Giving New Yorkers a Voice in Oversight of Hospital Consolidation

By Lois Uttley

Overview

Hospitals across New York State have been merging, closing and transforming at a rapid pace, changing the health care landscape that consumers must navigate. Forty-one acute care hospitals have closed across the state over the last 20 years, while others have eliminated emergency departments and maternity care. Nearly 500 acute care hospital beds were eliminated across the state in 2017. Large health systems have been steadily moving to acquire the remaining community hospitals, and now control 70 percent of the inpatient acute care beds in the state.

Hospital consolidation can require patients to travel to other locations to receive medical care from unfamiliar clinicians. Disabled and elderly patients, as well as those for whom English is not their primary language and those reliant on public transportation, may face particular challenges navigating changing delivery systems. While hospital executives often predict consolidation will improve care and efficiency, studies to date have not shown evidence of quality improvements. One recent study, in fact, warned that movement of care from one site to another through consolidation can pose threats to patient safety, if not carefully managed. Moreover, a number of recent studies have demonstrated that market consolidation can lead to increases in the price of health care, which are passed along to consumers through higher insurance premiums and deductibles.

Because of the significant consequences for patients, it is important that consumers have a say in state oversight of hospital consolidation. All too often, however, that does not happen, according to a study, "Empowering New York Consumers in an Era of Hospital Consolidation," funded by the New York State Health Foundation and published in 2018 by the MergerWatch Project. Instead, consumers—taken by surprise when health systems announce planned closures or service reconfigurations—scramble to understand, influence or protest the proposals. The study concluded that New York's 55-year-old Certificate of Need (CON) process should be updated to ensure that consumers are notified and engaged when their local hospitals propose to join health systems or plan to downsize, close or transform the way they deliver health services.

The study urged increased consumer representation on the state Public Health and Health Planning Council (PHHPC), which considers the most important hospital transactions, and recommended steps to make the entire CON process more transparent and consumer-friendly. The study also suggested that New York follow the example of some neighboring states by including consideration of the potential impact of proposed hospital consolidation on the price of health care.

The Changing Health Care Landscape

Across the nation, the pace of hospital consolidation is accelerating and health care delivery is transforming. Some financially stressed community hospitals are downsizing, converting into urgent care centers or freestanding emergency departments, or closing. Especially hard hit are rural hospitals, more than 119 of which have closed since 2005.[1] Some urban hospitals, particularly those that are publicly owned and disproportionately serve uninsured and Medicaid patients, are also struggling. Nationally, 15 percent of hospitals are considered at risk of closure due to financial pressures.[2] Many of the remaining independent community hospitals are joining regional and national health systems. Between 2013 and 2017, nearly 1 in 5 of the nation's 5,500-plus hospitals were acquired or merged with another hospital, according to Irving Levin Associates.[3]

There are many factors promoting consolidation, including clinical advances that make it possible to safely move treatment from inpatient hospitals to ambulatory sites. Another factor is payer demand for "value-based" care, necessitating capital investment in expensive technology to support collaboration among health care providers along the continuum of care, as well as administrative capacity to negotiate and manage value-based contracts. These requirements have proved challenging for smaller hospitals. Health systems have also acquired hospitals to increase market share, thereby gaining negotiating leverage with health insurers, as well as a larger patient base to feed the more specialized larger hospitals within each system. For rural and some urban hospitals, challenges may be precipitated by prohibitive costs to renovate ag-

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ing hospital buildings, lack of access to capital and high percentages of patients who are uninsured or who are insured by (lower paying) Medicaid.

What has been happening in New York State? MergerWatch research found that a total of 41 hospitals have closed general inpatient services over the last 20 years. Sixteen of those hospital campuses have been converted to non-medical uses—such as condominiums, assisted living facilities, office space and schools—or are abandoned. The remaining 25 former hospital sites continue to be used for a range of medical services, such as clinics, labs, ambulatory surgery centers, urgent care centers, psychiatric treatment facilities, nursing homes and drug or alcohol rehabilitation centers. Some of these closings were recommended in 2006 by a state hospital "rightsizing" initiative called the Commission on Health Care Facilities in the 21st Century.

