities." The bill will repeal CON regulations on Class II facilities, which include specialty hospitals serving a certain age or gender, by July 2021 (Table A).

Table A: Summary of Hospital Classes in Florida as of July 2019

CLASS	DEFINITION	EXAMPLE	CON
N/A	Remaining unregulated	Outpatient services, home health, medical equipment, and assisted living facilities	No CON in effect
I	General hospitals	Acute care hospitals	Removed effective July 2019
II	Specialty hospitals for age or gender group restrictions	Women's hospitals, nursing homes	Removed effective July 2021
III	Specialty hospitals with restricted range of services	Rehabilitation hospitals, orthopedic hospitals	CON required
IV	Specialty hospitals with residential treatment services	Psychiatric hospitals for children and adolescents	CON required

Other states have previously lifted this restriction to increase competition and patient choice across the state. Removal of CON allows facilities to expand as they desire and as stipulated by law, without the approval of the state. Florida has become the 16th state to deregulate CON in some fashion.[1]

1. CERTIFICATE OF NEED STATE LAWS, National Conference of State Legislatures, February 2019, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx.

However, there is continued speculation on the pending impact facing hospitals and health systems. Those in favor of CON removal stand firm on the idea that new competition will enhance value and access, reducing total cost of care for patients. Those opposed suggest CON laws protect the stand-alone, not-for-profit community hospitals; the removal of CON provides advantage for well-capitalized health systems (most notably corporate, for-profit health systems) to grow, placing competitive pressures on community-based hospitals and employers.

For years, Texas has often been the case study cited by CON proponents, accused of causing "empty beds and poor levels of care" as the state entirely deregulated CON in 1985,[2] with mass hospital closures in just the first 10 years following CON repeal.

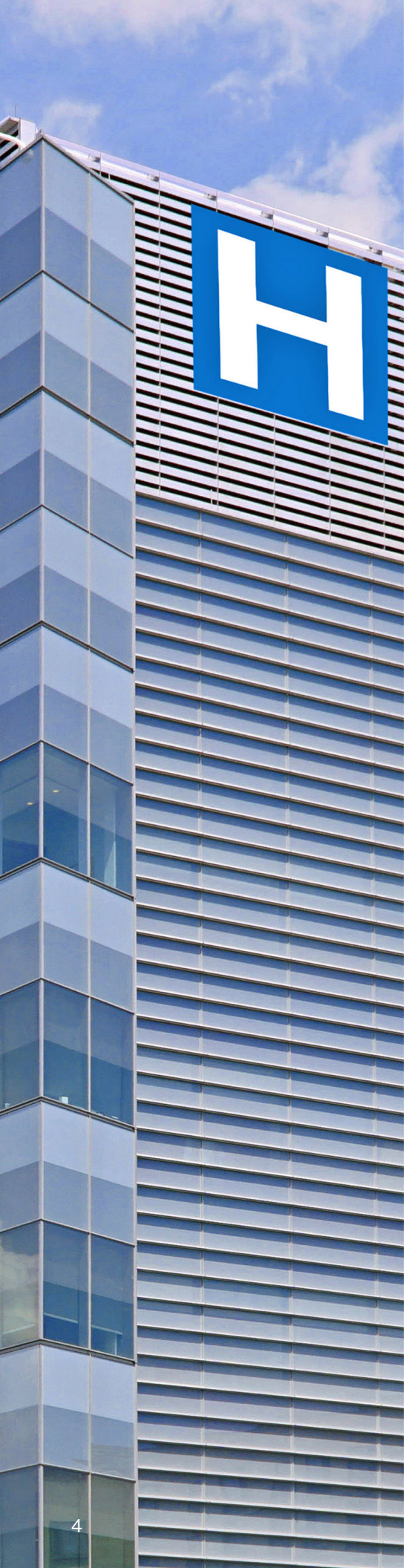
Nearly 35 years later, the provider landscape and population has changed substantially. Thus, Guidehouse has compiled several analyses and data points to conduct an in-depth assessment of today's Florida provider market and trends to anticipate the impacts to hospitals due to the recent removal of CON.

What new risks are hospitals facing? What should hospital leadership be considering and planning for? And will Florida be the second coming of Texas?

