

MINUTES
STATE COMMISSION ON THE EFFICACY OF CON
Sanders Fireplace Room at the Capitol Education Center
180 Central Avenue, Atlanta, Georgia

August 8, 2005; 1:00 pm

Daniel W. Rahn, MD, Chair, Presiding

MEMBERS PRESENT

Senator Don Balfour
Tim Burgess
Melvin Deese, MD
Donna Johnson, Esq.
Robert Lipson, MD
Dan Maddock
Joseph "Rusty" Ross, Esq
Representative Austin Scott

MEMBERS ABSENT

Jeff Anderson
Ronnie Rollins

GUESTS PRESENT

Angela Adams, Westcourt Reporting
Bill Lewis, Lewis Consulting
Bonnie Newroth, Columbia Regional Healthcare System
Brian Looby, Medical Association of Georgia
Bryan Ginn, Medical College of Georgia
C. Hayslett, GA. Alliance of Community Hospitals
Clay Campbell, Archbold Medical Center
Clay Huckabee, JTA
Dale McCord, MD
D.J. Jeyaram, Morris Manning
Dan Williams, Dekalb Medical Center
David Henderson, University Hospital
Deb Bailey, Northeast Georgia Health System
Deborah Winegard, Medical Association of Georgia
Dick Dwozan, Georgia Hospital Association
Dodie Putman, Hospital Corporation of America
Don Fears, DeKalb Regional Health System
Eric Norwood, Dekalb Medical Center
Erin Moriarty, Atlanta Business Chronicle
Frank Aaron, Houston Healthcare
Fred Watson, Georgia Healthcare Association
Haydon Stanley

STAFF PRESENT

Neal Childers, JD
Richard Greene, JD
Matthew Jarrard, MPA
Julie Kerlin
Victoria Kizito, JD
Robert Rozier, JD
Geeta Singh, MHA
Rhathelia Stroud, JD
Stephanie Taylor, MPS

Helen Sloat, Nelson Mullins
Holly Bates Snow, Georgia Hospital Association
Houston Payne, Georgia Society of Ambulatory Surgery Centers
Jane Langley, Tenet Healthcare
Jeffrey Baxter, Nelson Mullins
Jerry Usry, Phoebe Putney Health System
Jill Fike, Senate Research Office
Jimmy Lewis, Hometown Health, LLC
John Holland, Tenet Healthcare
John Parker, Esq., GA. Alliance of Community Hospitals
Jon Howell, GHCA
Joy Davis White, Rockdale Medical Center
Julie Windom, GA. Alliance of Community Hospitals
Kathy Browning, Medical Association of Georgia
Kay Godwin
Kevin Rowley, St. Francis Hospital
Kim Menefee, WellStar Health System
Kurt Stuenkel, GA Alliance of Community Hospitals
Lance Duke, Columbus Regional
Lasa Joiner, Georgia Society of Ambulatory Surgery Centers
Leah Fressell Watkins, Powell Goldstein
Linda Womack, Emory University
Lisa Norris, The Strategy House
Marge Coggins, HBO
Marvin Noles, Medical Center of Central Georgia
Michael Miller, Southern Regional Health System
Michael Schermech, Southeast Georgia Health System
Monty Veazey, GA. Alliance of Community Hospitals
Rusty Sewell, Boller, Sewell & Segars, Inc
Scott Maxwell, Mathews & Maxwell, Inc.
Sheila Humberham, Troutman Sanders PAC
Stan Jones, Nelson Mullins
Susan Meyers, Georgia House Speaker
Susan Thompson, Wellstar Health System
Taffey Bisbee, Mitretek Healthcare
Tarry Hodges, St. Joseph's/Candler Health System
Tashena Gasaway, Sullivan Consulting Group
Teesha Boyd, Columbus Regional Healthcare
Temple Sellers, Georgia Hospital Association
Traci Bowe, Holland & Knight
Travis Dwozen, Resurgens
Victor Moldovan, Phears & Moldovan

WELCOME AND REVIEW OF COMMITTEE'S CHARGE

Dr. Rahn called the meeting of the State Commission on the Efficacy of Certificate of Need Program (Commission) to order at 1:06 pm. He welcomed members and guests and introduced Commission member Robert Lipson, MD, President & Chief Executive Officer, WellStar Health System, who was absent from the first meeting.

Following the welcome, Dr. Rahn said that there has been lots of public inquiry regarding the appropriate mechanism that should be used to contact Commission members. Commission members were provided with forms to complete that would provide guidance to the Department on how such requests should be handled. Also, Dr. Rahn reported that a Commission Webpage is being developed. Meeting minutes, membership information, and meeting materials among other things are expected to be provided on the webpage.

Dr. Rahn then reviewed the Committee's charge. He stated the Commission was created for the purpose of studying and collecting information and data related to the effectiveness of the Certificate of Need (CON) program in Georgia. He said that 'effectiveness' refers specifically to the effectiveness of the program in accomplishing its original policy objectives: including the impact on the healthcare industry and the cost to continue or discontinue the program. He said that the Commission is asked to determine whether the CON program impacts access to high quality healthcare services for the citizens of Georgia in the most cost effective and efficient manner. He noted that the original policy objectives, established when the CON statute was originally written, state that the policy of this state and the purpose of the chapter are to ensure that adequate healthcare services and facilities are developed in an orderly and economical manner and are made available to all citizens, and that those services found to be in the public interest shall be provided in the state. Dr. Rahn asked Commission members to consider whether the CON program, as it is currently operating, contributes to this overarching goal.

Dr. Rahn welcomed and recognized State Representative Sharon Cooper, who chairs the House Committee on Health and Human Services and thanked her for attending the meeting.

REVIEW & APPROVAL OF MINUTES

Dr. Rahn called for a motion to approve the minutes of the June 27th meeting, copies of which were sent to members in advance of the meeting. A motion to accept the minutes was made by Rusty Ross and seconded by Dan Maddock. Commission members unanimously approved the minutes as submitted.

STAKEHOLDER PRESENTATIONS

Dr. Rahn reminded members that the ongoing work plan of the Commission is to invite public comment from industry stakeholders. He said that at the previous meeting members agreed to invite four organizations, namely Georgia Alliance of Community Hospitals, Georgia Hospital Association, Georgia Society of Ambulatory Surgery Centers and the Medical Association of Georgia to present to the Commission today. He welcomed the following stakeholders:

- Georgia Alliance of Community Hospitals (GACH), Kurt Stuenkel, FACHE, presenter
- Georgia Hospital Association (GHA), C. Richard “Dick” Dwozan, presenter
- Georgia Society Of Ambulatory Surgery Centers (GSASC), Houston Payne, MD, presenter
- Medical Association Of Georgia (MAG), Deborah Winegard, JD, presenter

The testimony of all presenters is attached to the minutes as Appendix A. Presentations occurred in alphabetical order and each presenter was given twenty-minutes to speak. Presenters were encouraged to submit written comments in advance of the meeting and/or following testimony.

The following materials were distributed by presenters to Commission members following stakeholder presentations:

- “A Compilation of Studies, Reports, & Articles Addressing Certificate of Need”, prepared jointly by Georgia Alliance of Community Hospitals, Georgia Hospital Association, Home Town Health, LLC, Tenet-Georgia and Healthcare Corporation of America.
- Remarks of C. Richard “Dick” Dwozan, President, Habersham County Medical Center & Chairman, Georgia Hospital Association, along with “Suggested Topics for Upcoming Meetings of the Study Commission on the Efficacy of Georgia’s Certificate of Need System”.

STAKEHOLDER’S QUESTION & ANSWER SESSION

Dr. Rahn invited the four presenters who testified before the Commission to the dais for a question and answer session. The following summarizes the questions and comments from Commission members and presenter responses:

Representative Scott inquired about Mr. Stuenkel’s references to a report about the State of Michigan. He said that the report is about objections to hospitals building additional facilities and not to physicians building additional facilities.

Mr. Stuenkel clarified that his intent in citing the State of Michigan during his presentation was to provide evidence of the correlation between the presence of Certificate of Need and costs to the healthcare system in CON states versus non-CON states.