The number of hospital beds in New York has been steadily decreasing as facilities are downsized and transformed. New York State Department of Health data on hospital bed changes from 2015-2017 reveal a sharp jump in the number of beds lost, from 102 in 2015 up to 474 in 2017. The greatest reductions have been in the number of medical/surgical beds, which decreased by 402 beds over the three-year period. The next largest reduction was in psychiatric care (down 202 beds), followed by maternity care (down 88 beds) and pediatrics (down 80 beds).

The trend of hospital consolidation, downsizing and transformation into outpatient facilities or freestanding emergency departments is likely to continue in New York. More than 30 hospitals are financially endangered and would have closed or significantly reduced services within the past four years, absent extraordinary state support, according to recent presentations by New York State Department of Health (NYS DOH) staff.[4]

As individual New York hospitals change, merge and close, the health systems that began to take shape 20 years ago are growing in size, geographic reach and power, and strategically affiliating with or acquiring struggling community hospitals. Between January 2011 and September 2017, a total of 78 mergers or acquisitions were approved or pending, according to the Department of Health.[5] Through such transactions, a small group of non-profit hospital systems have grown steadily larger in recent years. These systems now own or manage multiple hospitals, ambulatory surgery centers, urgent care centers and physician practices stretching over several counties. MergerWatch research found that the 12 largest systems in New York control more than half of the short-term acute care hospitals, 66 percent of inpatient beds, and account for more than two-thirds of all inpatient discharges.

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Study Findings: New York's CON Process Fails to Engage Affected Consumers

MergerWatch's study of New York's Certificate of Need (CON) process did not attempt to determine whether hospital consolidation is necessary or wise, but rather whether state oversight through CON is transparent to the public, engaging of affected consumers and appropriately protective of community access to timely, affordable care. The study compared New York's CON policies and procedures with those found in other states. Staff interviewed New York State Department of Health (DOH) staff and key organizational stakeholders of the CON process, such as hospital associations. The study included regular attendance at PHHPC meetings, including a PHHPC retreat held in September 2017, and review of a report the PHHPC issued in 2012 recommending CON reforms.

The MergerWatch study concluded that the current CON system in New York is not transparent to the public and fails to notify and engage consumers affected by hospital consolidation. Key findings were:

- **The consumer voice is not well represented on the 24-member PHHPC**. Public Health Law (Article 2, Section 220) specifies that "at least one member" of the PHHPC represent a consumer health advocacy organization. That "consumer seat" had been vacant from mid-2016 through early 2019, when this article was prepared. By contrast, New Jersey requires that five of the nine board members who review CON applications be consumer representatives. Maryland's review board has 15 members, nine of whom are consumer representatives. Delaware's board has four out of 15 members from the "public-at-large," and requires that the Chair and Vice Chair of the board are both appointed from among those four members.

- **Hospitals are being closed, downsized, merged into large health systems and/or transformed into outpatient care facilities without adequate public notice or engagement of affected consumers.** While state officials may encourage hospitals to hold community meetings, there is no state requirement for public hearings in the local community on proposed closure plans *in advance* of a planned hospital closing.
- **Hospital closings and most downsizing efforts (such as eliminating the emergency department or maternity services) are reviewed *only* by the NYS DOH staff and state Health Commissioner under "limited review" procedures**. These transactions are not subject to "full review" by the state's Public Health and Health Planning Council (PHHPC) in public meetings at which consumers could be informed and provide comments.
- **Even when proposed transactions are subject to full review by the PHHPC, obstacles in the process frustrate potential consumer participation**. Meetings are not widely publicized and the agendas and voluminous exhibits are sent out electronically just one week in advance, to a list of people who must know to sign up to receive them. PHHPC meetings are held only in Albany or New York City, and only on weekdays. The lack of adequate advance notice that a particular transaction will appear on a PHHPC agenda makes it even less likely that affected consumers will be able to participate. It is difficult to find user-friendly information on the NYS DOH website about CON applications, the CON review process or how to submit written comments on pending applications. Copies of CON applications are not available on the website, leaving consumers in the dark about exactly what facilities are proposing to do. The NYSE-CON electronic system created by the NYS DOH is difficult for consumers to find and navigate.
- **The local CON review function once carried out by Health Systems Agencies (HSAs), all but one of which have closed due to funding cuts, has not been replaced with any organized system of soliciting and gathering consumer comments at the local level**. As a result, the place where an HSA recommendation would be included in DOH summaries of proposed transactions typically says "N/A." A recommendation in a 2012 PHHPC report that Regional Health Planning Agencies be created and asked to provide local perspectives on CON applications was not implemented.
- **Unique to New York, hospital systems are allowed to begin the process of community hospital acquisition through "passive parent" relationships that are not subject to CON review**. These "passive parent" relationships are also not transparent to local health consumers—that is, their meaning for local health services availability and cost are unclear and often unexplored. CON review is required only when the parent system decides to apply for "active parent" status, often several years after the initiation of the "passive parent" relationship. By that time, acquisition of the community hospital has become viewed by hospital management (future employees of the merged system) as all but inevitable.
- **Although one of the original purposes of CON programs was to prevent unnecessary health cost increases, current CON review of hospital consolidations fails to consider whether these transactions might cause consumers, employers and insurers to pay higher prices**. This omission appears to be a missed opportunity at a time when studies are showing that hospital consolidation and resulting market concentration can lead to higher prices.[6]

