Elements to be Considered for Incorporation into Access Principle

What are the barriers to access?

1. Differences in payor coverage, uninsured.
2. Geographic access and transportation impediments.
3. Temporal; is service available only at certain times? Are emergency services available?
4. Ethnic, racial and cultural barriers.
5. Are all medically required services available? Are poorly reimbursed services in short supply.
6. Disabilities.
7. Should Medicare patients be considered underserved? Is there a differences for primary, secondary and tertiary care for Medicare patients?

Should all CON applicants demonstrate a willingness and commit to an explicit plan to provide services to a representative sample by payor type of patients from that service area?

1. Is this a reasonable expectation for a specific facility or just for owners' whole network in that service area?
2. How to define service area? Is conformation to service areas for CON need determination appropriate?
3. If all applicants for CON should demonstrate how they will provide for charity and medicaid patients, how will not-for-profits earn their tax exempt status? Unprofitable services, 24/7 coverage, education, research, support of primary care outreach, required calculation of community benefit?

Special considerations for rural portions of state.

1. Balancing of desirability for services close to home against increased costs per case for smaller facilities and decreased quality below minimum volume thresholds needed for core competencies.
2. Weakened base for cross-subsidization of unprofitable services and primary care in small and rural facilities.