Florida Facility Profile: Anticipating Hospital Risk

Guidehouse conducted a detailed review of previous Guidehouse analyses and data research to compare key metrics in Florida to other states, with a specific comparison to Texas. Key metrics included provider composition and saturation, hospital financial risk and essentiality, as well as distribution of health systems across a given state. Guidehouse's review found that Florida already resembles the Texas hospital landscape in many ways, and is even more competitive from an ambulatory footprint, suggesting that removal of CON may only further fuel an already hypercompetitive market. Thus, the impacts in Florida will not be the second coming of Texas, but hospital executives can be certain that, over time, certain hospital players will capitalize on the new regulation.

2. Christine Sexton, "House approves bill repealing 'certificate of need' regulations on hospitals," South Florida Sun Sentinel, March 21, 2019, https://www.sun-sentinel.com/news/florida/fl-ne-nsf-house-approves-con-health-bill-20190321-story.html.

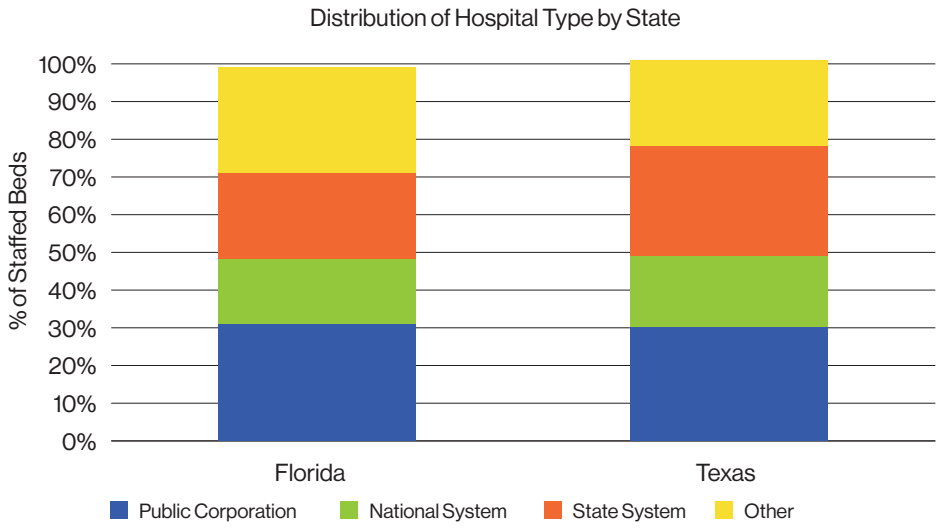


The Hospital Players

With better access to capital and operational scale, for-profit health systems — particularly the public corporations — are better able to thrive in competitive markets. As hospital concentration increases, so do the prices, further confirming why health systems with operational scale can better thrive in these unregulated markets.[3] In Texas, public hospital corporations HCA Healthcare (HCA), Universal Health Services (UHS), Community Health System, Tenet Healthcare, and LifePoint Health provide one of three hospital beds across the state and are known for having a large footprint in both rural and metro markets.

Thus, the question arises: do for-profits and publicly traded systems operate differently in a post-CON Texas, as opposed to a pre-CON Florida? Interestingly, the answer is no. Guidehouse's detailed review of the hospital landscape and ownership found a very similar composition across the two states. The public corporations compose about 30% of all hospital beds (HCA is near 20%) and all for-profit systems total approximately 40% in both Texas and Florida (Figure A). And roughly half of the more than 200 HCA hospitals are located in the two states, according to Definitive Healthcare.