Rep. Scott asked about the number of lawsuits that the Georgia Alliance of Community Hospitals (GACH) has filed against the Department of Community Health (Department). He further asked about the funding of GACH lawsuits and requested information on how contributions from member organizations are assessed to support lawsuits.

Mr. Stuenkel indicated that funding is done through a broad-based contribution by all members. He agreed to provide the requested information to the Commission at a later time.

Dr. Deese asked Mr. Dwozan about his hospital's ownership and affiliation with Emory University Hospital and Medical Center.

Mr. Dwozan indicated that there was a group, under the auspices of Emory that came together for strategic planning purposes to discuss managed care opportunities and other initiatives to better serve Georgians. He said that there was no money involved by the parties.

Dr. Deese said that members of the Georgia Society of Ambulatory Surgery Centers feel that competition in every other business has proven to be very good, has improved services, quality, and has lowered costs. He asked Mr. Stuenkel to cite examples of situations where limiting competition provides or causes lower prices, better quality, and better access.

Mr. Stuenkel indicated that he is a proponent of fair competition. He said that the healthcare marketplace is very complex and solutions should not be expected to be simple and should be approached very carefully. He said that the concern of community hospitals is that they will be left with an unsustainable patient mix. He cited examples including studies conducted by Dartmouth Atlas on Health Care, the Big Three automakers, and various other articles, that were provided in the notebook submitted to the Commission at today's meeting, as evidence that healthcare costs are higher in states that do not have CON processes in place.

Dr. Rahn asked the four presenters to discuss the issue of cross-subsidization of healthcare.

Ms. Winegard said that while cross-subsidization has been historically important in the health care market, it is increasingly on the decline. She said that while the Commission should examine this issue, cross-subsidization should not be a reason to continue CON.

Dr. Payne agreed with Ms. Winegard, stating that the elimination of the CON program should have no affect on cross-subsidization.

Both Mr. Dwozan and Mr. Stuenkel argued that cross-subsidization is real and necessary, pointing out that there is a large volume of uninsured patients that incur costs which have to be paid. They said that any changes that are made to the CON system should not neglect to account for the issue of delivering care to the uninsured population. They agreed that the presence of the CON ensures greater access to care for the uninsured.

Senator Balfour asked Ms. Winegard about her position that CON has to do with need more so than quality. Ms. Winegard said that when the state is reviewing a CON application that they examine the

ability of either the facility or the service to provide high quality care if there is a need for the service. She said that the CON program cannot control quality once the provider has been issued a CON and that the CON program has no statutory authority to enforce quality once the CON has been granted. She said that quality is better reviewed under the state licensure process. She also said, in response to a statement made by Mr. Stuenkel, that in 16 studies reviewed by the Federal Trade Commission/Department of Justice (FTC/DOJ) report that there was testimony presented by economists on both sides of the issue which concluded that CON is not effective in controlling costs.

Senator Balfour argued against Ms. Winegard's earlier statement that CON has to do with need and not quality. He pointed out many CON requirements are based on the fact that the applying facility has to show a need for a certain service. He contended that a provider generates greater volume than its competitor is generally perceived to have better quality by consumers.

Mr. Ross questioned Dr. Payne on how competition and consumer choice could be improved in the absence of CON laws? He also asked how a competitive model could be created without consumer involvement and further inquired about the type of regulation that would remain to provide a competitive model to assure access to needed services and to prevent extreme cases of cherry picking where only the most highly reimbursed services were built or expanded.

Dr. Payne responded by saying that the provision of services should be driven by the need in the community and the higher quality would be supported because patients are interested in better outcomes. He commented that the first entry point is the physician. He further stated that one of the critical issues is to determine what costs are incurred to provide quality healthcare versus which are driven by financing mechanisms.

Ms. Winegard also responded to Mr. Ross's inquiries. She said that one of the recommendations of the Commission could be the regulation of services in a form other than CON. She said that a system without any regulation of services would not work. She pointed to the sixteen states that eliminated their CON laws, saying that those states still maintain some form of regulation that monitors the expansion of services. She stated that while the financial benefits for physicians in ambulatory surgery centers are great, other motivating factors such as more control over scheduling make ambulatory surgery centers more attractive options for physicians.

Dan Maddock said that the Commission should be concerned about the issue of access to care for rural citizens.

Ms. Winegard said that there are better ways to address issues related to rural health than through the CON process.

Senator Balfour requested that all presenters provide a list of specific recommendations for changes to the existing Certificate of Need Program. Recommendations should specifically address additions, deletions, or improvements to the current CON process.

Dr. Deese said that not-for-profit hospitals receive significant tax advantages over for-profit hospitals to provide care to the uninsured.

Mr. Stuenkel indicated that the provision of indigent and charity care should be spread evenly across the entire state, by all providers, including limited purpose ambulatory surgery centers and freestanding ambulatory surgery centers. He said that this would be a fair mechanism to ensure adequate healthcare coverage of care for uninsured patients.

Dr. Deese asked for an explanation of the Indigent Care Trust Fund (ICTF) program.

Mr. Stuenkel indicated that the ICTF is a federal/state program that helps to provide funding, in small measure, to not-for-profit hospitals that experience revenue shortfalls because of provision of care to indigent and Medicaid patients. He said that for-profit hospitals do not participate in the ICTF program.

Dr. Deese said that for-profit hospitals, not meeting indigent care levels are levied a 2% fine. These funds are then allocated to not-for-profit hospitals to provide indigent care.

Dr. Lipson said that he would like to focus the group's discussion on the Commission's charge. He said that the Commission should consider many options including the following:

- Is it better for the state of Georgia to have a CON program?
 - If so, should the existing program be modified? How?
- Does it cost more or less to keep CON?
- Do cross- subsidies affect CON?
- What is the benefit to the state of having a CON Program?
- What is the benefit of doing away with CON?
- Who are the experts in the various fields (uncompensated care, cross-subsidies, rural health, etc)

Dr. Lipson suggested that experts from various fields should be invited to present testimony to the Commission regarding the health policy implications surrounding CON.

Mr. Ross asked Dr. Payne about the impact of an unregulated system if the state were to do away with CON and the role of consumer choice in an unregulated system.

Dr. Payne responded that there are several regulatory mechanisms in place including state inspections, Medicare inspections, and accreditation societies that protect quality. He said that most consumers select physicians based on professional reputation or referrals from friends.

Dr. Deese said that managed care impact physicians' ability to refer patients to any type of facility whether it is a hospital, another physician or an ambulatory surgical center.

Dr. Rahn said that the overall strategy of the Commission is to receive input from organizational and provider stakeholders relevant to the Commission's charge. He reemphasized that the charge is to address CON as a tool. He recognized the concerns voiced by some members over the surrogate decision making in health care. He further stated that the larger public purpose of the CON program is to assure access to adequate healthcare services for everyone. He said that competition is good, yet consumers are not directly engaged because of the financing mechanisms in the current health care system. He said that the current system relies on providers to be surrogates for consumer choice.

Dr. Rahn thanked the invited presenters for their testimonies and participation in the Commission's deliberations. He reiterated Senator Balfour's request, and asked all invited presenters to provide the Commission with specific recommendations about what they believe are the necessary changes to CON that would improve the health care system in Georgia.

COMMITTEE DISCUSSION AND NEXT STEPS

At the request of Dr. Rahn, Mr. Neal Childers reviewed the upcoming meeting schedule and the proposed list of presenters (Appendix B). Mr. Childers explained that Department staff was asked by Dr. Rahn to put together a proposed list of speakers to present testimony before the Commission over the next four months. He said that staff's approach in selecting presenters was based on the areas of services that are regulated by the CON program. Proposed presenters are grouped according to the broad categories of service. During the month of September, speakers are expected from the long-term care industry; During the month of October, testimony is expected from "specialized service providers", including traumatic brain injury, Psychiatric & Substance Abuse Services and others; During the month of November, other specialized providers including imaging centers, cardiac service providers, among others are expected; while in December, other interested parties, i.e. Advocacy groups, DHR and DCH representatives are expected.

Mr. Maddock reiterated Dr. Lipson's suggestion of inviting experts from outside of the State of Georgia to present to the Commission. He said that potential speakers could be from states that have eliminated CON and replaced it with a different form of regulation. He suggested that speakers come from the academic community and should focus their presentation on the economic impact of this issue.