Recommendations

The study produced recommendations for reform of the CON process, drawing on practices found in other states and, in some cases, recommendations from a 2012 PHHPC report that were not acted upon. Some of these recommendations could be fulfilled by changes in administrative practices and procedures. Others may require regulatory or legislative action.

1. Increase consumer representation on the PHHPC, and make the CON process more transparent and consumer friendly. The report urged the addition of more consumer representatives to the PHHPC to better ensure consumer views are heard. Following release of the report, nine major consumer health organizations and coalitions, including Health Care for All NY, Medicaid Matters and Consumers Union, wrote to Governor Andrew Cuomo urging appointment of consumer health advocates to fill the long-vacant consumer seat on the PHHPC, as well as another vacant seat. A similar letter was sent by a group of New York City Council members and state legislators. Two of those lawmakers, Assembly Health Committee Chair Richard Gottfried and State Sen. Brad Holyman (who both represent Manhattan districts in which St. Vincent's Hospital closed precipitously and Beth Israel Medical Center has announced a dramatic downsizing) have introduced legislation (A.4071 and S.00870) in 2019 to increase the number of PHHPC members to 34 and

require that at least four be consumer health advocates. That legislation has been approved by both the Assembly and Senate, and will go to the Governor.

Other study recommendations in this category included making it easier for consumers to find hospital CON applications on the NYSDOH website and to submit comments on them. One suggestion was requiring CON applicants to submit Letters of Intent 30 days prior to the filing of a CON, and posting those Letters of Intent promptly on the NYSDOH website, following a model found in the state of Washington.

2. Ensure that consumers who would be affected by proposed hospital closures or elimination of key hospital services are notified well in advance, and engaged in reviewing proposed closure plans. The study recommended requiring 90 days advance notice and provision of a proposed closure plan, as well as a public hearing in the affected community at least 60 days in advance and a full review of these transactions in public meetings by the PHHPC.

Multiple states require advance public notice when a hospital intends to close completely or discontinue essential services. Currently, New York State does not. Instead, New York requires a public hearing to be held by the Department of Health *within 30 days after* hospital closure and the DOH is expected to post information from that hearing within 60 days after that.[7] Moving the public notice to a period *before closure* and putting the responsibility on the hospital to help inform the public would greatly increase transparency and allow members of the affected communities to better prepare for impending changes.

Notice requirements are already in place in New York State for other non-health oversight processes. For example, under the New York Worker Adjustment and Retraining Notification (WARN) Act, employers with more than 50-full time employees must give 90 days' warning prior to any significant changes in employment. This notification must be given to the affected employees, Department of Labor, employee representatives, and the Local Workforce Investment Board. Since hospitals are large employers, they must already be required to notify their employees well in advance of closures and downsizings. The required practices from the WARN Act could be extended to residents of the communities that would be affected by hospital downsizings or closings, as well as public officials from those communities. The study recommended hospitals should be required to post notices at their facilities, and send a press release to all local newspapers and broadcast/on-line media, and to relevant local officials. The Department of Health should also post these announcements on its website.