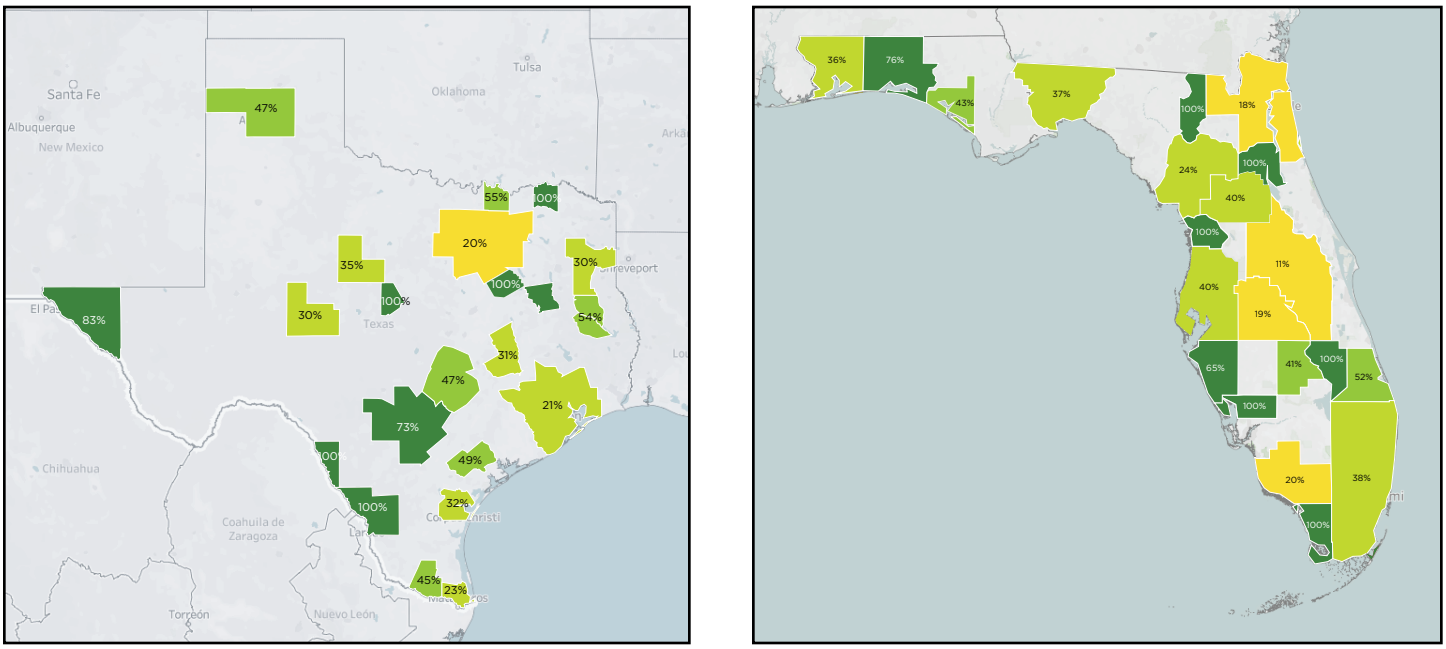
Figure A: Florida vs. Texas Hospital Composition, Number of Beds



3. Healthcare Cost Institute Website: Price and Use Rates, https://www.healthcostinstitute.org/research/hmi/hmi-interactive#HMI-Price-and-Use.

Looking into specific core-based statistical areas (CBSA), public corporate systems have been able to achieve the largest share of hospital beds in mostly midsize markets, with Miami/Ft. Lauderdale and Tampa Bay (large metro markets) being the exception in Florida. And while HCA has a presence in only eight markets in Texas, it is currently present in 18 markets in Florida, with leading presence in eight of those markets (Figure B).

Figure B: Publicly Traded Beds, by Market



Based on a Guidehouse analysis of Definitive Healthcare data.

Aside from the public corporations, both states also have large regional and national systems with substantial presence (percentage of beds) in the largest metro areas, leading predominantly to highly concentrated hospital markets. Table B shows a detailed output of the distribution.

In fact, inpatient HHI increased in all major CBSAs in both states, illustrating continued hospital consolidation driven by large health systems.[4] However, of all major CBSAs in both Texas and Florida, Miami/Ft. Lauderdale stands as the only CBSA categorized as an "unconcentrated market" based on inpatient HHI, perhaps signaling where health systems may first look to capitalize on the removal of CON.

4. Healthcare Cost Institute Website: Hospital Concentration, https://www.healthcostinstitute.org/research/hmi/hmi-interactive#HMI-Concentration-Index.

Table B: Florida vs. Texas Regional/National Hospital Leaders

MSA	SYSTEM	REGIONAL/ NATIONAL
Jacksonville, FL	Ascension (25%)	N
	Baptist Health (25%)	R
Orlando, FL	AdventHealth (53%)	N
	Orlando Health (27%)	R
Tampa Bay, FL	BayCare Health System (30%)	R
	AdventHealth (15%)	N
Miami/Ft. Lauderdale, FL	Multiple (no regional w/more than 10%)	N/A
Dallas/Ft. Worth, TX	Baylor Scott & White Health (23%)	R
	Texas Health Resources (25%)	R
Houston, TX	Memorial Hermann (26%)	R
	Houston Methodist (16%)	R
	CommonSpirit Health (14%)	N
Austin, TX	Ascension Seton (35%)	N
San Antonio, TX	>70% public corporations	N/A

Furthermore, the larger health systems in Florida have also maintained robust diverse facility portfolios, with an owned-network diversification focus beyond acute hospitals. A further review of these key players reveals that most of Florida's larger health systems have established robust ambulatory footprints, investing in a number of free-standing provider sites, including ambulatory surgical centers (ASCs), urgent care centers, and imaging centers (Table C).