Dr. Lipson suggested that a list of re-occurring themes should be generated from all of the Commission's meetings so that they could be addressed over the course of the Commission's deliberations.

Dr. Deese requested specific information pertaining to the Indigent Care Trust Fund.

Dr. Rahn said that at Mr. Maddock's request, copies of a report prepared by the Texas Hospital Association entitled, *Texas Hospital Association Report on Limited Service Providers, February 2005* was distributed to members prior to today's meeting. In addition, Dr. Rahn distributed the report: *Conover, C. & Sloan, F., Center for Health Policy, Law and Management/Terry Sanford Institute of Public Policy, Evaluation of Certificate of Need in Michigan, Volume I: Final Report (May 2003)*.

UPCOMING MEETING SCHEDULE

Dr. Rahn called members attention to the upcoming meeting schedule and suggested meeting dates that was provided in member packets. He asked Stephanie Taylor to work with Commission members to confirm the October, November and December meeting dates noting that the proposed dates are based on the availability of both his schedule and the meeting room's availability.

The next regularly scheduled Commission meeting is planned for **Tuesday, September 13th, at Sanders Fireplace Room at the Capitol Education Center, 180 Central Avenue, Atlanta, from 1:00 pm- 4:00 pm.**

OTHER BUSINESS

Dr. Rahn reported that Richard Greene, Neal Childers and he traveled to Washington, DC to visit with the leadership group from the Federal Trade Commission (FTC) and the Department of Justice (DOJ) He said that the purpose of the visit was to discuss the FTC/DOJ report and to begin the process of identifying who the Commission may look to for consultative assistance.

Dr. Rahn said that a number of options have emerged in the area of consultative services but the Commission needs to be very clear about the areas on which it needs consultation. He said that the focus should be on the Commission's charge and the intent of the legislation. He suggested that time should be reserved at an upcoming meeting to specifically discuss areas where external consultation is needed. In preparation for this discussion, he suggested that members review the following materials:

- Executive summary by the FTC/DOJ (provided at first meeting)
- Michigan Report provided today (Conover & Sloan)
- Texas Hospital Association report (sent prior to today's meeting)
- Material provided by the stakeholders at today's presentation

He said that the Commission should focus its discussion on the following issues:

- (1). How has the CON program affected those original policy objectives?
- (2). What has its impact been on:
 - a. Safety-net providers
 - b. Rural Providers
 - c. Teaching Institutions
 - d. Innovations
 - e. Costs
 - f. Access
 - g. Quality
- (3). Are the original policy objectives still relevant?
- (4). Does the CON program contribute to the accomplishment of those policy goals?
- (5). What are some of the pros and cons of the current CON program?
- (6). Are there processes within the Department that need to be improved in order to achieve policy objectives?

Dr. Deese asked for specific information regarding the trip to Washington DC.

Dr. Rahn indicated that it was a trip which he planned as Chair of the Commission to get some additional information and advice from FTC as the Commission begins its deliberations. He said that the meeting was two hours in length and that there was some discussion regarding the need to secure someone from the FTC to speak at one of the Commission's future meetings.

Dr. Deese requested that the Commission be informed of all future meetings pertaining to the Commission's work so that other members could join the meetings in person or possibly, via conference call.

There being no further business, the meeting adjourned at 4:15 pm.

Minutes taken on behalf of Chair by Geeta Singh and Stephanie Taylor.

Respectfully Submitted,

Daniel W. Rahn, MD, Chair

MINUTES
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August 8, 2005

APPENDIX A

STAKEHOLDER TESTIMONIES/TALKING POINTS

Georgia Alliance of Community Hospitals
Kurt Stuenkel, FACHE, Presenter

Georgia Hospital Association
C. Richard (Dick) Dwozan, Presenter

Georgia Society of Ambulatory Surgery Centers
Houston Payne, MD, Presenter

Medical Association of Georgia
Deborah Winegard, JD, Presenter

Remarks of Kurt Stuenkel
President, Floyd Medical Center
And
Chairman, Georgia Alliance of Community Hospitals
as prepared for delivery to
Study Commission on the Efficacy of Georgia's
Certificate-of-Need System
August 8, 2005

Mr. Chairman, members of the Commission, good afternoon. I am Kurt Stuenkel. I am president of Floyd Medical Center, a 304-bed community not-for-profit hospital serving Rome and northwest Georgia. Floyd Medical Center is a trauma care center, serves about 60,000 patients a year in the emergency room alone, and has the only neonatal intensive care unit in the area.

I am here today in my capacity as the current chairman of the Georgia Alliance of Community Hospitals.

The Alliance is an association of not-for-profit and public community hospitals throughout the state. It was established two decades ago to represent the discrete interests of community not-for-profit hospitals on a range of health policy issues, including Certificate-of-Need.

The Alliance believes CON has served Georgia well as a rational regulatory system. It has, we submit, helped ensure broad financial access to health care for all Georgians, regardless of economic status. It has helped hold down costs, ensure high quality care, and preserve the excellence of this State's academic medical centers and community teaching hospitals.

Make no mistake: Certificate of Need serves the public interest.

That fact is clear and is supported overwhelmingly by an ever-expanding number of empirical studies and findings by researchers, the business community, and health care providers, including many physicians.

In support of my testimony, the Alliance and our fellow hospital organizations have submitted a binder containing a number of empirical studies, reports, and recent articles on issues pertaining to health care costs and overutilization ... safety and quality concerns related to office-based ambulatory surgery and freestanding diagnostic imaging ... "cherry picking" of profitable services and patients by freestanding self-referral surgical centers, limited

service hospitals, and freestanding imaging centers ... and the growing crisis in emergency room care due to lack of coverage by certain surgical specialists who have abandoned hospitals for their own surgical facilities which have no emergency rooms.

All of these studies lend overwhelming support for a strong CON program. Time won't permit me to cover the studies in detail here today, but I would like to quickly cite a few pertinent facts.

First, the Cleverley Study. Three years ago, one of the nation's leading healthcare finance experts looked at the price differential for inpatient and outpatient care in Georgia, a CON state, versus two other rapidly growing Sun Belt states, Arizona and Texas, which eliminated their CON programs in the 1980's.

As this slide illustrates, Georgia, under CON, has substantially lower prices, at both the procedure and aggregate levels, across all charge measures, as shown by the national database studied by Dr. William Cleverley, an Ohio State professor. Whether you look at Medicare charges, room rates, the price of chest X-rays, or basic mark-up rates, the picture is the same, and it is compelling.

We see similar conclusions in very interesting studies from the Big Three automakers. As everyone knows, healthcare costs are one of the biggest problems for U.S. businesses. As this graph shows, DaimlerChrysler found that the lowest healthcare costs, without exception, were at its plants in states with CON programs. The highest-cost plants were in non-CON states – and this wasn't just a factor of regional cost differentials. For example, Chrysler's healthcare costs per worker in Kenosha, Wisconsin, were nearly three times what they were in Syracuse, New York.

Ford Motor Company found the same thing. Its costs in Indiana and Ohio, both non-CON states, were 21 percent higher than in Michigan, a CON state; costs in Kentucky and Missouri, both CON states, were very close to the Michigan costs.

The most in-depth study on the subject of health care costs and the impact of an unregulated supply of health care facilities and services comes from one of

the most authoritative, ongoing studies of the nation's healthcare system, the Dartmouth Atlas on Health Care.

The Dartmouth Atlas, first published in 1996, shows that in health care, supply often dictates demand, rather than the other way around. Consistent with the theory behind Certificate-of-Need, the Dartmouth Atlas reveals that increased capacity in the number of health care facilities and services results in higher costs, with no evidence of improved quality. In other words, the more duplicative services and facilities you add, the more they are overutilized, resulting in higher costs for the whole health care system and the consumer.

This phenomenon is influenced by a variety of factors unique to health care, including heavy funding of health care by government and the impact of self-referral incentives on overutilization where physicians own their own surgical centers or MRI units.