When hospitals or systems give this notice, they should be required to provide a rationale for closure or elimination of services, including, but not limited to the following information: last year's service volume for the hospital or for the services to be eliminated; projected community need for the service within the hospital's service area; and details about where patients will be able to obtain access to the affected care once it is no longer at that facility. The CON applicant seeking approval to reduce, eliminate or relocate a service should be required to describe the "effect on the ability of low-income persons, racial and ethnic minorities, handicapped persons and other underserved groups and the elderly to obtain needed health care."[8]

This closure plan should be submitted to the DOH and disseminated to the general public through local officials, provision to local media and through posting on the NYS DOH website. Provision of this plan would give consumers the opportunity to provide informed comments at the public hearing we urge be required prior to such closure, and would enable NYS DOH officials to work with local health officials to ensure continued access to care, including by requiring modifications to the closure plan and/or assessing the ability of remaining providers to fill the resulting service gap. This process would also give consumers time to understand any changes to their care and ensure they are still able to access the same services in a reasonable way.

The study also urged that the state require at least one public hearing in the affected community, at night or on a weekend, at least 60 days in advance, when a hospital proposes to close, downsize or close a key service, such as the emergency department or maternity services. Public hearings are a vital way to engage members of the community, provide them with information on how their local hospitals are proposing to change and elicit consumer comments that could affect closure plans. Vermont, New Jersey and North Carolina are three states that provide potential models of how to use public hearings to engage affected consumers. In Vermont, the Green Mountain Care Board, which evaluates CON applications, holds a public hearing for every application, with few exceptions for expedited review. Members of the public can also submit written comment on an application up to 10 days after the public hearing.

New Jersey holds public hearings when there is an application for a change in ownership or to close a health facility. North Carolina goes an important step further. Although they do not mandate a public hearing on every application, they require one for projects that are seen as competitive, that spend more than $5,000,000 on construction or downsizing/closing or relocation of services, that are determined to be in the public interest by the State

Health Planning and Development Agency or for which an "affected party" requests a hearing. In North Carolina, an "affected party" is defined broadly. This can be any person living in the area served by the applicant, anyone who uses health facilities in that area, any provider who practices in the area, a third party payer for facilities in the area, and includes the applicant. Most significantly, North Carolina holds hearings in the service area that is impacted. The department works with the members of the community to hold the hearing and make it accessible, so that the public may express concerns or comments on their local facility. A system like this could greatly improve consumer engagement around New York State.

The study urged adoption of a requirement for a public hearing in the affected community at least 60 days in advance of a proposed hospital closing, downsizing or closing of a key time-sensitive service, such as the emergency department or maternity services. The authors acknowledged that NYS DOH staff members do not have the capacity to organize, publicize or run multiple public hearings around the state each year. Instead, the study suggested that local Population Health Improvement Program (PHIP) entities or county health departments be asked to take on the responsibility of organizing and publicizing public hearings for facilities in the areas they oversee, in collaboration with the hospital seeking CON permission to close or downsize.

3. Require "full review" CON applications, with opportunity for public comment, for closing of a hospital or for elimination of any hospital unit or service that could compromise timely and affordable access to those services in the affected community, as well as for converting emergency departments to part-time operation. Full review should also be required for "transformation" of multiple units within a hospital to ambulatory settings.

The study urged that "full" CON review by the PHHPC in public meetings be required for hospital closings, elimination of units that provide time-sensitive care, such as emergency departments or maternity services, and for hospital downsizing or transfer of services and/or beds from one facility to another within a given health system, when such transfers could have a potential negative affect on the availability of timely, affordable care in the affected community.

Given the trends described earlier in this article—particularly the movement of services from hospital inpatient settings to outpatient settings—it is particularly important to improve the transparency of hospital "transformation" initiatives and more fully engage affected consumers in reshaping local health delivery systems.

Currently, hospitals and health systems are being allowed to file a series of multiple, narrowly framed "limited review" CON applications to decertify beds and services over time. Through this process, hospital systems are able to gradually close facilities unit by unit and move services either to their other hospitals or to ambulatory settings without undergoing full CON review at a public meeting. An example of this use of limited review CONs involves Mount Sinai Beth Israel in Manhattan. From November 2016 to March 2017, Mount Sinai submitted a series of limited review applications to close or decertify beds in multiple units, including maternity care, cardiac surgery and pediatric intensive care. Full CON review by the PHHPC (with opportunity for public comment) will be required only when the system proposes to build a new facility (such as the 70-bed hospital Mount Sinai plans to construct to replace its current much larger facility).