Table C: Key Health Systems in Florida

TYPE OF SYSTEM	NAME	# OF HOSPITALS	# OF FREE-STANDING	MARKET DEVELOPMENTS
Public Corporation	HCA	48	42 – ASC 18 – Urgent care centers 24 – Imaging centers	As of September 2019, HCA bought 55 acres of land in Jacksonville to continue establishing its presence in the county.[5]
	Tenet	10	24 – ASC 39 – Urgent care centers 11 – Imaging centers	No recent updates as of September 2019.
	UHS	3	0 – ASC 0 – Urgent care centers 0 – Imaging centers	No recent updates as of September 2019.
Florida System	Baptist Health	13	7 – ASC 15 – Urgent care centers 15 – Imaging centers	Planning to open ASCs after acquisition of Boca Raton Hospital.
	Orlando Health	8	11 – Urgent care centers 6 – Imaging centers	Multiple free-standing labs opening in the past 2 years; Continues to purchase more land in Orlando area.
	BayCare	15	5 – ASC 18 – Urgent care centers 36 – Imaging centers	Urgent care open.
National System	AdventHealth	36	9 – ASC 58 – Urgent care centers 34 – Imaging centers	Investments in free-standing ERs across the state.
	Ascension Health	6	0 – ASC 12 – Urgent care centers 15 – Imaging centers	Purchased Ardent Health Services in December 2018, which had one hospital with a physician clinic in Panama City.
Stand-alone	N/A	55 (25% of hospitals statewide)		28% of total hospital beds in the state.

5. Alia Paavola, "HCA buys 55-acre plot in Florida," Becker's Hospital Review, September 16, 2019, https://www.beckershospitalreview.com/facilities-management/hca-buys-55-acre-plot-in-florida.html.

What does it mean? Large health systems (both for-profit and not-for-profit) will look to grow and/or maintain market presence by expanding physician and ambulatory footprints. With more contiguous markets in Florida than in Texas, systems and public corporations can now (following CON removal) "connect the dots" by placing inpatient and ambulatory facilities where current geographic or network gaps exist for a single integrated delivery network. HCA already has a stronger statewide presence in Florida, setting the stage for it to expand even further. CON will still be required for specialty hospitals, providing some protection for stand-alone hospitals from investors that collaborate with large specialty practices. Of note, hospital price increases tend to rise as hospital consolidation and inpatient HHI increase.[6] Removal of CON could certainly create increases in Florida prices and concentration, particularly in Miami (already one of the nation's highest priced markets). At what point, if any, could the state see the demand curve reach a peak? How will hospitals position themselves to be able to keep up with a hypercompetitive market while maintaining defensible, competitive prices?

Free-standing Facilities

Prior to hospital CON removal, Florida ranked 16th among all states in hospital beds per thousand, and among the highest in free-standing ambulatory facilities, which had no prior CON requirements (Table D).

Table D: Florida vs. Texas Facility Saturation Rank (per 1,000 residents)*

	FL	TX
Beds per 1,000, rank	15	30
ASCs per 1,000, rank	9	17
Urgent care per 1,000, rank	1	4
FS Imaging per 1,000, rank	15	1
FS ED per 1,000, rank	23	33

*Guidehouse analysis of Definitive Healthcare data.

Growing and aging populations have fueled a hypercompetitive Florida provider market for years, reaching levels similar to Texas for ambulatory facilities. Guidehouse review further indicates patients in Florida are high utilizers of inpatient services (ranking 12th among all states; Texas ranks 30th), but among the lowest for hospital outpatient services (similar to Texas).

What does it mean? Ambulatory services have already moved outside the walls of the hospitals to lower-cost sites of care. Competition in this space will continue to accelerate with free-standing providers on nearly every corner (as long as investors see profits), and hospitals/health systems will be forced to compete (more) in this space or be entirely financially dependent on inpatient services. Hospitals that do not have the financial means to establish an ambulatory footprint and integrated delivery network will continue to downsize as the outpatient business moves to lower-cost settings, and the higher-acuity inpatient services migrate to larger, well-known tertiary hospitals.

6. Healthcare Cost Institute Website: Hospital Concentration, https://www.healthcostinstitute.org/research/hmi/hmi-interactive#HMI-Concentration-Index.