Those factors, unique to health care, are present today more than ever, and they can be contained by a strong Certificate-of-Need program. Thus, we respectfully disagree with Dr. Deese's suggestion at the first Commission meeting that there is no longer any reason for CON from a cost standpoint. Similarly, we disagree with those who suggest that a 2004 report by the Federal Trade Commission and Department of Justice on health care competition offers any empirical support whatsoever for the argument that more competition would reduce health care costs. The binder we've submitted includes the remarks of an FTC official who authored that 2004 report, stating unequivocally that it is "not an empirical study" at all. She acknowledged as well that its recommendations regarding the potential effects of Certificate of Need on competition were made in a vacuum and do not account for important considerations such as the provision of indigent care, medical education, emergency rooms, intensive care units, and perverse financial incentives from disparately high government funding of freestanding health care facilities.

As shown by many of the studies and articles in our binder, much of the recent explosion in health care costs is attributable to the proliferation of freestanding surgical facilities and diagnostic imaging centers, particularly where ownership by physicians has created self-referral financial incentives leading to overutilization and "cherry-picking" of profitable services, a resulting explosion in health care cost increases, and critical shortages in surgical coverage of hospital emergency rooms.

A recent look at these issues comes in a new study from Georgetown University. This study examines the effects of the recent trend toward physician-owned, limited-service hospitals and ambulatory surgical facilities. These "niche" facilities are spreading rapidly in non-CON states, and single specialty, physician-owned ambulatory surgical centers are also proliferating in Georgia due to an unintended statutory loophole that has evolved from loose agency interpretation of the 1991 amendments to our CON statute.

Georgetown's Public Policy Institute looked at physician owned limited-service hospitals and ambulatory surgery centers in Oklahoma and Arizona, two non-CON states, and found, in both instances, "substantial increases" in volume for the niche procedures in question.

To quote from the study: "These findings suggest that the financial incentives linked to ownership caused physician owners to change their practice patterns. Physician self-referral arrangements resulted in increased utilization of medical procedures, and increased costs to third-party insurers."

Let me build on this last point in regard to the cost of health care.

The physician-owned ambulatory surgery community will argue that the cost of surgical procedures performed in their freestanding am-surg centers often is lower than in hospitals. As an aside, it should be lower because studies consistently show that the freestanding centers generally perform simpler, profitable procedures, while leaving the more costly and complex procedures to hospital-based outpatient surgery centers. But it's not the case that even the simpler cases cost less in freestanding ambulatory surgery centers.

As this slide illustrates, the Medicare Payment Advisory Commission, or MEDPAC, found that for eight of the ten most common outpatient surgical

procedures, Medicare actually paid higher reimbursement rates to free-standing am-surg centers than to hospital outpatient facilities.

We already see these same economic forces at work here in Georgia. In Columbus, for example, orthopedic surgery coverage is no longer available from local private orthopedists for the largest hospital's emergency room, because orthopedic surgeons now have their own surgical facility.

And it is not just physician-owned surgical centers that lead to overutilization and cherry-picking of profitable health care procedures. A recent nationwide study by Stanford University researchers for the Blue Cross Association shows that health care costs per capita increase in a community each time a new freestanding imaging center is added. The Blue Cross study also found that the increase in costs is the highest whenever those imaging centers are owned by physicians with self-referral financial incentives. The Wall Street Journal focused on this issue in a story just last week about a federal investigation of freestanding imaging centers in Florida. I quote:

"The investigation .comes amid a continuing boom in scanning and rising concern that financial incentives for doctors who order scans may be prompting overcharges and overuse.. . Scanning costs are Medicare's fastest-growing item. They rose at three times the rate of other medical services from 1999 to 2002, increased a further 16% in 2003, the latest year of federal data, and have continued to grow since"

But in addition to increased costs, as I have noted, there are other important reasons not to dismantle or weaken CON. One of those is quality of care.

In a nutshell, practice makes perfect. When a given community has an excess of medical facilities, physicians and nurses do not get the optimal volume of practice that they need working together as a team in the same facility to maintain skills.

Here again, we make this judgment not on personal opinion, but on scientific research, which has consistently found a correlation between volume

and quality of health care services performed in hospitals.

For example, a study published in the Journal of the American Medical Association in 2002 looked at this issue in cardiac care. Researchers at the University of Iowa found, based on a nationwide database, that hospitals in non-CON states performed far fewer heart-bypass surgeries, on average, than those in CON-regulated states ... with a 22 percent higher risk of fatalities at the hospitals in the non-CON states.

And just last month Cancer magazine published the results of a study on cancer surgery, which mirrored the University of Iowa study on open-heart surgery. Across the board, as this slide shows, it found better survival rates at high-volume hospitals for cancer patients.

These concerns are not limited to hospitals and complex surgery, however. As CON programs have been rolled back in some areas of the country, they have seen an explosion in freestanding imaging centers. That has also been the experience in Georgia, which has more than 200 MRI units in a five-county area of metro-Atlanta alone, because physicians and imaging companies have exploited an unintended loophole in the 1991 CON amendments.

A report in The New York Times looked at 462 imaging facilities, and found that more than a third of those run by non-radiologists could not pass state inspection. Georgia, to the best of my knowledge, does not regulate freestanding imaging centers at all from a licensing and safety aspect, and very few of the facilities are owned by radiologists. Many are owned by surgeons with no particular training in diagnostic imaging.

And beyond the studies of outcomes and success rates, is one more simple fact: Our state, and our country, have a serious shortage of skilled health-care nurses and technicians. Every new medical facility you add, duplicating services already available in the area, still requires a full complement of nurses, technicians, and other staff. These skilled personnel must be recruited, for the most part, from existing facilities that are already short of staff themselves, in such vital patient care areas as the ER, OR suites, and intensive care units. The bidding for these employees just drives up the most expensive component of

health care - skilled personnel.

This panel is considering recommendations that might lead to the removal or weakening of an established regulatory system that we know puts a brake on healthcare costs, improves the quality of care, protects financial access for all Georgians to needed health care services, and preserves the financial viability of essential community institutions, our safety net hospitals and medical training centers.

Let me be clear that this is not a fight between physicians on one side, and hospitals on the other. The opposition to CON has been led by a relatively small group of doctors who want to own surgery and imaging centers, with the support of the Medical Association of Georgia and a related group, the Georgia Society of Ambulatory Surgical Centers. But physicians are very divided on this issue. Indeed, most have no quarrel with the CON program. A majority of Georgia doctors aren't even members of MAG and many disagree with MAG's advocacy of CON deregulation. Physicians of many specialties such as emergency room doctors, radiologists, neonatologists, and primary care physicians strongly support CON.

Our hospitals are fighting for an established program that works. And we have always supported common-sense measures to streamline and improve the effectiveness of the administrative process.

As I wrap up these remarks, I would ask you to be mindful of both the CON program, and the CON process. We will acknowledge that the process can be somewhat cumbersome. But, the CON process in itself performs an important public service by giving all parties a forum to debate the necessity and appropriateness of a proposed new health care facility or service. The state has never allocated sufficient budget or staff resources to fully and adequately review each CON application and audit approved facilities. It has therefore fallen to the interested parties - applicants and existing providers, for the most part - to assume much of that responsibility. That requires both sides to present their case, and more often than not, a reasonable judgment winds up being made. Again, that process takes time, but it does serve the public interest.

That said, we are always looking for ways to strengthen, streamline, and make the process more efficient, and we will be prepared at an appropriate point in this Commission's deliberations to make specific recommendations regarding the scope of CON review of non-clinical facilities and modifications to the present multi-tiered appeals process in order to reduce the costs of the process for the state and providers alike.

At the same time, we strongly believe that two glaring loopholes have evolved in agency interpretation of the scope of the CON law, which call for tightening through statutory amendments.

First, the capital threshold for review of major diagnostic imaging equipment needs to be lowered back to its original 1991 statutory amount of \$500,000. In 1991, no one could acquire an MRI unit or develop a multi-modality freestanding imaging center for \$500,000, and the legislature did not intend for an annual cost inflation index that has been applied to that threshold to open the floodgates for the recent explosion we have seen in freestanding imaging centers.