The study recommended that if a hospital (or its parent health system) seeks to close (or transfer elsewhere, such as to an ambulatory setting or a different facility within the system) more than one service within a year, it should be mandated to go through full CON review to do so. Within this full CON review, hospital systems should be required to lay out their plans for how and where health consumers will obtain those services in the future, how patients will be kept informed and what they should expect their new system to look like in the next three to five years. A transformation plan should explain the likely impact of the proposed delivery system changes on consumers who rely on Medicaid or are uninsured, and those for whom travel to other facilities may present an obstacle to obtaining care. This information is necessary for community members to understand how and where they will be accessing the care they need, potentially at new locations, and to provide comments to the PHHPC and DOH to inform CON decision-making.

4. Improve transparency, consumer engagement and post-transaction accountability when hospitals join health systems.

While there can be positive results when community hospitals join large health systems, there can also be downsides, such as loss of local control of a community hospital. Executives of these large systems can and do make decisions to close services at local hospitals (such as emergency departments and maternity care) and direct consumers to other facilities within the system that offer the care. The result could be reduced access to care within a community and longer travel times to obtain care. Health system consolidation and the movement of care into new sites can also pose risks to patient safety if not carefully managed, warned Dr. Atul Gawande and colleagues at the Harvard School of Public Health and Brigham and Women's Hospital in a recent JAMA article.[9] In such situations, the authors point out, clinicians frequently must travel to new practice settings, navigate

unfamiliar infrastructure and care processes, and treat different types of patients. Consolidating a system's service line—such as obstetrics, psychiatry or substance use treatment—at one facility could increase the number of patients being seen at that facility and introduce types of patients with whom the clinicians are not familiar, creating cultural and other barriers to good quality care. The authors have developed a patient safety toolkit to guide management of system changes and expansion of practice sites.

When system takeovers of local hospitals are proposed, the affected consumers deserve to know the full implications, both positive and negative. One of the obstacles to such transparency is the use in New York State of "passive parent" governance by systems to begin takeover of community hospitals without any CON review. No other state allows for the distinction between passive and active parent in system takeovers of local hospitals. The level of transparency and accountability in the arrangement is simply too low. The study urged that New York eliminate "passive parent" governance and allow only an "active parent" relationship that requires full CON approval, so that all of the issues associated with such consolidation can be grappled with in public and with focus. In addition, we recommend that mergers, acquisitions, and "active parent" relationships be made subject to post-transaction monitoring to allow for increased oversight of changes to large health systems.

For transactions involving a consolidation, the study recommended requiring CON applicants to clearly articulate the public need served by the transaction and provide long-range plans (at least three years) predicting the impact on affected patients' ability to obtain care. The study further recommended requiring a public hearing in the affected community to solicit consumer comment and a plan for continuing engagement of local health consumers in governance of the hospital.

Recognizing the significant changes that can occur with changes of governance, Connecticut requires the provision of a three-year plan for all transactions that involve a change of ownership. This plan must include a description of how health care services will be provided in the first three years after the change in ownership, including any planned introduction of new services or elimination, consolidation or reduction of existing services.[10]

The study recommended a similar requirement in New York, with some additional features. For all transactions involving consolidation of hospitals, the CON applicant should be required to articulate how the transaction will serve a public need, such as providing services not currently available in the hospital's catchment area, strengthening the quality of care or addressing public health priorities that have been identified by local health departments or health planning partnerships. Even if the transaction is seeking to simply provide better access to capital for the smaller hospital, addressing the issue of public need should help to make the reasons for the active parent status more transparent. The application should also explain how local participation in governance of the hospital will be maintained following the acquisition, merger or establishment of active parent powers, such as through maintaining seats on the hospital board for local representatives.

The applicant should also be asked to describe how the new governance arrangement would affect the current service delivery patterns, such as relocating some services to other facilities, closing units of the hospital or establishing referrals to a system's center of excellence for certain types of complex care. For each planned reconfiguration of services, the applicant should be required to explain how patients would be assisted in traveling to new locations and navigating an unfamiliar system of care. As well, the applicant should predict how current case mix (provision of Medicaid clients vs. commercially insured clients, those with Medicare and those with no insurance) would potentially change under the new arrangement.

The study concluded that post transaction monitoring and oversight is necessary for hospital mergers and when health systems become active parents of community hospitals. For such transactions, the study recommended requiring the CON holder to provide yearly reports to the DOH and PHHPC for a period of three to five years. These reports should describe any changes in service configurations or case mix that have occurred since project approval and demonstrate adherence to any conditions that were attached to the CON approval. In addition to the reports provided by the applicant, an "independent monitor" could be hired to act as a compliance reporter for large mergers and acquisitions. Such reporting would increase transparency of the actual effects of the transaction and could lead to an extension of a limited life CON, with increased pressure to comply with terms of the approval in order to win a permanent CON.