Hospitals Already at Risk Today

Since 1985, Texas has experienced closure of almost 100 rural hospitals, 50 of which occurred in just the first five years following CON repeal. While Texas continues to lead rural hospital closures in the past decade (since 2010), Florida has seen just one rural hospital shut its doors, and, with only 23 rural-designated facilities across the state, ranks among the lowest of all states in rural beds per thousand.[7]

While Florida may not face the same rural pressures as Texas and other states across the Southeast, Guidehouse's review suggests the state may already be "over-bedded,"[8] posing real risks for several hospitals with the removal of CON regulations. Guidehouse's analysis indicates that just 25% of all Florida hospitals are "critically or moderately essential" to the communities they serve, in comparison to 51% in the Southeast and 46% in Texas. Interestingly, the same analysis indicated 59% of Florida hospitals are at "high or medium financial risk" (similar to both national and regional figures) with just 23% of hospitals breaking even on Medicare in the nation's most densely populated Medicare state.

Table E: Florida Hospital Financial Risk and Essentiality

	% OF STAFFED BEDS					
	Financial Risk			Essentiality Rating		
CBSA	High	Medium	Low	Critically	Moderately	Low
Miami-Fort Lauderdale-West Palm Beach	20%	30%	51%	18%	0%	81%
Tampa-St. Petersburg-Clearwater	9%	37%	54%	12%	0%	88%
Orlando-Kissimmee-Sanford	2%	23%	76%	47%	15%	38%
Jacksonville	0%	57%	43%	0%	24%	76%
North Port-Sarasota-Bradenton	0%	53%	47%	19%	35%	46%
Lakeland-Winter Haven	0%	84%	16%	0%	76%	24%
Deltona-Daytona Beach-Ormond Beach	0%	8%	92%	0%	46%	54%
Palm Bay-Melbourne-Titusville	0%	49%	51%	0%	0%	100%
Pensacola-Ferry Pass-Brent	1%	67%	31%	0%	58%	42%
Gainesville	0%	34%	66%	66%	34%	0%
All Other	19%	47%	34%	26%	41%	33%

What does it mean? Hospitals in both rural and metropolitan markets face risk of closure, particularly those with higher Medicare population and payer mix. In removing the CON, the state has signaled it will likely not be protecting rural hospitals in financial risk, as other states have done.

7. University of North Carolina, Cecil G. Sheps Center for Health Services Research, "108 Rural Hospital Closures: January 2010 – Present," https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
8. Healthy Marketplace Index, Health Care Cost Institute, https://healthcostinstitute.org/research/hmi/hmi-interactive#HMI-Use-Index.

Conclusion and Predictions

Florida is not the next Texas. Rather, many hospitals across Florida already face more dire circumstances, including competition from large, capital-laden health systems and an ever-growing ambulatory market — all of this prior to the removal of hospital CONs.

As outpatient services have migrated out of hospitals at U.S.-leading rates (no prior CON required for outpatient facilities), hospitals without an ambulatory footprint (or capabilities to create one) will bleed market share and be forced into a size and staffing model to accommodate a decreasing inpatient demand. While CON laws were not previously in place for most ambulatory facilities, competition will continue to grow in this space to establish network entry points at lower-cost settings.

National, regional, and publicly traded corporate systems will look for opportunities to place hospitals (or micro-hospitals) in "gap markets" — smaller markets between larger markets with a presence — to continue to build their coverage, referral, and integrated delivery networks. Over time, stand-alone hospitals and smaller systems will be faced with decisions of autonomy vs. continuity, and the larger systems will be looking for acquisition opportunities.

Approving, planning, and building new hospitals is not an overnight activity. It will be several years before impacts are recognized across the state, but hospital executives should be planning their future strategies now.

Key Considerations for Hospital Executives

1. How does my hospital rank across the state in financial risk and essentiality?
2. If we are to survive on a mostly inpatient model, do we have the cost structure and trajectory to maintain this business model into the future? Should we be considering a micro-hospital model?
3. What are my revenues at risk today and how can we project our future revenues? Are my prices/rates appropriately set to maintain market defensibility and competitiveness while aligning with my strategic service line growth initiatives?
4. Realizing specialty hospitals still require a CON, what is our physician alignment strategy to ensure we have relationships with essential specialty practices in the market?
5. Do we have the right network design and patient access points (network design) to support the longevity of a traditional general hospital?
6. Are we in a market that is likely to be targeted by larger systems for hospital expansion?

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