Second, and equally important, the excessive proliferation of freestanding, physician-owned single specialty ambulatory surgery centers needs to be addressed. That can be done through tightening of the CON statutory language to prevent the excesses that have flowed from loose agency interpretations. Every licensed ambulatory surgery center in this state should have to undergo CON review and make an indigent care commitment, just as all new hospital-based surgery centers and all other licensed healthcare institutions in this State do now. There is no logic or fairness in exempting licensed physician-owned surgical centers from CON review and the indigent care commitments that attach to CON-approved facilities. There are more than 230 licensed ambulatory-surgery centers in Georgia, a majority of which in recent years, contrary to legislative intent, have obtained complete exemptions from CON review from the Department of Community Health with the claim that they are located in single specialty physician offices. We certainly don't need more of these specialty surgical centers, and the self-referral financial incentives behind them are bad for overutilization and health

care costs; bad for patient safety; bad for safety net providers and their patients; bad for hospital emergency room coverage; and bad for the continued financial viability of our teaching hospitals. In conclusion, let me stress that CON holds down overutilization and health care costs. CON promotes quality health care. CON protects safety net hospitals which provide essential access for all Georgians, regardless of ability to pay, and it protects our teaching hospitals which provide costly medical education. CON protects the availability of full-service emergency rooms, trauma programs, and intensive care units in general hospitals. And independent studies prove it. We urge you to heed the conclusions of those studies. Mr. Chairman, members of the Commission, the issues here are not regulation and bureaucracy. The issues here are the affordability, quality, and accessibility of health care in this State and the effectiveness of our health care delivery and financing system. Please do no harm. Instead, please help us strengthen Georgia's Certificate-of-Need program. Thank you so much for your consideration.

Talking Points for C. Richard Dwozan
President, Habersham County Medical Center
and
Chairman, Georgia Hospital Association
for presentation to
Study Commission on the Efficacy of Georgia's
Certificate-of-Need System
August 8, 2005

1. **Opening Remarks:** Good afternoon ladies and gentleman. I'm Dick Dwozan, Chairman of the Georgia Hospital Association Board of Trustees and President of Habersham County Medical Center, a 53 bed acute care hospital located in Demorest, Georgia.
2. **Purpose:** I am here today to represent to you **thoughts and concerns held by GHA's members** and in some instances **illustrate** my points by telling pertinent stories from my experience as an administrator of a small hospital in rural Georgia. And **yes** there are a lot of small hospitals in our State that serve as the **access point** for medical care for many Georgians. **And yes, we rural Georgians support** the notion of you **taking the full time allotted** to you by the Legislature to **study** and investigate – in earnest, the **impact** of CON change. **Impact on rural** Georgians, on the **poor**, on those in need of **urgent or emergent** care – day, night or weekend regardless location – rural, suburban or urban.

Please **study** the **value of CON** on a hospital's ability to fund its operation, capitalization and recapitalization. Hospitals must have the money needed to assure access to ALL Georgians **and** Georgia is one of the **fastest growing** States. Not to mention that the **older** us '**baby boomers**' get the greater our need for health care.

3. **GHA's entire membership is united** in its support of a **strong CON** Program in Georgia. **Why?** Every Georgia hospital **believes a strong** CON Program enhances the ability of hospitals to sustain the provision of essential healthcare services and enhances the accessibility of those services to all of our population, **regardless of ability to pay**.

4. Georgia's CON Program is **far reaching in its impact** on our **healthcare delivery system**; therefore, we are pleased the legislature has given the Commission sufficient time to undertake a thorough discussion of each important issue. (**Refer to** handout of "**Suggested Topics for Upcoming Meetings**" and review topics briefly. Note that many of **these topics have been the focus of studies and reports** included in the binder that will be provided to them today).
5. **Hospitals' mix of patients and services depend on our CON for financial stability**. A **stability that is under threat from an ever increasing population of under- and un-insured**. Hospitals lose money providing many essential services because (1) certain types of procedures and services are profitable while others, such as emergency and trauma services, actually lose money; (2) some **payors do not cover** hospitals' **costs** for providing services (Medicaid pays 85.6% of the hospitals cost for outpatient services and approximately 80% of cost for inpatient services); (3) emergency services are provided to anyone that comes to the hospital whether or not they can pay anything for them; and (4) millions of uninsured patients pay little if anything for services provided.
6. **The only way for hospitals to provide these services is to cross-subsidize them by offering profitable services.**

Stated differently – hospitals' payment system – has in effect turned hospitals into a taxing arm – using the profits of certain services and payor classifications to cover the cost of indigent care and the shortfall of Medicaid paying less than cost.

7. **Some speak of free enterprise and competition is "GOOD" but what are we competing for? "Competition"** in states without CON is only for the most profitable services such as imaging and certain highly reimbursed surgical services. There is no competition to provide emergency and trauma services and to serve Medicaid patients and the uninsured.
8. **Numerous studies**, many of which are included in the binders we have provided, have found that states that abandon their CON Programs see a proliferation of physician owned surgery centers and specialty hospitals that provide only the most profitable services.

These centers do **not** provide **emergency** services, **serve few Medicaid and indigent patients** and redirect the profits needed to subsidize unprofitable services away from the full service community hospitals and into the hands of a small number of physicians.

9. **Physician ownership** creates an **unfair playing field** because physicians have the ability to **choose where to refer their patients**. Numerous studies have found that physician-owners (1) refer the **healthiest patients to their facilities** and the **sickest patients to the full service community hospitals**; and (2) refer the **patients with better-paying insurance to their own facilities** and the uninsured, indigent and Medicaid patients to the full service community hospitals.
10. This cherry picking leads to high profits for physician owners and places the financial health of full-service hospitals in jeopardy. It also **places at-risk programs** such as **outpatient clinics** that serve indigents, **trauma and emergency services, health education/wellness, outreach, community medical education** and others.
11. The **CON Program** also **prevents over-utilization of services** – according to . . . numerous studies which conclude that financial incentives linked to physician ownership cause physicians to change their practice patterns. Physician owners order more of the services and procedures offered at their facilities than they did before obtaining ownership interest. This over-utilization increases the overall costs of health care.
12. **Many Georgia physicians**, including emergency room physicians, anesthesiologists, radiologists, primary care physicians, and many surgeons **recognize and appreciate how essential a viable hospital system is to their practices** and to patient care and do not want to see that viability threatened. **I hope** you provide these physicians with the **opportunity to address the Commission** in the near future.
13. **Georgia's hospitals face financial uncertainty even with CON**. It is also important for the Commission to take note of the current uncertainty resulting from the revolution taking place in the state's Medicaid program. The Governor is working on plans to completely

transform the current Medicaid program. There are already numerous changes that are in various stages of implementation. Next year the state is implementing **Medicaid managed care** and disease management for the aged, blind and disabled population. The future of programs currently used to bring Federal Medicaid funding into the state, such as the **Upper Payment Limit (UPL)** and **Indigent Care Trust Fund, are uncertain**. These changes, combined with yearly **cuts in the Medicaid** budget, create uncertainty for many Georgians and for Georgia hospitals. In light of this uncertainty, any weakening of the current CON Program should be viewed by the state with greater than usual skepticism.

14. **In conclusion, GHA and our members look forward to assisting the Commission with its efforts to understand the many complex issues related to the CON Program. We will be happy to act as a resource and to arrange for experts to provide testimony at future meetings, including some of the authors of the studies and reports included in the binder.** (Conclude by again referring to **handout of “Suggested Topics for Upcoming Meetings”**).

State Commission on the Efficacy of the Certificate of Need Program Certificate of Need and its Effect on Cost, Quality, and Access in Georgia

Presented by

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August 8, 2005

The Origins of CON Theory

Cited in the establishment of many CON laws restricting the construction and expansion of healthcare facilities was the "Roemer Effect." In their 1959 study, Roemer and Shain argued that hospital beds would be intentionally filled by providers who induce ill-informed patients into hospital stays.[1]

The Introduction of Prospective Payment Systems

Medicare and Medicaid originally paid for hospital services using a "cost plus" reimbursement basis, where hospitals were paid for all of their costs and more. Under this reimbursement system, hospital profits were directly linked with patient volumes. While the basis of the argument for this set of circumstances, i.e. "supply creating demand," may have been valid during the "cost-plus reimbursement era" before the implementation of the prospective payment system ("PPS") for hospitals in 1983, it is widely asserted that it has not been demonstrated to be the case today, in an era characterized by the shifting of financial risk to providers.