Connecticut has a system of "post-transfer independent consultants" in place to monitor the progress of larger mergers, meet with representatives from the parent organization and its new affiliate, and report back to the state's Office of Health Care Access. The "monitor," often a consulting or public accounting firm, is selected by the applicant and approved by the state agency. The applicant pays for the monitor, and reports to the state on matters involving compliance of the applicant with "conditions" established in the awarding of the CON. This process allows for more oversight and accountability of new active parent relationships. In addition, more active monitoring

would assist the DOH in gathering information about trends in mergers and acquisitions to better understand the current system as a whole.

5. Require CON review of major proposed transactions, such as hospital mergers and system acquisition of hospitals (but not hospital closings), to include consideration of the potential impact on the price of health care.

While one of the original purposes of state Certificate of Need programs was to control costs at a time of hospital expansion, construction and equipment acquisitions, there is little evidence in the literature that this goal has been fulfilled. As trends have shifted from hospital expansion to consolidation, there is a new opportunity to employ CON to restrain price increases that are associated with health systems acquiring greater market share through consolidation, takeovers of community hospitals, and acquisition of outpatient centers and physician practices.

Consolidation in the health industry (both hospital mergers and hospital acquisitions of physician practices) is widely recognized as leading to greater market power for large health systems and thus higher prices charged to insurers. For example, a Robert Wood Johnson survey[11] of studies reported that, when hospitals merge in already concentrated markets, price increases might exceed 20 percent. More recently, Cooper, Gaynor and others[12] found that the primary determinant of health care costs is the price of provider services, and that the most powerful determinant of provider price is market power—not quality, not size, not academic status or reputation. A 2018 study conducted for the *New York Times* by researchers from the Nicholas C. Petris Center at the University of California, Berkeley, examined 25 metropolitan areas with the highest rate of consolidation from 2010 through 2013 (including the Albany, NY, market.) The study found that the price of an average hospital stay soared, with prices in most areas going up between 11 percent and 54 percent in the years afterward.[13]

A 2016 study for the New York State Health Foundation by Gorman Actuarial found that "a hospital's market leverage—its bargaining power when negotiating with insurers—is a key factor in the prices a hospital can command."[14] The study reported that hospitals with greater market share are generally higher priced, and those higher prices extend to hospitals that are part of a hospital system with large regional market share, regardless of an individual hospital's size or market share. A study by the Massachusetts Health Policy Commission[15] found that market power is the primary determinant of hospital prices in that state. The Attorney General of Massachusetts made similar findings[16] in 2010. Another contributor to price increases is that community hospitals are generally paid less for their services by third parties than are "academic" health systems that are acquiring the smaller hospitals.

The NYS DOH and PHHPC reviews of CON transactions do not explicitly examine the potential impact on the price of health care in a region. Instead, the financial aspects of CON review are focused on the financial feasibility of the project—essentially whether the applicant can afford to carry it out, and what the long-term impact of the project would be on the applicant's financial health.

The study recommended consideration of the potential impact on the price of care in DOH and PHHPC review of selected "full review" CON applications (such as system takeovers of formerly independent hospitals or mergers of nearby facilities). DOH staff time currently spent on analyzing the "financial feasibility" of a project, a procedure DOH staff describe as time consuming and most often of "low value," could be redirected to assessing the potential impact on health care prices.

One possible method of doing this would be to ask CON applicants to predict the effect of their proposed transactions on their prices. Another method would be to require an outside assessment, such as by a consultant. Another approach would be to use data reporting submissions from health plans, as the New York State Department of Financial Services did through a mandated Request for Information it issued to inform a 2016 report on hospital pricing in New York.[17] As the state moves to implement an All Payer Database,[18] this could be a valuable resource for assessment of the actual price effects of hospital mergers.

When it comes to analyzing and monitoring project price increases associated with a CON application, third parties may be useful. Staff of the Attorney General's Anti-Trust Bureau, for example, have expertise in assessing the likely effect on price of anti-competitive business transactions. Insurers are also able to analyze predicted price increases associated with hospital consolidation and track the actual price increases.

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