The Federal Mandate for CON

Beginning in the mid-1970s CON laws for inpatient medical care were enacted under a Federal mandate across the U. S. in an attempt to control the supply of expensive healthcare services.

The End of Federal Support of CON

Federal support for CON ended in 1986 with the repeal of the National Health Planning and Resources Development Act of 1974.[1] Legislators were concerned

that CON “failed to reduce the nation’s aggregate health care costs, and it was beginning to produce a detrimental effect in local communities.”[2]

[1] Carolyn W. Madden, *Excess Capacity: Markets, Regulation, and Values* 33: 6 *Health Servs. Research* 1651, 1659 (Feb. 1999).

[2] Patrick John McGinley, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a “Managed Competition” System*, 23 *Fla. St. U. L. Rev.* 141, 157 (1995).

The Federal Trade Commission CON Studies

During the late 1980s, the Federal Trade Commission (FTC) conducted the first of several studies on CON concluding that, “Market forces generally allocate society’s resources far better than decisions of government planners,”[1] and recommended that states remove their CON regulations.

The FTC expressed similar sentiments before the Georgia General Assembly. “The Federal Trade Commission staff said that a proposal before the Georgia General Assembly to relax temporarily part of the state’s “Certificate-of-Need” (CON) regulation “represents a worthwhile undertaking which may lead to greater diversity and better quality in health care services and increased price competition in the health care market.” [2]

[1] Press Release, FTC (Aug. 10, 1987)

[2] Press Release, FTC (Aug. 10, 1987).

The FTC / DOJ Hearings on Competition in Healthcare

In November, 2002, FTC Chairman, Timothy J. Muris, announced that the FTC would hold joint hearings with the DOJ on competition in healthcare in 2003.[1] On July 23, 2004, following the conclusion of the hearings lasting over six (6) months, the FTC and DOJ (“agencies”) issued a joint report, entitled “Improving Health Care: A Dose of Competition” in which the agencies recommended that states decrease barriers to entry into provider markets. The agencies encourage states to reconsider whether CON programs “best serve their citizens’ health care needs.”[2]

[1] Press Release, FTC, *FTC Chairman Announces Public Hearings on Health Care and Competition Law and Policy to Begin in February 2003* (Nov. 7, 2002) at www.ftc.gov/opa/2002/11/murishealthcare.htm (last visited Aug.

5, 2004).

[2] Fed. Trade. Comm.& Dept. of Just., Improving Health Care: A Dose of Competition” A Report by the Federal Trade Commission and the Department of Justice 22 (2004).

Following testimony at numerous hearings from industry representatives and legal, economic, and academic experts on the healthcare industry and health policy, the agencies concluded that the burdens placed on competition by CON programs “generally outweigh” its “purported economic benefits.” The agencies suggested that instead of reducing costs, there is evidence that CON programs actually drive up costs by “fostering anticompetitive barriers to entry.”[3] “More importantly, CON regulation tends to foster higher prices, lower quality and reduced innovation in health care markets.”[4]

[3] Fed. Trade. Comm.& Dept. of Just., Improving Health Care: A Dose of Competition” A Report by the Federal Trade Commission and the Department of Justice 1-2 (2004).

[4] Press Release, FTC (Mar. 9, 1988)

The agencies expressed concern that CON programs drive up healthcare costs because they depress supply and protect healthcare providers from competition. In reliance upon empirical studies that showed CON programs generally failed to control costs and may actually result in higher healthcare costs, the agencies expressed further concern that CON programs prevent entry into the market by entities that can provide higher quality care, and contended that CON programs may delay the introduction of new technology. In support of their conclusions, the agencies relied upon empirical studies that showed CON programs generally failed to control costs and actually may result in higher healthcare costs.[5]

[5] Fed. Trade. Comm.& Dept. of Just., Improving Health Care: A Dose of Competition” A Report by the Federal Trade Commission and the Department of Justice 4 (2004).

The FTC/DOJ Report Regarding
ASCs and CON

Regarding Ambulatory Surgery Centers (ASCs) (relatively new market entrants) the agencies stated their belief that ASCs are beneficial for consumers and that state CON laws pose an anticompetitive barrier to entry. In response to ASC provider allegations that CON laws may be used to prevent ASCs from entering the market, the agencies committed to “aggressively pursue” activities of anticompetitive conduct. [6]

[6] Fed. Trade. Comm. & Dept. of Just., *Improving Health Care: A Dose of Competition* A Report by the Federal Trade Commission and the Department of Justice 27 (2004).

The FTC/DOJ Report Regarding Hospital Abuse of CON

The FTC has also recognized the potential for competitive abuse in CON by stating, "...state law frequently requires a hospital to obtain a "certificate of need" (CON) before it can build a new facility. The Commission has discovered that existing hospitals have sometimes opposed these CON applications, not in good faith, but merely to delay the entry of a new competitor and to burden it with heavy costs." [7]

[7] Press, Release, FTC, *Calvani Outlines FTC's Concerns in Health-Care Competition* (Feb. 21, 1986).

Earlier FTC Remarks on CON

Additionally, "'there is near universal agreement' among health care economists that Certificate of Need Regulation 'has been unsuccessful in containing health care costs.'" [8] This consensus is based on several reasons, including the fact that CON restricts new firms from entering a healthcare market in competition against incumbent providers. "One reason that CON may have been unsuccessful in constraining health care costs is that it restricts the ability of new firms to enter a health care market and compete against incumbent providers." [8] Because it tends to protect existing providers from competition, the CON process may increase prices to consumers and interfere with improvements in the quality of care.

[8] Press Release, FTC (June 22, 1989).

THE IMPACT OF INDEPENDENT ASC'S ON HOSPITALS' FINANCIAL STABILITY

The development of ASCs and surgical hospitals has often been cited by general hospital groups as the cause of not only declining general hospitals finances, but also of general hospital closures. Certain facts question this conclusion. The annual number of hospitals closures declined between 1987 and 1994. These years correspond with a period that saw more than a doubling of the number of ASCs [1] .

[1] "Does ambulatory surgery center development cause hospital closures?" *Outpatient Surgery*, Oct. 1997, p. 1.

Reasons for Hospital Closures

Numerous other factors have been cited as a cause for hospital closures which have occurred:

1. The excess bed capacity of hospitals during the enormous shift from inpatient to outpatient care; 2. Failure to adjust to managed care and large reductions in average length of stay; 3. Hospital mergers and acquisitions leading to large scale market consolidation, including closure of facilities, during the 1990s; and, 4. the costly failure of vertical integration efforts including the acquisition of physician practices.[1]

[1] "Does ambulatory surgery center development cause hospital closures?"
Outpatient Surgery, Oct. 1997, p. 2.

Reasons for the Growth of ASCs

The government has encouraged the development of ASCs, not only to improve access to, and the convenience of, healthcare services, but also as a cost saving measure that maintains or enhances quality. The 2003 HHS report determined that higher reimbursement levels for hospital outpatient departments (HOPDs) over freestanding ASCs was costing taxpayers \$1 billion dollars annually.[1] The response of hospitals was that they need to be overpaid in order to shift costs to support their emergency rooms, intensive care units, 24 hour service, and generally sicker patients.[2]

1] "Hospitals cry foul: HHS report urges reimbursement adjustments"
Modern Healthcare, Feb. 17, 2003, p. 10.

[2] "Hospitals cry foul: HHS report urges reimbursement adjustments"
Modern Healthcare, Feb. 17, 2003, p. 10.

A February 2003 report issued by the HHS Inspector General urged CMS to set consistent reimbursement levels for hospital outpatient departments ("HOPD") and freestanding ASCs.[1] In two-thirds of the procedures examined in the report, all of which can be performed in either setting, HOPDs were reimbursed more than ASCs for the same procedures. The median overpayment was \$282. This discrepancy results in overpayments to hospitals of \$1 billion dollars annually. Overpayments to ASCs for the remaining procedures accounted for \$100 million annually.

[1] "Hospitals cry foul: HHS report urges reimbursement adjustments"
Modern Healthcare, Feb. 17, 2003, p. 10.

CON REGULATIONS IN GEORGIA AS COMPARED WITH OTHER STATES

The Scope of State CON Regulations

- Thirty-six (36) states and Washington D.C. currently have some form of CON regulations.
- There are twenty-seven (27) states, including Georgia, that have CON regulations for Ambulatory Surgery Centers (ASC).

Estimating the Scope of CON Regulation in Georgia

- Georgia had CON regulations for 11 types of facilities. At this time, the average number of facilities types subject to CON in the United States is 7.9.
- Georgia regulates 19 types of services through CON. The average number of types of services subject to CON in the United States is 15.
- Georgia regulations cover 8 types of equipment, while the average number of types of equipment subject to CON in the United States is 6.5.

The Future With or Without CON

The Effect of Repeal of CON

CON Proponents say:

The repeal of CON regulations will lead to a surge in healthcare costs for patients and payers.

Counterargument:

A recent empirical study on this topic entitled, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?" reviewed health spending in the period from the late 1970's and 1993, including spending before and after state CON laws were repealed.

The study stated, "The major findings about CON can be summarized as follows: first, we found no surge in expenditures after CON was lifted; second, despite a statistically significant reduction by mature programs on acute spending per capita, there was no corresponding reduction in total per capita spending (apparently due to offsetting expenditures on non-hospital services)."[1] "We found that mature CON reduced hospital bed supply per capita population, but could detect no increase in bed supply following the removal of CON." [1] The study also found that established CON programs increased cost per adjusted patient day and cost per admission. [1]

[1] Christopher Conover & Frank Sloan, Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?, *Journal of Health Politics, Policy & Law*, Vol. 23 (1998), p. 466, 469, 473-474.

CON is Anticompetitive

The central argument against CON regulatory policy is that it is anti-competitive. By intervening in the market, CON disrupts the natural market forces and serves as a barrier to new market entrants. CON is considered by most healthcare economists as a strong disincentive of the clear cost and quality benefits of the introduction and diffusion of new technologies.

CON and Innovation

“In industry after industry, the underlying dynamic is the same: competition compels companies to deliver increasing value to customers. The fundamental driver of this continuous quality improvement and cost reduction is innovation. Without incentives to sustain innovation in health care, short-term cost savings will soon be overwhelmed by the desire to widen access, the growing health needs of an aging population, and the unwillingness of Americans to settle for anything less than the best treatments available. Inevitably, the failure to promote innovation will lead to lower quality or more rationing of care – two equally undesirable results.”[1]

[1] Michael Porter, et. al., *Making Competition in Health Care Work*, Harvard Business Review, Vol. 72, no. 4 (1994), p. 131.

CON Regulatory Policy and Cost Control

The great public health experiment that is CON has been in effect, in some form, for as long as four (4) decades in much of the U.S. CON’s effectiveness and the economic and regulatory burdens of this regulatory policy have been studied extensively by both federal and state governments, academic institutions, as well as by other researchers and organizations. From the perspective of the market economy, by all measures, CON laws appear to have failed to control costs. In a review of CON and its marked impact, Patrick J. McGinley wrote,

“In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering healthcare costs.”[1]

[1] Patrick John McGinley, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a "Managed Competition" System*, Florida State University Law Review, Vol. 23 (1995), p. 157.

The Benefits of Competition

There is also a continuing consensus among health economists that competition in healthcare drives improvements in quality of care and patient outcomes, while also acting as a force for greater cost efficiencies.

"there is ... agreement across all perspectives of [health economics theory] on one issue: the negative consequences of too much concentration of economic power." [1]

[1] Carolyn W. Madden, *Excess Capacity: Markets, Regulation, and Values* Health Services Research, Vol. 33, no. 6 (Feb. 1999), p. 1663.

Competition has been demonstrated to correlate with lower average costs for hospitals in more competitive markets, as compared to costs in less competitive markets.[1] Healthy competition gives economic power to patients and payers by creating consumer choices and by raising quality standards as providers and payer compete for patient loyalty, raise quality, and lower costs.

Without healthy competition and patient choice, decisions about access, quality, and beneficial outcomes can be made by monopoly or oligopoly providers in the market, who, without strong competition, can ignore patient demands and needs.

[1] J. Zwanziger, G. Melnick G, & A. Bamezai, *California Providers Adjust to Increasing Price Controls*, in *Health Policy Reform: Competition and Controls*, AEI Press, 1993, p. 241-258.

Conclusion

n CON is a complex issue as illustrated by the diversity of this commission. Factual information is difficult to obtain.

n In my comments today I have tried to present as much objective information as possible with references where appropriate.

n From the information presented it seems that CON is not critical to maintaining cost control and may be detrimental.

n Competition is certainly limited and the benefits of a free market are restricted in that environment.

n Patient access to health care, innovation created by competition, and ongoing cost control do not appear to be fostered by the present regulatory environment.

CON COMMISSION TESTIMONY

August 8, 2005

Deborah J. Winegard
Medical Association of Georgia
General Counsel

I. Introduction

A. Thanks

B. MAG

1. Largest physician organization in the state, the voice of medicine
2. MAG's Mission: to enhance patient care and the health of the public by advancing the art and science of medicine
3. Clear interest in the work of the Commission

C. Goal of Testimony

1. Demonstrate the clear public policy interest in enhancing the ability of Georgia's patients to receive high quality care at physician-owned ambulatory surgery centers and diagnostic and treatment facilities
 - a. Interest of patients because receive high-quality care at convenient times and locations
 - b. Interest of employers and taxpayers who fund healthcare because cost of care at physician owned centers is much less than in a hospital setting.
2. Demonstrate how the current CON Act and regulations have been used as an anticompetitive tool by certain hospitals to squelch competition from physician-owned centers
3. Make specific recommendations to the Commission for revising CON Act

II. Background

A. National Health Planning and Resources Development Act

1. Belief that supply for healthcare services created demand for Services

2. Therefore, controlling the number of facilities would help control
The amount of healthcare services sought and consequently the costs.
3. Theory that “practice makes perfect:” the more procedures
Performed, the more expertise
4. Law was repealed in 1985
5. Sixteen states have abolished CON laws

B. FTC DOJ Report

1. CON NOT effective in controlling health care costs
2. CON erodes consumer welfare
--inhibits innovation and alternatives to costly treatments
3. Urges states to reconsider whether CON programs are effective
4. “The Agencies believe that, on balance, CON programs are not successful in containing healthcare costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent’s market.Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns.” (p. 20)

C. Georgia’s CON Act

1. Need a CON to develop a “new institutional health service”
O.C.G.A. 31-6-40(a)
2. Ambulatory surgery is considered a “new institutional health service” except that “surgery performed in the offices of an individual private physician or single group practice of private physicians if such surgery is performed in a facility that is owned, operated, and utilized by such physicians who are also of a single specialty and the capital expenditure associated with the construction, development, or other establishment of the clinical health service does not exceed...” the then current capital expenditure.

3. What does this mean?
 - a. Physician-owned single specialty ambulatory surgery Centers do not need a CON
 1. Instead, they typically apply for a letter of non-reviewability, commonly referred to as an “LNR” which states that their project qualifies for the exemption
 2. Keep in mind: THERE IS NOTHING IN THE CON ACT ABOUT LNRs; they are simply a regulatory creation
 - b. CONs are likewise not required for surgery performed in physicians’ offices
 - c. CONs are required for
 1. Physician-owned multi-specialty amburg centers
 2. Centers constructed for more than the capital threshold (currently \$1.5 million)
 3. And, because DCH arbitrarily classifies general surgery as a multi-specialty, amburg centers for general surgery
 4. CONs required for diagnostic and therapeutic equipment costing more than the capital threshold (currently \$775,103)
4. Alliance consistently refers to the exemption for physician owned Centers as an “unintended loophole”
 - a. Disagree
 - b. When construing legislative language, courts also look at the clear meaning of words
 - c. “this provision shall not applyif such surgery is performed in a facility that is owned, operated, and utilized by such physicians who are also of a single specialty and the capital expenditure association with the construction, development, or other establishment....does not exceed....”

III. Physician Owned AmbSurg Centers are in the Public Interest

A. Why?

1. High quality care
2. Lower cost to payors of healthcare services than care provided in the hospital setting
3. Access to state-of the art equipment in convenient locations
4. Tool to recruit specialists to rural areas, benefiting both patients in those areas and the economy.
5. Summary of public policy reasons for promoting amburg centers expressed in the November 18, 2003 draft component state health plan: “The increase in the number of surgeries performed in freestanding ASCs has outpaced the growth of hospital outpatient departments and physician offices. Payor incentives, patients convenience, and physician preference can be attributed to the growth in the volume of surgeries performed in freestanding outpatient settings. Payors may cover more of the cost for patients that receive services in an ambulatory surgery center. Some data suggest that patients may prefer the more convenient locations, lower insurance co-payments, decreased exposure to infectious agents, and timely appoint scheduling that are provided by ambulatory surgery centers.”

B. Quality

1. Talk about quality solely in the context of public interest.
--CONs are not awarded to all quality facilities that apply; rather awarded based on need.
2. Alliance says that physician owned amburg centers are not regulated
--not accurate: ORS responsible for licensing ASCs
 - a. ORS conducts annul surveys to assure that ASCs meet exacting physical and operational standards designed to protect patients, staff and visitors.
 - b. ORS also surveys ASCs which seek Medicare reimbursement every three years for Medicare certification purposes.

- c. Most private health plans require that ASCs be accredited by a nationally recognized organization, such as the Joint Commission for Accreditation of Healthcare Organizations (“JCAHO”) or the Association for Accreditation of Ambulatory Healthcare (“AAAHC”)
3. Department of Health and Human Services, Office of the Inspector General Report found that quality of care provided in freestanding amburg centers is comparable to care provided in the hospital setting.
4. Studies cited by Alliance relate to issues with quality in office-based surgery NOT with respect to amburg centers.

[OIG reports criticize some states’ oversight of amburg centers NOT quality of care at amburg centers.]

5. There is also considerable evidence showing that CON regulations generally tend to negatively impact the quality of care delivered because they delay the entry of entities that could provide higher quality services than existing facilities..
 - a. FTC stated as early as 1988, that CON regulations “foster lower quality and reduced innovation in health care markets.” (FTC Bureau of Economics, Staff Comments to Georgia State Senator Culver Kidd, March 7, 1988)
 - b. Georgia State University study concluded that CON regulations have “lowered the quality of healthcare services” and that there is “little or no evidence that states with CON regulations have access to care or higher quality of care than states without CON regulation.”
 - c. One study examining the causal relationship between CON regulations and the quality of care determined that states with rigorous CON regulations had mortality rates 6% higher than states without rigorous CON regulations among Medicare patients.
6. Alliance of Community Hospitals regularly attempt to argue that quality of care is lower in freestanding amburg centers based on studies examining surgery in physicians offices NOT in amburg centers where licensure works to assure quality.

C. Lower Costs

1. Generally recognized that cost of providing care at a freestanding ASCs much less than providing care in a hospital.
2. OIG Report: "ASCs can significantly reduce the costs for Federal healthcare programs, while simultaneously benefiting Patients."
3. GA Medicaid currently pays twice as much for ambulatory surgery performed in hospitals as opposed to freestanding ASCs.

D. Consistent with general information that CON laws increase costs

1. FTC/DOJ Report
2. 1987 study showed that hospital expenses higher in states with CON laws.
3. GA State University study concluded that CON regulation is "ineffectual in restraining health care costs." That study also looked at 16 studies and found that only one of them found a decrease in costs in CON states and that study was methodologically flawed.

E. Respond to GHA and Alliance of Community Hospitals Argument that physician-owned ASCs are not in the public interest because these facilities "cherry pick" patients, allegedly siphoning off revenues necessary to keep ERs open.

1. Not accurate: physicians feel an obligation and DO treat indigent and Medicaid patients.
2. Hospitals forget that it is PHYSICIANS who provide the care in ER, often in the middle of the night and without pay whereas the hospitals can and do collect from the Indigent Care Trust Fund.

IV. Current Law Has Been Used Anticompetitively to Stymie Development of Physician Owned Centers

A. Reminder: The CON Act does not contain ANY mention of LNRs.

1. Rather, the CON Act creates an exception for single specialty physician owned amburg centers constructed for less than the capital threshold.
2. THERE SHOULD BE NO ROLE FOR COMPETITORS IN THIS PROCESS.

B. Stated Goal of Community Hospitals: To stop the “proliferation” of physician-owned amburg centers

C. How are They Seeking to Accomplish this Goal?

1. Filing Mandamus Actions in Court Seeking Orders directing DCH to rescind the LNRs.
2. According to a recent deposition of Monty Veazy, the Alliance files these actions in any case in which a physician owned center would compete with one of its member hospitals and they would do this even if the impacted hospital did not support the challenge!
3. Moreover, the Alliance is using these actions to conduct wide ranging discovery even though a mandamus action is supposed to be limited to the administrative record below.
4. Filing these actions every time an LNR is granted even though the legal standard is gross abuse of discretion.
5. Impact:
 - a. Patients deprived of ability to get high quality care from the physician of their choice in a physician owned center
 - b. Increased costs to healthcare system through unnecessary legal costs--by the way, the Alliance always seeks to recover their legal fees
 - c. Unnecessary costs to taxpayers because state has to expend resources to defend these actions, including the cost of responding to significant discovery

D. Other Anticompetitive Behaviors

1. TAC

- a. Physician interests consistently outvoted by hospital interests
- b. e.g. interventional radiology not added as single specialty despite testimony that cancer patients need access to this specialty and many hospitals don't have the equipment.

2. General Surgery

- a. General surgery is universally recognized as a separate specialty by organized medicine.
- b. Separate residency; specific board
- c. Even DCH qualifies general surgery as single specialty for annual hospital survey forms
- d. Court of Appeals decision stands only for the proposition that DCH had the authority classify general surgery as a single specialty, not that DCH could never change its rules and in fact DCH has changed its rules since CON Act was amended.
- e. Despite that, lobbying efforts to persuade DCH not to change rule to add general surgery

V. Recommendations

- A. Eliminate CON Review for ALL Physician Owned Ambulatory Surgery Centers
- B. Eliminate the capital threshold for diagnostic and therapeutic equipment.
- C. If Commission is not willing to go that far
 1. Increase capital threshold for amburg centers.
 2. Allow the development of multispecialty amburg centers and centers offering general surgery.
 3. Increase threshold on diagnostic and therapeutic equipment.

MINUTES
STATE COMMISSION ON THE EFFICACY OF CON
August 8, 2005

APPENDIX B

UPCOMING MEETING SCHEDULE

Upcoming Meeting Schedule

Meeting Dates

September 2005

September 13, 2005

Long Term Care Providers

Skilled Nursing Homes

Georgia Healthcare Association
160 Country Club Drive
Stockbridge, Georgia 30281

Continuing Care Retirement Communities (CCRC)

American Association of Homes & Services for the Aging (AAHSA)

Personal Care Homes

Georgia Assisted Living Federation of America
115 Grayson Industrial Parkway, Suite 6
Grayson, Georgia 30017

Home Health Services

Georgia Association for Home Health Agencies
2100 Roswell Road
Suite 200C-PMB 1107
Marietta, Georgia 30062

October 2005

October 2005

Specialized Providers

Psychiatric & Substance Abuse Services
Comprehensive Inpatient Physical Rehabilitation
Long Term Acute Care Services
Traumatic Brain Injury Services

17th, 24th & 26th

Possible Presenters

Provider Associations
Professional Physician Associations (i.e. Radiologists, Oncologists, Cardiologists, etc.)

November 2005

November 2005

Other Specialized Service Providers

Radiation Therapy (Linear Accelerator, GAMMA Knife, Cyber Knife, Trilogy, X-Knife, etc.)
Imaging (MRI, PET, CT, etc.)
Cardiac Services: Open Heart (Adult & Pediatric)
Cardiac Catheterizations (Diagnostic & Therapeutic)
Perinatal Services

15th, 21st & 22nd

Possible Presenters

Hospital Associations
Professional Physician Associations (i.e. Radiologists, Oncologists, Cardiologists, etc.)

December 2005

December 2005

Other Interested Parties

Advocacy Groups
Department of Human Resources - Office of Regulatory Services
Department of Community Health
Indigent Care Trust Fund
Office of Rural Health Services
Composite Board of Medical Examiners
Physician Workforce

12th, 14th & 16th